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Les indicateurs de la qualité des soins en France et à l'étranger

Bibliographie thématique

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Synthèses & Bibliographies

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Sommaire

Problématique

La qualité des soins et l'accès aux soins sont très souvent considérés par les patients comme les éléments essentiels de la performance d'un système de santé. Par ailleurs, la qualité des soins préoccupe les acteurs des systèmes de soins de nombreux pays, quels que soient le système ou la structure de financement. Cette priorité s'est d'abord imposée dans les pays anglo-saxons, avant de s'inviter en France avec les ordonnances de 1996.[1]

La qualité des soins est un concept multidimensionnel [2]. Bien que la capacité à définir la qualité des soins se soit beaucoup améliorée ces dernières années grâce aux travaux internationaux, il existe en effet de nombreuses définitions[3].

Donabedian, un pionner des travaux dans ce domaine, parle de la qualité à propos de soins qui « maximisent le bien-être des patients après avoir pris en compte le rapport bénéfice/risque à chaque étape du processus de soins »[4].

L'Organisation mondiale de la santé (OMS) définit la qualité comme la capacité de « garantir à chaque patient l'assortiment d'actes thérapeutiques […] lui assurant le meilleur résultat en termes de santé, conformément à l'état actuel de la science, au meilleur coût pour le même résultat, au moindre risque iatrogénique, pour sa plus grande satisfaction en termes de procédures, résultats, contacts humains…[5] ».

L'Organisation de coopération et de développement économiques (OCDE) définit la qualité de soin ainsi : « La mesure dans laquelle les services de santé aux individus et aux populations augmentent les probabilités d'obtenir les résultats de santé attendus et qui tiennent compte des connaissances actuelles ». La notion de qualité des soins englobe l'efficacité des soins, la sécurité des patients et les soins axés sur le patient.[6]

Mais la définition la plus largement admise vient de l'Institut de médecine des Etats-Unis (IOM) qui précise que la qualité est « la capacité des services de santé destinés aux individus et aux populations d'augmenter la probabilité d'atteindre les résultats de santé souhaités, en conformité avec les connaissances professionnelles du moment »[7].

[1] Ordonnance n° 96-246 du 26 avril 1996 (suite au plan Juppé)
[2] Minvielle (2013). Comment évaluer et réguler la performance en matière de qualité de la prise en charge des malades ? Quaderni, n° 82.
[3] Or Z. et L. Com-Ruelle (2008). La qualité des soins en France : comment la mesurer pour l'améliorer ? Journal d'économie médicale, 26, n° 6.
[4] Donabedian A. (1980). The definition of quality and approaches to the management, vol. 1 : Explorations in quality assessment and monitoring. Ann Arbor : Health Adminstration Press.
[5] Roemer MI, Montoya-Aguilar C. (1988). Quality assessment and assurance in primary health care. OMS Offset Publication, n° 105.
[6] Kelley E, et J.Hurst (2013). Health Care Quality Indicators Project Conceptual Framework Paper. Paris : OCDE
[7] Institute of Medicine (2001). Crossing the quality chasm : A new health system for 21st century. Washington DC : National Academy Press.

Cette définition est largement acceptée par la communauté internationale grâce à sa flexibilité et son adaptabilité à des contextes différents[8]. Mais selon la définition adoptée, l'analyse de la qualité et les stratégies d'amélioration sont plus ou moins restreintes. Par exemple, la définition de l'IOM est plus limitée que celle de Donabedian qui vise à maximiser le bien-être des patients, mais plus large en termes d'approches puisqu'elle intégre la promotion de la santé et la prévention, pour les individus et la population, en plus des soins curatifs destinés aux patients. Par ailleurs, la définition de l'OMS introduit la notion de coût : « Au meilleur coût », tandis que l'IOM défend que la préoccupation des ressources disponibles ne doit pas intervenir dans la définition de la qualité.

De plus, la définition de la qualité a évolué au cours de ces dernières années, en intégrant le point de vue des acteurs, et notamment des patients. La plupart des pays occidentaux ont alors investi dans des agences spécifiques pour développer des visions et des stratégies de qualité des soins selon les priorités et les possibilités nationales. Des cadres conceptuels exprimant les valeurs de qualité et les dimensions prioritaires se sont ainsi développés au niveau national et international afin de mettre en place et de suivre des politiques complètes et cohérentes. Dans le cadre du projet « Health care quality indicators », l'OCDE a élaboré une série d'indicateurs de la qualité qui seraient comparables à l'échelle internationale

L'objectif de cette bibliographie est donc de recenser des sources d'information (ouvrages, rapports, articles scientifiques, littérature grise, sites institutionnels…) sur les indicateurs de la qualité des soins pour la période s'étendant de 2000 à mars 2018.

Le périmètre géographique retenu concerne les pays industrialisés.

Les recherches bibliographiques ont été réalisées sur les bases suivantes : Base bibliographique de l'Irdes, Banque de données santé publique (BDSP), Cairn, Medline et Econlit.

Lorsque les requêtes de recherche rapportaient plus de 1 000 références dans la littérature scientifique notamment anglo-saxonne, la sélection s'est orientée vers les revues de la littérature (review, systematic review, literature review, scopus review) et les documents accompagnés de résumé.

Les aspects ciblés sont les suivants :

- Présentation des indicateurs : définition, conception et mise en œuvre ;
- Impact des modes de rémunération (paiement à la performance, tarification hospitalière, bundled payment..) sur la qualité des soins ;
- Impact de la diffusion des indicateurs sur l'amélioration de la qualité.

Les références bibliographiques sont présentées par ordre alphabétique d'auteurs et/ou de titres.

[8] Or Z. et L. Com-ruelle (2008). La qualité des soins en France : comment la mesurer pour l'améliorer ? Journal d'économie médicale, 26, n° 6.

Les indicateurs de la qualité des soins : définitions, conception et mise en œuvre

ÉTUDES FRANÇAISES

Abad, M. et Johanet, S. (2015). "Synchroniser les temps des acteurs autour du patient pour conjuguer qualité des soins, bien-être au travail et efficience économique." Journal De Gestion Et D'economie Medicales **33**(2): 107-108.
https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2015-2.htm

> [BDSP. Notice produite par ORSRA mklR0xIq. Diffusion soumise à autorisation]. Pour mesurer l'impact d'une amélioration de la synchronisation des temps médicaux et non médicaux autour du patient hospitalisé, les auteurs ont accompagné onze établissements de santé. Dans ces derniers, des actions de synchronisation des temps des professionnels ont été mises en oeuvre dans les structures les plus sensibles : blocs opératoires, hospitalisation conventionnelle et ambulatoire, consultations externes, etc. Les auteurs analysent les effets induits sur ces sites de production de soins par une meilleure synchronisation des temps médicaux et non médicaux. Le soin réalisé par une équipe hospitalière est l'aboutissement d'une intervention collective. Mais collectif ne veut pas dire coordonné. Pour autant si de nombreuses publications font état d'une relation entre la sécurité des soins et la qualité de la communication au sein de l'équipe hospitalière, le sujet des impacts de la synergie temporelle des soignants autour du patient paraît encore très peu exploré. Le projet d'accompagnement au développement de la synchronisation des temps médicaux et non médicaux a concerné onze établissements de santé essentiellement publics. (résumé auteur).

Ammi, M. et Peyron, C. (2015). Heterogeneity In General Practitioner's Preferences for Quality Improvement Programs: A Choice Experiment And Policy Simulation in France. Working paper series ; 150020. Toronto Canadian Centre for Health Economics**:** 37 , tabl., fig.

> Despite increasing popularity, quality improvement programs (QIP) have had modest and variable impacts on enhancing the quality of physician practice. We investigate the heterogeneity of physicians' preferences as a potential explanation of these mixed results in France, where the national voluntary QIP - the CAPI - has been cancelled due to its unpopularity. We rely on a discrete choice experiment to elicit heterogeneity in physicians' preferences for the financial and non-financial components of QIP. Using mixed and latent class logit models, results show that the models should be used in concert to shed light on different aspects of the heterogeneity in preferences. In particular, the mixed logit demonstrates that heterogeneity in preferences is concentrated on the pay-for-performance component of the QIP, while the latent class model shows that physicians can be grouped in four homogenous groups with specific preference patterns. Using policy simulation, we compare the French CAPI with other possible QIPs, and show that the majority of the physician subgroups modelled dislike the CAPI, while favouring a QIP using only non-financial interventions. We underline the importance of modelling preference heterogeneity in designing and implementing QIPs.

Bahrami, S., et al. (2005). COMPAQH : Conception et rôle des indicateurs de qualité dans l'évaluation des pratiques professionnelles : l'expérience COMPAQH. Paris CREGAS (Inserm)**:** 33 , 33 ann., 33 graph., 31 tabl.
http://ifr69.vjf.inserm.fr/compaqh/docs/EPP.pdf

Le comité de pilotage du projet COMPAQH a adopté le respect des bonnes pratiques cliniques parmi ses huit Objectifs Prioritaires. Pour répondre à cet objectif, l'équipe de coordination a développé un ensemble d'indicateurs de bonnes pratiques professionnelles, dans ce cadre méthodologique toujours ouvert. Des options ont été prises, avec la montée en charge, en 2005, de la collecte des données relatives à ces indicateurs, il devenait nécessaire d'expliciter les options prises. Ce rapport poursuit ainsi un double objectif : - décrire l'état de l'art en matière de construction d'indicateurs de bonnes pratiques cliniques, à partir d'une revue systématique de la littérature ; - présenter le positionnement du projet COMPAQH sur l'ensemble des points décrits. Ainsi, la première partie de ce rapport est consacrée à la stratégie de la recherche documentaire. La deuxième partie précise quelques définitions et concepts qui permettent de positionner les indicateurs de qualité dans le champ de l'évaluation des pratiques professionnelles, et dans celui plus général de l'évaluation de la qualité des soins. Sont notamment distinguées les deux acceptions possibles du terme "indicateur de qualité", selon que l'indicateur est perçu comme un outil (acception étroite) ou comme une méthode (acception large). Les auteurs expliquent également comment la "méthode indicateurs" s'appuie sur l'outil. Les chapitres 3 et 4 abordent successivement les éléments spécifiques à la méthode, puis à l'"outil indicateur". Enfin, le chapitre 5 décrit les différents modes d'utilisation envisageables de la "méthode indicateurs", l'objectif final étant, bien entendu, l'amélioration de la qualité des pratiques professionnelles (d'après l'introduction de l'auteur).

Beaulieu, M.-D., et al. (2015). "Élaboration d'indicateurs de qualité pour soutenir la gestion des maladies chroniques." Sante Publique **27**: 67-75, tabl., graph.

[BDSP. Notice produite par EHESP BR0x8DA8. Diffusion soumise à autorisation]. Cet article présente le résultat de la démarche suivie par l'Institut national d'excellence en santé et en services sociaux du Québec pour élaborer des indicateurs de qualité de la prise en charge de six maladies chroniques fréquentes. Un total de 164 indicateurs ont été élaborés. Une bonne convergence entre les patients et les professionnels sur la pertinence d'une majorité d'indicateurs est établie. Les professionnels ont émis des réserves sur les indicateurs mesurant l'expérience de soins des patients sous forme de questionnaires, les jugeant trop subjectifs. Le recours au Modèle de gestion des maladies chroniques a contribué à enrichir l'éventail des indicateurs. Les consultations ont permis de mieux comprendre certaines réserves des professionnels quant à certains indicateurs ce qui contribuera à faciliter le travail d'appropriation.

Begaud, B., et al. (2017). Les données de vie réelle, un enjeu majeur pour la qualité des soins et la régulation du système de santé : L'exemple du médicament. Paris La documentation française**:** 105 , tab., graph., fig.
http://www.ladocumentationfrancaise.fr/rapports-publics/174000870-les-donnees-de-vie-reelle-un-enjeu-majeur-pour-la-qualite-des-soins-et-la-regulation?xtor=EPR-526

Ce rapport sur le suivi en vie réelle des médicaments est basé sur des données issues de la prescription, de la délivrance et de la consommation des médicaments par les patients. Il est le fruit de réflexions menées avec un groupe de travail associant toutes les parties prenantes : autorités de santé, assurance maladie obligatoire et complémentaire, usagers, professionnels de santé, industriels, chercheurs. Le rapport souligne qu'avec la révolution numérique et les possibilités croissantes de collecte et d'analyse d'informations qu'elle permet, la production et l'utilisation de données observationnelles deviennent un objectif stratégique pour tous les systèmes de santé et renouvellent l'approche traditionnelle des études sur les médicaments, historiquement centrées sur les essais cliniques. Agnès Buzyn a décidé de constituer un groupe de travail entre les services du ministère, la Cnamts et la HAS

pour travailler sur les modalités d'évaluation des médicaments. Celui-ci devra préparer la mise en œuvre des propositions formulées par Bernard Bégaud, Dominique Polton et Franck von Lennep. Il devra également travailler à d'autres pistes de réforme en ce domaine, en rouvrant notamment le chantier lancé par le rapport sur l'évaluation du médicament remis par Dominique Polton en novembre 2015.

Belorgey, N. (2011). "« Réduire le temps d'attente et de passage aux urgences ». Une entreprise de « réforme » d'un service public et ses effets sociaux." Actes de la recherche en sciences sociales **189**(4): 16-33.
http://www.cairn.info/revue-actes-de-la-recherche-en-sciences-sociales-2011-4-page-16.htm

Berard, E., et al. (2009). "Usages des indicateurs de qualité en établissement de santé." Journal D'economie Medicale **27**(1-2): 5-20, rés., tabl.

[BDSP. Notice produite par ORSRA pBj78R0x. Diffusion soumise à autorisation]. Actuellement les indicateurs de qualité se multiplient au sein des établissements de santé. Au niveau national, les régulateurs de soins souhaitent en généraliser l'usage, dans le cadre de procédures de traitement annuelles avec publication de résultats comparatifs. Ainsi que nous l'expliquons, les indicateurs sont associés à une "doctrine d'usage" : ils sont censés produire certains effets. Pour les régulateurs de soins, les indicateurs qualité ont vocation à être utilisés comme outils de reporting, permettant d'avoir une vue d'ensemble de la situation des établissements de santé. Pour les établissements, les indicateurs ont vocation à être utilisés comme des supports pour le diagnostic et pour l'action, dans un objectif d'amélioration de la qualité. La question à laquelle cet article s'intéresse est de savoir quelles sont les pratiques d'usage de ces indicateurs, au sein des établissements de santé. L'article cherche à établir si les outils font l'objet d'une pratique bureaucratique, ou bien d'un usage à des fins de pilotage pour l'action. Les résultats de l'étude de cas font apparaître que les mêmes indicateurs peuvent faire à la fois l'objet d'un usage bureaucratique, et être effectivement utilisés de manière opérationnelle par l'établissement. Par ailleurs, il est difficile de déterminer quel rôle joue l'utilisation des indicateurs par les pouvoirs publics. Enfin, la légitimité de l'indicateur comme artefact ne détermine pas l'usage qui sera fait de cet outil de gestion. En revanche, il semble que la nature des résultats obtenus constitue une incitation directe à l'action de la part des établissements.

Bérard, É., et al. (2009). "Usages des indicateurs de qualité en établissement de santé." Journal D'economie Medicale **27**(1-2): 5-20.
http://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales1-2009-1-page-5.htm

Berthelot, P., et al. (2008). "Lutte contre les infections nosocomiales : indicateurs, information des usagers et impact sur l'amélioration de la qualité des soins." Techniques Hospitalieres(712): 49-52.

[BDSP. Notice produite par EHESP R0xFq7F8. Diffusion soumise à autorisation]. Dans un souci de transparence en direction des usagers du système de santé, le ministère de la santé a souhaité mettre en place des indicateurs relatifs à la lutte contre les infections nosocomiales. Parmi les cinq indicateurs qui composeront à terme le tableau de bord des IN, trois ont été publiés en 2006,2007 et 2008 : l'Icalin (indicateur composite des activités de lutte contre les infections nosocomiales), l'Icsha (indicateur de la consommation des solutions hydro-alcooliques), l'IcaTB (indicateur de consommation des antibiotiques). Après avoir souligné les limites des indicateurs retenus et le danger d'une comparaison entre établissements, l'auteur répond à la question suivante : la diffusion de ces indicateurs permet-t-elle une meilleure information des usagers et par là une amélioration de la qualité des soins ?

Bertillot, H. (2015). Quand l'évaluation modifie les institutions. Comment l'hôpital est transformé par les indicateurs qualité. Paris SciencesPo - LIEPP**:** 6 ,fig.

> Ces dernières décennies, le secteur hospitalier français a fait l'objet de nombreuses réformes, dans l'ambition affichée de rationaliser son fonctionnement. Parmi celles-ci, le déploiement de nouveaux instruments de tarification (T2A) fait l'objet de toutes les attentions et de toutes les critiques. Pourtant, dans l'ombre de ces réformes à forte visibilité, se joue depuis la fin des années 1990 un autre mouvement majeur, opérant à bas bruit autour du déploiement d'instruments d'évaluation de la qualité des soins. Ce fascicule prend pour objet le déploiement d'indicateurs qualité (IQ) dans les établissements français depuis le milieu des années 2000. Construits comme une technologie douce pour rationaliser l'hôpital sans faire de vague, ces instruments colonisent les établissements français avec discrétion. Ils y instillent pourtant des changements décisifs : traçabilité accrue du soin, enracinement local de la médecine des preuves et auditabilité croissante de l'hôpital.

Bertrand, E. d. et Schlatter, J. d. (2017). Qualité et sécurité en établissement de santé : panorama de la gestion des risques en France - 2017, Bordeaux : LEH Édition

> Depuis plusieurs années, la gestion des risques a trouvé sa place dans les organisations complexes que sont les établissements de santé en France. Il s'agit néanmoins d'une notion «?récente?» qu'il faut encore définir, faire découvrir et surtout légitimer. Pour anticiper et agir face aux agressions potentielles, tous les acteurs, qu'ils soient ingénieurs, médecins, cadres de santé, infirmières ou directeurs, ont besoin d'outils méthodologiques pour identifier et réduire les risques liés à leur activité. Cet ouvrage se veut une cartographie de l'état actuel des risques en établissement de santé. Pour cela, il se veut très pratique et composé de deux parties principales. Une première partie est consacrée à des thématiques générales et une seconde partie aux risques vécus ou perçus directement dans des services cliniques ou médico-techniques. L'ouvrage est divisé en chapitres dont chacun est rédigé par un ou des auteur(s) spécialisés et reconnus dans leur domaine. Les thèmes abordés offrent une vision très diversifiée, allant du risque médical aux questions épidémiques, évoquant même la cybercriminalité. Le fil conducteur du livre est la perception de chaque auteur sur les risques précis uniquement dans les établissements de santé.

Besombes, B., et al. (2007). "Évaluation de la performance. Élaboration d'un tableau de bord d'aide au pilotage du plateau médico-technique." Gestions Hospitalieres(465): 261-269, graph., tabl.

> [BDSP. Notice produite par ENSP KjR0x0i6. Diffusion soumise à autorisation]. Dans le cadre d'un projet de recherche pluridisciplinaire associant plusieurs laboratoires et des partenaires hospitaliers de la région Rhône-Alpes, les auteurs se sont intéressés à l'accompagnement du changement et à l'aide à la décision dans le cadre des regroupements des services hospitaliers. Basé sur une expérimentation avec le CHU de Saint-Étienne, l'objet de cet article concerne plus particulièrement la problématique de la mise en place d'indicateurs de performance pour le pilotage des plateaux médico-techniques. La description de l'organisation fonctionnelle et décisionnelle, ainsi que la mise en place d'indicateurs de performance soulignent les enjeux du partage de ressources et de la décision dans le mode de management, tant dans la phase de conception du PMT que lors de son pilotage et de sa conduite.

Bonastre, J., et al. (2013). "Activité, productivité et qualité des soins des hôpitaux avant et après la T2A." Questions D'economie De La Sante (Irdes)(186): 8.
http://www.irdes.fr/Publications/Qes2013/Qes186.pdf

Introduite en 2004-2005, la tarification à l'activité (T2A) permet de financer l'activité de court séjour des hôpitaux publics et privés afin d'améliorer l'efficience des établissements de santé et du secteur hospitalier. Pour autant, le suivi de l'impact de la T2A sur l'évolution de l'activité, de la productivité hospitalière et de la qualité des soins restait partiel à ce jour. Cette étude fournit de nouvelles données et analyses quantitatives permettant de répondre à différentes questions : la mise en place de la T2A a-t-elle permis d'accroître la productivité ? La structure de la production a-t-elle été modifiée ? Comment la qualité des soins a-t-elle évolué ?

Bonastre, J., et al. (2017). "L'accès aux soins en cancérologie : évolution de l'offre et recours aux soins entre 2005 et 2012." Questions D'economie De La Sante (Irdes)(221): 8.
http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/221-l-acces-aux-soins-en-cancerologie-evolution-de-l-offre-et-recours-aux-soins-entre-2005-et-2012.pdf

Avec près de 355 000 nouveaux cas par an, la prise en charge des cancers représente un défi tant en termes médical qu'économique. Au cours des dix dernières années, l'offre de soins en cancérologie a connu une importante restructuration, d'une part sous l'effet de la Tarification à l'activité (T2A) comme mode de financement des hôpitaux, d'autre part à la suite de la mise en place de seuils d'activité minimale, sans que l'on ne connaisse aujourd'hui les répercussions en termes de redistribution des activités de cancérologie sur le territoire, d'accès géographique et de qualité des soins. L'évolution de l'offre de soins hospitaliers en cancérologie entre 2005 et 2012 est décrite ici pour les structures pratiquant la chirurgie des cancers et la chimiothérapie. Les effets de la recomposition de l'offre en cancérologie sont examinés à partir de l'évolution des distances d'accès et des taux de recours départementaux.

Borgès Da Silva, G. (2003). "La qualité des soins en hôpital psychiatrique : revue de la littérature et perspectives." Sante Publique **15**(2): 213-222.
http://www.cairn.info/revue-sante-publique-2003-2-page-213.htm

Dans les établissements hospitaliers, l'existence de référentiels de bonne pratique pourrait permettre de construire un plan cohérent d'amélioration de la qualité des soins. Une requête sur les bases bibliographiques francophones montre une faible fréquence de publications d'audit interne sur la pertinence des soins. Pourtant notre expérience d'audit externe montre l'intérêt de l'évaluation de la qualité des soins en hôpital psychiatrique. Nos études constatent le non respect fréquent des règles d'utilisation des psychotropes et l'importance de l'exposition aux risques iatrogènes des patients. Il existe un hiatus entre la richesse des référentiels et leur faible utilisation, par les établissements, dans les plans d'amélioration de la qualité et donc dans les publications des professionnels concernés. L'analyse de la pertinence de la décision médicale est peu acceptée. La pratique clinique est encore considérée comme un art alors qu'elle est devenue une technique faisant appel à l'expérience collective des pairs.

Bounekkar, A. et Lamure, M. (2004). "Indicateurs de performances dans les établissements hospitaliers." Journal D'economie Medicale **22**(7-8): 393-402, rés., tabl., fig.

[BDSP. Notice produite par ORSRA gehcR0xt. Diffusion soumise à autorisation]. Ce travail rentre dans le cadre d'un projet régional concernant l'aide à la décision pour le regroupement, la mutualisation et le pilotage de plateaux médico-techniques. Nous avons donc défini et mis en place des indicateurs de performances, en collaboration avec les médecins des établissements concernés. Les salles de chirurgie sont au centre du plateau médico-technique, tel qu'il est défini dans le cadre de ce travail. Les salles d'opération ne

sont pas utilisées en continu en raison de plusieurs facteurs. Nous avons mis au point des indicateurs de "fragmentation" du temps relatifs au temps de débordement, de non-utilisation, de perte, etc. (résumé d'auteur).

Bourgain, J.-L. (2012). "Performance du bloc opératoire. Apport de la check-list de sécurité à la performance du bloc opératoire." Gestions Hospitalieres(514): 174-176, tabl.

[BDSP. Notice produite par EHESP IpoR0xs9. Diffusion soumise à autorisation]. Depuis quelques années, nous assistons à un bouleversement de l'organisation hospitalière : initialement centré sur le chef de service, omnipotent, le système devient centré sur le parcours patient et les démarches qualité. Les services sont maillés avec des outils communs, des interconnexions et des indicateurs qualité partagés. Dès lors, les acteurs partagent leurs expériences autour de la prise en charge globale, pour un maximum d'efficacité et d'efficience médicale. (intr.).

Bousquet, F. (2004). "Quelles problématiques et quels indicateurs pour construire l'évaluation de la tarification à l'activité ?" Dossiers Solidarite Et Sante(1): 45-58.

La mise en oeuvre de la tarification à l'activité dans les établissements de santé est un exemple de la nécessité d'évaluer les objectifs atteints ou à atteindre dans le cadre d'une réforme des politiques publiques. La difficulté de l'exercice réside notamment dans le choix des outils et des moyens à mobiliser pour parvenir à cet objectif "d'évaluation". Dans le cas de la tarification à l'activité, les objectifs assignés à la réforme ont été définis de la façon suivante : une plus grande médicalisation du financement, une responsabilisation plus importante des acteurs, une équité de traitement entre les secteurs publics et privés et enfin le développement d'outils de pilotage économique visant à une rationalisation de la gestion. Après avoir présenté les objectifs qui doivent sous-tendre l'évaluation, l'auteur analyse les propositions de techniques et de méthodes qui permettraient d'en d'aborder de manière cohérente les différents aspects au fur et à mesure de la montée en charge de la réforme.

Bousquet, F. et Burnel, P. (2006). "Indicateurs et certification. Nouvelle donne pour la troisième version." Revue Hospitaliere De France(513): 31-34.

[BDSP. Notice produite par EHESP J8CEIR0x. Diffusion soumise à autorisation]. Les indicateurs s'imposent dans un grand nombre de pays développés comme de nouveaux outils incontournables de l'amélioration de la qualité en santé. Relativement récent et assez spectaculaire, ce développement cherche à renforcer les méthodes plus traditionnelles (accréditation, recommandations de bonnes pratiques...) et à accroître la transparence du système de soins en matière de qualité. Les modalités d'utilisation de ces indicateurs sont diverses. Certaines, comme leur diffusion publique afin d'informer les usagers, font encore débat. En revanche, le consensus est fort sur leur utilité en matière de pilotage de la performance qualité au sein des établissements. La procédure de certification ne pouvait donc ignorer leur intérêt. La direction de l'accréditation de la Haute Autorité de Santé étudie deux pistes : l'intégration des indicateurs comme éléments d'information supplémentaire et suivis dans le temps, et leur utilisation à des fins de reconfiguration de la procédure.

Bras, P. L. (2012). "Hôpitaux : vers un même niveau d'exigence pour la performance qualité que pour la performance économique ?" Seve : Les Tribunes De La Sante(35): 29-41.

La tarification à l'activité adresse aux établissements de santé une incitation puissante à rechercher la performance économique. Celle-ci est mesurée et sanctionnée. Il est à craindre

que la focalisation sur les résultats économiques incitent les équipes de direction et les autorités de tutelle à privilégier l'exigence économique au regard des exigences de qualité. Il est donc nécessaire de se donner les moyens de mesurer et de gérer la performance qualité des établissements au même titre que leur performance économique. Cette démarche est engagée à l'étranger. La France en ce domaine souffre d'un certain retard. Il importe de le combler pour équilibrer le système de gestion de l'hôpital. Par ailleurs, mesurer et gérer la qualité permet d'informer les patients et contitue un élément de motivation des équipes à améliorer leurs pratiques (résumé de l'éditeur).

Bruant-Bisson, A., et al. (2012). Évaluation des effets de la tarification à l'activité sur le management des établissements de santé. Rapport IGAS ; 2012 011. Paris IGAS**:** 97. http://www.igas.gouv.fr/spip.php?article287

[BDSP. Notice produite par MIN-SANTE R0xkBq89. Diffusion soumise à autorisation]. Ce rapport consacré à l'évaluation des effets de la tarification à l'activité (T2A) sur le management des établissements de santé a été inscrit au programme d'activité de l'Inspection générale des affaires sociales. Prévue par la loi de financement de la sécurité sociale pour 2004, la tarification à l'activité se substitue à la dotation globale versée aux établissements de santé publics et privés participant au service public hospitalier depuis 1984, et au paiement à la journée applicable dans les établissements privés a but lucratif, avec un double objectif : rétablir un lien entre le financement et l'activité des établissements de santé ; instaurer l'équité de traitement entre établissements. Il s'agissait de faire disparaître progressivement les disparités de financement constatées entre des établissements ayant des tailles, des volumes et des secteurs d'activité comparables.

Caron, D. (2005). "DOMES, outil de benchmarking des centres de lutte contre le cancer. Bilan et perspectives à cinq ans." Revue Hospitaliere De France(505): 46-49.

[BDSP. Notice produite par ENSP cIfR0xc1. Diffusion soumise à autorisation]. La tarification à l'activité (T2A) crée un effet de mode sur les outils de pilotage et le benchmarking. La Fédération nationale des centres de lutte contre le cancer a développé à partir de 1998 un réseau de mutualisation des données entre les vingt centres de lutte contre le cancer (CLCC). Son objectif : améliorer la performance de chacun par le partage des meilleurs pratiques. Nous présentons ici l'outil mis au point, son évaluation après cinq ans d'utilisation et son évolution dans le nouveau contexte réglementaire.

Cartier, T., et al. (2014). "Hospitalisations potentiellement évitables : une responsabilité des seuls soins de premier recours ?" Revue D'epidemiologie Et De Sante Publique **62**(4): 225-236.

La mesure des hospitalisations potentiellement évitables est utilisée comme un indicateur de performance des systèmes de soins primaires dans de nombreux pays. Cet article s'interroge sur la validité et l'intérêt de cette mesure de manière générale et dans le contexte français en particulier. Une revue ciblée de la littérature a été effectuée en vue d'une analyse critique du concept. Les différents usages des hospitalisations potentiellement évitables ont déjà fait l'objet de deux revues systématiques récentes. Les taux d'hospitalisations potentiellement évitables semblent bien plus corrélés aux caractéristiques socio-économiques des patients qu'à l'offre de soins primaires. Les rares travaux recensés en France confirment cette tendance internationale. Plusieurs faiblesses ont été identifiées dans la construction de cet indicateur : le choix des pathologies considérées comme pouvant être à l'origine d'hospitalisations potentiellement évitables, leur repérage parmi les codes diagnostiques de motifs d'hospitalisation, la qualité du codage hospitalier, le biais écologique du recueil des variables explicatives. Des pistes d'amélioration sont proposées. En particulier, nous

discutons la possibilité de l'usage de cet indicateur à l'échelle globale du système de santé. L'utilisation des hospitalisations potentiellement évitables comme indicateur de la performance du système de santé serait prématurée en France, à la fois pour des raisons de pertinence et de méthodologie (Résumé auteur).

Cases, C., et al. (2009). "L'évaluation : pourquoi et comment ?" Actualite Et Dossier En Sante Publique(69): 17-26.

[BDSP. Notice produite par EHESP R0xt9GA8. Diffusion soumise à autorisation]. Que doit être le "bon usage" de l'évaluation en santé publique et les conditions de son développement ? Ce sont les questions que pose ce dossier. Il présente les concepts d'évaluation et des exemples pratiques réalisés tant aux niveaux nationaux que régionaux. Ce premier article revient sur l'histoire et l'évolution de la culture d'évaluation en France. Développée dans un but de mesurer la performance, l'évaluation en santé publique nous est définie dans sa pluralité : objet de l'évaluation ; conceptualisation de la performance ; but de l'évaluation et le public visé ; et enfin la faisabilité opérationnelle de la démarche.

Causse, D. et Barreteau, A. (2006). "Urgences et territoires. Comment penser le nouveau paysage hospitalier ?" Revue Hospitaliere De France(510): 35-39.

[BDSP. Notice produite par ENSP YR0x771q. Diffusion soumise à autorisation]. Avec 14 millions de passages annuels dont 12 assurés par les établissements publics, les urgences sont la première image qui vient à l'esprit de nos concitoyens, lorsqu'ils sont interrogés sur le service public hospitalier. Les urgences représentent également avec les maternités, le premier sujet de dilemme entre les exigences conjuguées de proximité des soins et de sécurité. Pour ces raisons, la conjonction de la parution des SROS III, établissant les nouveaux territoires de santé du 31 mars 2006, et la publication des décrets récemment parus sur les urgences datés du 22 mai 2006 méritent une réflexion d'ensemble, au titre de la redéfinition en filigrane du nouveau paysage hospitalier des dix prochaines années : notre approche se situe donc à l'horizon des SROS IV.

Cnam (2017). Rapport sur les charges et produits de l'assurance maladie pour 2018 : Améliorer la qualité du système de santé et maîtriser les dépenses : propositions de l'Assurance Maladie pour 2018. Paris Cnamts**:** 229 , tabl.
https://www.ameli.fr/fileadmin/user_upload/documents/cnamts_rapport_charges_produits_2018.pdf

Ce rapport annuel de la Caisse nationale d'assurance-maladie propose un ensemble de recommandations pour maîtriser les dépenses de santé, soit 1,94 milliard d'€ d'économies pour 2018, soit la moitié des 4 milliards attendus par le gouvernement. Quelque 750 millions d'€ sont visés grâce à une meilleure prescription des médicaments ou à la promotion des génériques, en mettant l'accent sur les biosimilaires. La Cnam souhaite ensuite économiser 510 millions sur la "pertinence et (le) bon usage des soins", dont 160 millions pour la limitation des dépenses de transports, 100 millions en matière d'indemnités journalières (arrêts maladie). Le virage ambulatoire, qui vise à réduire les hospitalisations, et "l'adéquation de la prise en charge en établissement", doit ensuite permettre de réduire les dépenses de 470 millions d'€. Enfin, "la lutte contre la fraude et les abus en ville et à l'hôpital" doit permettre d'économiser 210 millions. Ces mesures "n'incluent pas les actions sur les prix des produits de santé, dont les médicaments, liées aux négociations conduites dans le cadre du comité économique des produits de santé (CEPS)", précise l'Assurance-maladie, ni certaines actions de la sphère hospitalière (achats, limitation de la masse salariale, etc). .. L'Assurance-maladie suggère de créer un fonds dédié à l'innovation

"organisationnelle", qui financerait des expérimentations à grande échelle. Il prendrait, par exemple, en charge la rémunération des professionnels impliqués dans de nouveaux circuits de soins en attendant leur intégration au circuit de prise en charge conventionnel. Les expériences seraient ainsi évaluées, avec des publications scientifiques à la clef. Parmi les projets éligibles, la Cnam cite le maintien à domicile grâce aux objets connectés, la mise en réseau des acteurs sanitaires et sociaux, de nouveaux modes d'organisation des soins de ville, Elle souhaite également instaurer dès 2018, dans 3 ou 4 régions et pour deux ou trois ans, un paiement forfaitaire en chirurgie, incluant le coût des éventuelles réhospitalisations. Ce nouveau mode de financement dit "à l'épisode de soins", repose sur une forme de garantie médicale, assortie d'un service après-vente. Ce serait la première fois en France que la non-qualité - liée par exemple à des infections contractées sur le site opératoire - serait pénalisée via la tarification de l'activité. Ce projet devrait figurer dans le projet de budget 2018 de la Sécurité sociale.

CNSA (2015). Gestion du risque - axe efficience en EHPAD. Analyse statistique des remontées des ARS dans les comptes administratifs 2012. Paris CNSA**:** 81 , tabl., cartes.
http://www.cnsa.fr/IMG/pdf/2015-03-13_Gestion_du_Risque_EHPAD_2012_VF.pdf

Le volet « gestion du risque en EHPAD » animé par la CNSA, initié par la direction de la sécurité sociale (DSS) en lien avec la DGCS, consiste à recueillir chaque année huit indicateurs de gestion du risque auprès des EHPAD, qui sont calculés, entre autres, à partir de données issues des comptes administratifs (CA) de la section soins des EHPAD et de données issues de la CNAMTS (outil RESID EHPAD). L'échantillon 2012 est constitué de 2 210 EHPAD. Les indicateurs analysés sont les suivants : le taux de consommation de la dotation « soins », sa composition , notamment ce que représentent les frais de personnel, le coût des soins de ville, le taux d'occupation des EHPAD, le taux d'hospitalisation des résidents pendant leur séjour, le temps de présence du médecin coordonnateur, du personnel médical et paramédical.

Com-Ruelle, L., et al. (2008). "Volume d'activité et qualité des soins dans les hôpitaux : quelle causalité ? Enseignements de la littérature." Questions D'economie De La Sante (Irdes)(135): 4.
http://www.irdes.fr/Publications/Qes/Qes135.pdf

Si la concentration de l'offre de soins hospitaliers est souvent présentée comme un moyen d'améliorer la qualité des soins, le sens de la relation entre volume d'activité et qualité des soins fait toujours débat. La revue systématique de la littérature menée par l'IRDES montre que pour certaines procédures et interventions, en particulier pour la chirurgie complexe, la possibilité d'améliorer la qualité des soins lorsque le volume d'activité augmente est réelle. L'effet d'apprentissage au niveau individuel (chirurgien) mais aussi au niveau de l'hôpital (transfert de connaissances, mode d'organisation) semble expliquer une grande partie de cette corrélation. Mais dans certains cas, hypothèse alternative du « renvoi sélectif », selon laquelle les patients sont orientés vers les hôpitaux ayant de meilleurs résultats, ne peut être réfutée. Ce lien de causalité entre volume et qualité doit par ailleurs être nuancé : les résultats sont sensibles à la nature des procédures et interventions analysées ainsi qu'aux seuils d'activité retenus. Plus l'intervention est spécifique et complexe, plus la corrélation volume-qualité est affirmée. Pour la plupart des interventions, il n'existe pas de seuil d'activité unanimement accepté. De plus, certaines études montrent que la relation volume-qualité devient marginale au-delà d'un seuil qui peut être relativement bas.

Com-Ruelle, L., et al. (2008). Volume d'activité et qualité des soins dans les établissements de santé : enseignements de la littérature. Rapport Irdes ; 1734. Paris Irdes**:** 152.
http://www.irdes.fr/Publications/Rapports2008/rap1734.pdf

Si la concentration de l'offre de soins hospitaliers dans de grandes unités est souvent présentée comme un moyen d'améliorer la qualité des soins, le sens et l'ampleur de la relation entre volume d'activité et qualité des soins font toujours l'objet de débats. Ce rapport dresse un examen complet et systématique de la littérature portant sur la relation entre le volume d'activité dans les établissements de santé et les résultats des soins. Au total, 175 articles ont été évalués selon un protocole standard. Par ailleurs, ce rapport étudie également les concepts d'économie industrielle pour en comprendre les mécanismes sous-jacents du lien entre volume d'activité et résultats.

Corriol, C., et al. (2003). COMPAQH : rapport d'étape 2003. Paris Cregas (Inserm)**:** 117. http://www.sante.gouv.fr/htm/dossiers/compaqh/accueil.htm

Ce document est un rapport d'étape du projet COMPAQH (COordination pour la Mesure de la Performance et l'Amélioration de la Qualité Hospitalière). Il a pour objectif de décrire les travaux réalisés en 2003 (mars 2003-Déc 2005). Ce projet a pour but de développer et mettre en ?uvre une vingtaine d'indicateurs de qualité dans des établissements de santé publics et privés pendant la période 2003-2005. Au cours de l'année 2003, la détermination de huit objectifs prioritaires a permis d'établir une première sélection de plus de 80 indicateurs. A partir d'une méthode de travail participative par consensus (DELPHI) et d'une sélection rigoureuse reposant sur des critères de validité et de faisabilité, la batterie d'indicateurs a été retenue par le comité de pilotage courant décembre 2003, pour expérimentation dans les 36 établissements volontaires de 2004 à fin 2005.

Corriol, C., et al. (2008). "COMPAQH : recherches sur le développement des indicateurs qualité hospitaliers." Revue D'epidemiologie Et De Sante Publique **56**: 179-188, rés., tabl., fig.

[BDSP. Notice produite par ORSRA DAR0xmGp. Diffusion soumise à autorisation]. Trois années d'existence du programme Coordination de la mesure de la performance pour l'amélioration de la qualité hospitalière (COMPAQH) permettent d'en tirer les premiers enseignements et d'évaluer ses perspectives de développement jusqu'en 2009. Quels indicateurs sont utilisés ? Comment sont-ils testés ? Quelles différences de qualité peut-on révéler ? Quel emploi pratique envisager au sein des établissements de santé ? Quel équilibre établir entre initiatives propres aux établissements et incitations externes, tels que le développement des classements ou les incitations financières ? Enfin, quelle cohérence donner à ce mouvement d'évaluation par la mesure de la qualité des soins ? Autant de questions auxquelles ce programme cherche à répondre.

Cotton, S. (2011). "Le chemin clinique au service de l'efficience." Revue Hospitaliere De France(543): 34-37.

[BDSP. Notice produite par EHESP R0xEotlI. Diffusion soumise à autorisation]. Les concepts de qualité et de financement défendent des paradigmes très différents. Comment faire coïncider ces deux concepts a priori paradoxaux et permettre la naissance d'une véritable osmose ? L'auteur présente deux exemples de démarche développée au CHRU de Lille : la mise en oeuvre d'un chemin clinique lié à la T2A qui valorise les bonnes pratiques de prise en charge en justifiant les coûts de chacune d'entre elles, le développement d'une évaluation de pratiques professionnelles transversales permettant une déclinaison de différents plans d'action et l'élaboration d'un tableau de suivi d'indicateurs.

Coulomb, A. (2005). "Définition des indicateurs et benchmarking. Une priorité pour la Haute Autorité de santé et le système de santé français." Revue Hospitaliere De France(505): 39-42.

[BDSP. Notice produite par ENSP wR0x3h3r. Diffusion soumise à autorisation]. Le Haut Conseil pour l'avenir de l'assurance maladie a souligné dans son rapport, daté du 23 janvier 2004, la nécessité de "structurer davantage le fonctionnement du système de soins, d'éprouver la qualité et l'utilité de ce que l'on rembourse et d'entrer dans des démarches exigeantes d'évaluation des pratiques et d'accréditation". La création de la Haute Autorité de santé (HAS) constitue une réponse concrète à ces recommandations. Ainsi, l'ensemble des missions de la HAS associe une activité de gestion des connaissances et une activité de mesure de performance dans une logique d'évaluation a posteriori des actions de santé publique mises en place et d'évaluation des pratiques.

Cregas (2005). COMPAQH : rapport d'étape 2004. Paris Cregas (Inserm)**:** 66 , 65 graph., 62 tabl.

Ce document est un rapport d'étape du projet COMPAQH (COordination pour la Mesure de la Performance et l'Amélioration de la Qualité Hospitalière). Il a pour objectif de décrire les travaux réalisés en 2004 (mars 2003 - mars 2006). Le projet COMPAQH poursuit les objectifs suivants : (1) Sélectionner une batterie d'indicateurs de qualité hospitalière ; (2) Tester la qualité métrologique de ces indicateurs ; (3) Etablir une comparaison inter-hospitalière ; (4) Définir les modes de gestion des indicateurs comme aide à l'amélioration de la qualité. 36 établissements de statuts différents participent à ce projet, qui est soutenu par la DHOS, en collaboration avec l'HAS. Il est également porté par les fédérations hospitalières (FHF, FHP, FEHAP, FNCLCC, FNMF), la branche hospitalière de l'assurance-maladie (UGECAM), et les associations d'usagers (CISS). Le maître d'?uvre est l'INSERM (Centre de Recherche en Economie et Gestion Appliquées à la Santé, unité mixte Inserm-Cnrs), avec une participation du CCECQA (Comité de Coordination de l'Evaluation Clinique et de la Qualité en Aquitaine). En 2004, l'objectif a été de mettre en ?uvre la batterie d'indicateurs sélectionnés (25 en MCO, 25 en CLCC, 19 en Psychiatrie, 20 en CLCC, soient 42 au total). Des outils nécessaires à la collecte de données ont été élaborés, des indicateurs ont été lancés au test, et le document présente quelques résultats obtenus, à la fois au niveau de l'établissement et entre établissements. Une revue de la littérature sur les méthodes de comparaison a été engagée à cette occasion. Enfin, un dispositif spécifique visant à tester la faisabilités de cinq indicateurs d'infections nosocomiales a été conçu.

De C.hambine, S., et al. (2008). "Les indicateurs de mesure de la performance hospitalière." Gestions Hospitalieres(479): 585-593, tabl.

[BDSP. Notice produite par EHESP R0xBB9oq. Diffusion soumise à autorisation]. L'Assistance publique-Hôpitaux (AP-HP) de Paris organise régulièrement pour ses cadres des conférences intitulées "Rencontres du management". Celle du 21 février 2008 portait sur les indicateurs de mesure de la performance hospitalière. Pour en rendre compte, ce cahier n°216 prend en considération tous les aspects de la performance hospitalière, attachant une attention particulière mais non exclusive à la performance médicale. Certes, la réflexion sur l'évaluation qualitative et quantitative des acteurs de santé a toujours été menée mais l'effort accompli ces dernières années est notable, même s'il est parfois dispersé entre les grands acteurs nationaux (HAS, Dhos, Drees, CHU notamment). Il est important de se poser la question sur l'utilisation de ces indicateurs par les financeurs et l'opinion publique, dans un contexte de plus en plus exigeant et concurrentiel, en prenant garde que l'activité ne finisse pas pour autant par être organisée en fonction des indicateurs mis en place. Reste à savoir si l'utilisateur n'est pas principalement la collectivité hospitalière dans une optique de comparaisons et de reporting internes ? Plus précisément, au sommaire de ce cahier n°216 : Performance médicale et outils de mesure ; Opinion des usagers. L'enquête de satisfaction Saphora ; Perception des services publics. Le baromètre de l'institut Paul-Delouvrier/BVA ;

Palmarès des hôpitaux. L'enquête annuelle du Point ; Les indicateurs de performance. Utilisation au CHU Saint-Antoine ; Performance et pôles.

Dely, C., et al. (2012). "Les réadmissions évitables des « pneumopathies communautaires » : utilité et fiabilité d'un indicateur de la qualité du parcours de soins du patient." Presse Medicale (La) **41**(1): e1-e9.

DREES (2014). "Indicateurs de suivi de l'état de santé de la population." Serie Sources Et Methodes - Document De Travail - Drees(44): 585.
http://www.drees.sante.gouv.fr/indicateurs-de-suivi-de-l-etat-de-sante-de-la-population,11299.html

[BDSP. Notice produite par MIN-SANTE R0xD8qoB. Diffusion soumise à autorisation]. L'objectif des travaux dont les résultats sont présentés ici était de mettre à jour, pour établir un état descriptif de l'état de santé de la population, la liste des indicateurs sur la base de l'expérience acquise depuis leur définition en 2005 et sur les mêmes thématiques, de l'évolution des systèmes d'information depuis cette date, et des propositions du Haut Conseil de la santé publique. Indépendamment du choix des objectifs stratégiques de la politique de santé, qui devraient être en nombre limité pour une période donnée, il semble en effet nécessaire de poursuivre la mise en commun et la publication régulière d'un ensemble d'indicateurs de suivi des principaux déterminants qui affectent la santé de la population, des principales pathologies et de l'état de santé de certains groupes de population.

DRESS (2009). "Mesure de la sécurité des patients dans les établissements de santé : état des lieux et perspectives." Serie Etudes Et Recherche - Document De Travail - Drees(89): 74 , tabl.
http://www.drees.sante.gouv.fr/IMG/pdf/serieetud89.pdf

[BDSP. Notice produite par MIN-SANTE 98R0xlr8. Diffusion soumise à autorisation]. Ce rapport fait l'analyse critique du développement de la conception "Indicateurs de sécurité du patient (ISP)" existants sur le plan international. Il s'agit, étant donné l'importante masse d'expertises sur ce sujet, d'en faire une synthèse avant même d'envisager le lancement d'indicateurs dans le contexte français. Celle-ci est guidée par un souci d'évaluation de ces mêmes indicateurs selon plusieurs critères : fréquence d'utilisation dans les diverses expériences, importance, degré de diffusion dans les diverses expériences nationales et internationales, et validité métrologique. Enfin sont abordées les conditions d'application de ces indicateurs dans le contexte français où la sécurité est devenue l'un des thèmes prioritaires pour les autorités publiques.

DRESS (2011). "Analyse critique du développement d'indicateurs composites : le cas de l'infarctus du myocarde après la phase aiguë." Serie Sources Et Methodes - Document De Travail - Drees(19): 86.

[BDSP. Notice produite par MIN-SANTE CR0xtBp8. Diffusion soumise à autorisation]. Ce rapport a pour objet de faire état du travail concernant la construction d'un indicateur composite portant sur la prise en charge de l'infarctus du myocarde après la phase aiguë. Il fait suite à une demande de la Haute autorité de santé (HAS) et de la Direction de la recherche, des études, de l'évaluation et des statistiques (DREES) sur la "possibilité de créer un indicateur composite à partir des six indicateurs généralisés par la HAS en 2008".

Dubourdieu, E., et al. (2013). "Dossier Recherche de l'efficience : Qualité, innovation, pertinence." Gestions Hospitalieres(530): 522-574, fig.

[BDSP. Notice produite par EHESP R0xBJms7. Diffusion soumise à autorisation]. La course à la performance des établissements de santé, publics comme privés, peut être destructrice si

cette performance est réduite à sa définition financière et analysée dans le très court terme. Il est nécessaire d'intégrer dans cette recherche de l'efficience qualité, sécurité, innovation, pertinence, responsabilité sociale et environnementale et d'établir des indicateurs permettant d'évaluer et de comparer. Les articles qui composent ce dossier se penchent sur cette notion d'efficience mêlant réflexions générales et présentation d'outils ou d'expériences. Au sommaire du dossier : - L'outil intranet Question/Réclamation destiné à recueillir sur une plate-forme commune les questions et réclamations des établissements relatives au périmètre des marchés de dispositifs médicaux stériles - Une réflexion prospective sur les soins de suite et de réadaptation - La formule du crédit-bail mobilier pour financer le renouvellement total des équipements d'une blanchisserie - Le rôle de la documentaliste au sein d'un Centre hospitalier universitaire - Le tutorat infirmier en psychiatrie - La mise en jeu de la sexuation dans l'exercice du pouvoir - Les résultats d'un étude menée sur la motivation du personnel infirmier - Les apports de la modélisation des processus (concept d'objet-frontière) dans le cadre d'un projet de centralisation de la programmation d'un bloc opératoire - L'adaptation du tableau de bord prospectif, ou Balanced Scorecard (BSC), au contexte hospitalier marocain.

Duclos, A., et al. (2006). "Du PMSI à la gestion des pôles : une analyse critique sur l'Indice de Performance de la Durée Moyenne de Séjour (IP-DMS)." Journal D'economie Medicale **24**(2): 71-82, rés., tabl., fig.

[BDSP. Notice produite par ORSRA Hq8YR0x1. Diffusion soumise à autorisation]. Objectif : Démontrer la nécessité de valider une approche comparative sur l'IP-DMS, avant d'utiliser cet indicateur pour fixer des objectifs de performance contractualisés aux pôles d'un Centre Hospitalier Universitaire français. Méthode : Nous avons suivi une séquence d'approche simple comprenant trois étapes : 1-Identification d'un GHM traceur (GHM 04M13Z - oedème pulmonaire et détresse respiratoire), 2-Estimation du nombre de journées théoriquement puis réellement perdues sur ce GHM pour l'année 2004,3-Caractérisation de ses principales filières de prises en charge. A partir des informations extraites de la base PMSI de l'Hôpital Européen Georges Pompidou (HEGP) et des statistiques par GHM de la base PMSI nationale, nous avons effectué des comparaisons sur une batterie de variables médico-économiques (résumé d'auteur).

Duhamel, G., et al. (2009). Evaluer et améliorer la qualité des soins dans les établissements de santé. Traité d'économie et de gestion de la santé., Paris : Editions de Santé ; Paris : SciencesPo Les Presses**:** 306-314.
http://www.pressesdesciencespo.fr/livre/?GCOI=27246100728790

Dumas, M., et al. (2012). "L'appropriation d'un outil de la qualité des soins à l'hôpital." Journal De Gestion Et D'economie Medicales **30**(3): 127-149.
http://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2012-3-page-127.htm

L'objet de cet article porte sur l'appropriation des outils afférents à la mise en place des politiques internes de management dans le cadre des procédures d'accréditation. A ce titre, la GRH et le management tiennent un rôle central en tant qu'agent et accompagnateur des changements induits par la mise en place des démarches qualité.
Optant pour une approche qualitative et inductive et au regard du nombre conséquent de dispositifs élaborés par les acteurs, il est décidé de se concentrer sur l'outil « phare » de ces transformations : le dossier du patient.
L'étude porte sur deux services d'un centre hospitalier. Les résultats montrent que le processus d'appropriation aboutit à un ensemble de réalités collectives et individuelles.
L'approche collective obéit à l'idée d'orienter l'usage de l'outil vers le patient exigeant par là

une coordination forte entre les membres de l'équipe pour mener à bien le travail. L'appropriation individuelle assoit un impératif de réalisation du travail caractérisée par une faible intégration dans le groupe. Les pratiques de GRH de type administratif semblent donc avoir peu d'effets sur l'activité et la qualité. La formation à travers des modalités adaptées aux besoins du service et des personnes pourrait devenir un appui important pour le cadre.

Durand-Zaleski, I., et al. (1997). "Elaboration et mise en place des recommandations de pratique clinique : L'expérience de l'hôpital Henri Mondor. Discussion." Gestions Hospitalieres(369): 653-656.

[BDSP. Notice produite par INIST 0qa8vR0x. Diffusion soumise à autorisation].

Ettorchi-Tardy, A., et al. (2010). "PMSI et évaluations des objectifs fixés par la loi du 9 août 2004." Gestions Hospitalieres(492): 48-53.

[BDSP. Notice produite par EHESP Hr9R0xp7. Diffusion soumise à autorisation]. En 2004, cent objectifs de santé publique (SP) ont été déterminés et annexés à la loi sur la politique de santé publique. A chaque objectif est associé un ou plusieurs indicateurs. Le programme de médicalisation du système d'information (PMSI) reste la seule base d'exhaustivité des données concernant les hospitalisations en France ; on se doit d'analyser son utilité dans l'évaluation des objectifs de SP à un niveau régional, voire local. Nous avons étudié un objectif concernant les accidents vasculaires cérébraux (AVC) dont l'indicateur retenu (nombre et taux d'hospitalisation en MCO pour AVC) se prête bien à une analyse des données en PMSI. Cette analyse a concerné les données 2007 au CHU de Bordeaux. L'implication des départements d'information médicale (DIM) dans l'évaluation de tels objectifs constitue un grand pas de mise en oeuvre de la politique de régionalisation de SP.

Ettorchi-Tardy, A., et al. (2011). "Le benchmarking : une méthode d'amélioration continue de la qualité en santé." Pratiques Et Organisation Des Soins **42**(1): 35-46. http://www.cairn.info/revue-pratiques-et-organisation-des-soins-2011-1-page-35.htm

Evain, F. et Yilmaz, E. (2012). "Les déterminants de la rentabilité économique des établissements de santé." Economie Publique(28-29): 317-349, tabl., graph.

L'objet de cette étude est d'identifier les déterminants de la rentabilité et, par-là, de comprendre hétérogénéité des situations financières des établissements de santé à travers une approche multi-variée, en intégrant des facteurs structurels (activités, facteurs de production) et contextuels. Plusieurs sources, à la fois comptables, administratives et médicales ont été mobilisées. L'échantillon retenu est constitué hôpitaux publics et de cliniques privées à but lucratif ayant une activité de court séjour entre 2005 et 2009 ; Les résultats mettent en évidence, outre l'importance des facteurs organisationnels (taux d'occupation des lits, durée de séjour, quantité de personnel), l'impact de la spécialisation sur la performance économique.

Fache, P., et al. (2014). "?Le déploiement d'une politique publique d'évaluation de la qualité par les indicateurs hospitaliers : genèse et développement du cas français?" Quaderni **85**(3): 9-28. http://www.cairn.info/revue-quaderni-2014-3-page-9.htm

Cet article porte un regard rétrospectif sur les quinze dernières années considérées comme une période charnière dans la régulation de la qualité hospitalière. Il se concentre principalement sur l'innovation instrumentale qu'a pu constituer l'adoption des indicateurs de qualité. Fondé sur une démarche historique appuyée par un travail d'enquête, il restitue les facteurs clés qui ont contribué à l'émergence de ce nouvel instrument. Ce faisant, l'article

présente à la fois les enjeux dont il a fait l'objet, les soutiens dont il a bénéficié et les résistances rencontrées lors de sa mise en œuvre.

Falise-Mirat, B., et al. (2010). "Tic et Hôpital. Tic et performance des organisation des santé." Gestions Hospitalieres(495): 245-249.

[BDSP. Notice produite par EHESP R0xponrC. Diffusion soumise à autorisation]. La performance des organisations de santé-définie par la qualité du service rendu à la population, la réactivité des organisations et l'équité des financements-dépend largement de la capacité à mesurer, suivre et piloter le système. Pour ce faire, les technologies de l'information et de la communication (TIC) en sont l'instrument privilégié, disposant de plus d'un potentiel majeur pour appuyer la transformation du système de santé. Néanmoins, malgré son impact démontré sur la qualité des soins et l'accessibilité, ce levier reste peu utilisé, sans doute à cause de la difficulté à appréhender la portée économique des investissements dans les TIC, en particulier la complexité de la répartition des gains engendrés. La condition préalable à l'apparition de ces gains est de sécuriser les projets de systèmes d'information, par leur cadrage, la mise en oeuvre de bonnes pratiques de gouvernance et la mise en place d'une communication permettant de développer l'usage des technologies implantées. RA.

Ferrua, M., et al. (2015). "Incitation Financière à l'Amélioration de la Qualité (IFAQ) pour les établissements de santé français : Résultats de l'expérimentation (2012-2014)." Journal De Gestion Et D'economie Medicales **33**(4-5): 277-290, tabl., graph., rés.

[BDSP. Notice produite par ORSRA o8R0xoCI. Diffusion soumise à autorisation]. Une expérimentation sur l'Incitation financière à la qualité (IFAQ) a été lancée en France en juin 2012 par le Ministère de la Santé et la Haute Autorité de Santé. Un groupe de travail composé des fédérations hospitalières, des administrations chargées de la santé et de l'assurance maladie a été créé. L'équipe du projet COMPAQH (EA7348-Management des Organisations de Santé, EHESP) a été missionnée pour l'élaboration de la méthode et la conduite de l'expérimentation. La construction du modèle s'est notamment appuyée sur le programme référent en termes de paiement à la performance développé aux Etats-Unis : Hospital Value Based Purchasing (VBP). L'objectif d'IFAQ est de construire un modèle approprié au contexte français permettant de classer les établissements de santé et de rémunérer les meilleurs d'entre eux en fonction de leurs résultats, mais également de leur progression. Le modèle est basé sur l'évaluation de la qualité des établissements de santé à partir d'indicateurs de qualité et de sécurité des soins issus des démarches nationales, de la certification HAS et du niveau de développement de l'informatisation. 222 établissements de santé ont été retenus pour participer à l'expérimentation, 93 ont reçu une rémunération. Le montant de la rémunération dépend du classement et de la valorisation financière de son activité d'hospitalisation en MCO (Médecine Chirurgie Obstétrique) versée par l'assurance maladie. L'expérimentation IFAQ s'est inspirée du modèle VBP mais des différences existent notamment en termes de choix des composantes, du choix de l'expression des résultats des indicateurs, de la prise en compte de l'évolution des résultats et du système d'incitation.

Ferrua, M., et al. (2015). "Incitation Financière à l'Amélioration de la Qualité (IFAQ) pour les établissements de santé français : Résultats de l'expérimentation (2012-2014)." Journal De Gestion Et D'economie Medicales **33**(4-5): 277-290.
http://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2015-4-page-277.htm

Francois, P., et al. (2001). "Evaluation du taux de réadmissions précoces comme indicateur de la qualité des soins à l'hôpital." Revue D'epidemiologie Et De Sante Publique **49**(2): 183-191.

[BDSP. Notice produite par INIST MdPCuR0x. Diffusion soumise à autorisation]. Position du problème : L'objectif de notre étude était d'évaluer la pertinence du taux de réadmissions précoces pour mesurer la qualité des soins, de quantifier la part des réadmissions imprévues évitables dans un hôpital français, puis d'estimer la faisabilité et l'intérêt d'une utilisation en routine de l'indicateur. Méthodes : Un échantillon de 469 réadmissions survenant dans les 30 jours après une hospitalisation conventionnelle a été tiré au sort à partir du fichier des 40 242 Résumés Standardisés de Sortie (RSS) du premier semestre 1997. Les caractères "imprévu" et "potentiellement évitable" des réadmissions ont été étudiés à l'aide des dossiers des patients par deux médecins indépendants, avec mesure de l'accord véritable entre les médecins par un test du Kappa. Les critères de la base de données susceptibles de classer automatiquement les séjours en "imprévu" et "évitable" ont été analysés. Résultats : 119 réadmissions étaient imprévues (25,4%). Les médecins ont classé avec un avis concordant 97 réadmissions imprévues dont 50 ont été jugées évitables (soit 42% des réadmissions imprévues). Aucune caractéristique de la base n'a permis d'identifier la totalité des séjours imprévus et le caractère évitable d'une réadmission. Seul le passage par les urgences a permis d'identifier avec certitude 66% des réadmissions imprévues, dont 60% étaient évitables. (...)

François, P., et al. (2015). "De l'évaluation des pratiques professionnelles au développement professionnel continu : engagement et opinion des praticiens hospitaliers dans les activités d'évaluation des pratiques professionnelles." Sante Publique **27**(2): 187-194. http://www.cairn.info/revue-sante-publique-2015-2-page-187.htm

Introduction : L'objectif de cette étude était de faire le bilan de l'engagement des praticiens dans des programmes d'évaluation des pratiques professionnelles (EPP) dans un hôpital universitaire et de recueillir leur opinion sur l'intérêt de ces programmes.
Méthodes : Il s'agissait d'une étude observationnelle fondée sur l'enregistrement des programmes EPP validés par la commission médicale d'établissement (CME) d'un hôpital universitaire de 2007 à 2011. Les données étaient extraites des formulaires d'engagement individuel des praticiens et des documents fournis pour la validation des programmes. Le critère de jugement était le pourcentage de praticiens permanents ayant validé leur obligation d'EPP.
Résultats : En 5 ans, la CME a validé 64 programmes d'EPP et 509 engagements individuels impliquant au total 366 praticiens. Parmi les praticiens permanents présents à la date de point, 264 (47 %) avaient validé leur obligation d'EPP. Les principales méthodes d'EPP étaient des revues de mortalité et morbidité (23), des réunions de concertation pluridisciplinaires (23), des staff-EPP (8), et des comités de retour d'expérience (6). Les principaux intérêts relevés par les praticiens étaient la collégialité et le travail en équipe (49 %) et l'amélioration de la prise en charge des patients (30 %). Les principales difficultés étaient liées à des questions d'organisation (27 %) et de disponibilité (23 %).
Conclusion : Les praticiens hospitaliers ont adhéré aux programmes d'EPP implantés dans les équipes. On constatait une dynamique en faveur des programmes continus, reposant sur des approches collectives. La mise en œuvre du développement professionnel continu devrait contribuer à soutenir cette dynamique.

Fratte, S., et al. (2008). "Indicateurs de qualité des soins en endoscopie digestive." Journal D'economie Medicale **26**(4): 185-189, tabl.

[BDSP. Notice produite par ORSRA 8o7lkR0x. Diffusion soumise à autorisation]. L'objectif de cette étude était d'évaluer la qualité des pratiques des trois endoscopistes constituant l'équipe du Centre Hospitalier de Belfort-Montbéliard, à travers des critères de processus et

de résultats (dont la satisfaction du patient), et de mettre en place les améliorations nécessaires et les indicateurs pérennes utiles à la surveillance des facteurs critiques identifiés. Sur la période considérée, 202 coloscopies totales ont été réalisées, chez 201 patients. La démarche de comparaison aux données issues de la littérature (benchmarking) a permis de révéler les dysfonctionnements les plus fréquents au niveau de l'équipe. Les actions d'améliorations, définies et donc comprises par les acteurs, ont montré leur efficacité par le suivi régulier d'indicateurs sur les points de dysfonctionnement les plus fréquents.

Gache, K., et al. (2014). "Main barriers to effective implementation of stroke care pathways in France: a qualitative study." Bmc Health Services Research **14**(95): 1-10. http://www.biomedcentral.com/1472-6963/14/95

Stroke Care Pathways (SCPs) aim to improve quality of care by providing better access to stroke units, rehabilitation centres, and home care for dependent patients. The objective of this study was to identify the main barriers to effective implementation of SCPs in France.

Gardel, C. et Minvielle, E. (2008). "Évaluation des pratiques professionnelles, certification et performance hospitalière." Journal D'economie Medicale **26**(4): 190-194, tabl.

[BDSP. Notice produite par ORSRA BBkmR0xr. Diffusion soumise à autorisation]. Les professionnels des établissements de santé sont concernés par plusieurs dispositifs réglementaires en matière d'évaluation des pratiques professionnelles (EPP). La procédure de Certification des établissements de santé demande aux établissements de mener des actions d'évaluation à travers 215 critères sur : la pertinence des hospitalisations et des actes, la sécurité des processus de soins, les modalités de prise en charge des pathologies et problèmes de santé. Dans toutes ces actions, le développement des indicateurs est préconisé, l'objectif étant à terme d'intégrer des indicateurs de qualité dans la procédure de certification. Le projet de recherche COMPAQH (Coordination pour la mesure de la performance et l'amélioration de la qualité hospitalière) a pour objectif de concevoir et valider des indicateurs de performance en matière de qualité des soins.

Gasquet, I. (2002). Adaptation au contexte français d'un outil générique de mesure de la satisfaction par rapport au système de santé. Villejuif Hopital Paul Brousse. Département de Santé Publique**:** 42 , ann.

Selon l'OMS, les systèmes de santé doivent avoir pour objectifs d'améliorer ou de maintenir l'état de santé des populations et de répondre aux attentes des personnes. Ainsi, l'évaluation du niveau de performance d'un système de santé donné nécessite de prendre en compte un résultat médical (ou sanitaire), mais aussi un résultat non-médical, qui relève des besoins exprimés par la population consommatrice ou potentiellement utilisatrice du système de santé.

Gaudron, P., et al. (2012). "Dossier. Les acteurs de la performance." Gestions Hospitalieres(514): 140-169, graph.

[BDSP. Notice produite par EHESP 9R0xGF9t. Diffusion soumise à autorisation]. Les acteurs de la performance sont multiples. Chacun à sa manière oeuvre pour améliorer ses pratiques et résultats, ceux des établissements de santé. Au fond comme en matière de développement durable, le principe "think global, act local" est appliqué. A travers diverses contributions, Gestions hospitalières a souhaité montrer cette convergence des initiatives des hospitaliers, corps de contrôles, autorités de tutelles, agence : parangonnage organisé, illustration de terrain, intervention externe, toutes les modalités, toutes les ressources sont

mobilisées vers un même but : améliorer la performance. La création de la chaire de management s'inscrit dans ce même objectif et favorise l'initiative des professionnels associés aux enseignants chercheurs. Gestions hospitalières a souhaité assurer le relais des travaux et séminaires de la chaire comme elle accompagne le Graph depuis de longues années. Ainsi, le sens de l'action trouve une traduction, montrant que la recherche de la performance n'est pas la simple conséquence d'une mise sous contrainte des acteurs ou l'application mécanique du dispositif issu de la loi organique relative aux lois de finance ou de la révision générale des politiques publiques. (intr.).

Gomez, M. L., et al. (2012). "L'usage des indicateurs de performance sur la qualité-sécurité des soins : le cas de l'indicateur de tenue du dossier anesthésique." Journal De Gestion Et D'economie Medicales **30**(7-8): 455-468, rés., tabl.

[BDSP. Notice produite par ORSRA CR0xrp8l. Diffusion soumise à autorisation]. Les indicateurs de qualité se multiplient à l'hôpital. Ils ont pour objectif affiché par les pouvoirs publics d'améliorer les pratiques médicales et maîtriser les risques. Or, la recherche en gestion montre que l'usage réel des indicateurs diffère souvent de la doctrine et que leur déploiement n'implique pas nécessairement appropriation. Dans cette perspective, l'article analyse l'usage d'un indicateur de tenue du dossier anesthésique (DAN). Il s'appuie sur une étude qualitative menée dans quatre hôpitaux ainsi qu'à la Haute Autorité de Santé (HAS) et la Société Française d'Anesthésie-Réanimation (SFAR). Les résultats révèlent que le périmètre d'appropriation de l'indicateur dans les établissements est limité mais qu'il a des répercussions sur l'ensemble des équipes, notamment par la modification de la structure du dossier anesthésique. On note aussi des pratiques émergentes comme l'utilisation de l'indicateur dans la négociation de moyens par les services, et au niveau de la SFAR dans le réinvestissement pour la recherche. Cette étude contribue à une meilleure compréhension de la façon dont les professionnels de santé s'emparent des outils de pilotage de la qualité, en créant parfois des usages non prescrits par les concepteurs. Elle apporte également un éclairage sur le rôle des sociétés savantes dans le déploiement des politiques publiques. (résumé d'auteur).

Gory, I., et al. (2003). "Elaboration d'indicateurs de qualité de soins dans un centre hospitalier psychiatrique." Sante Publique **15**(1): 99-113, tabl.

[BDSP. Notice produite par ENSP 6OZR0xWg. Diffusion soumise à autorisation]. Le centre hospitalier psychiatrique Camille Claudel a élaboré une batterie d'indicateurs utilisant une fiche descriptive et une grille de lecture critique récemment développés. Les objectifs de cet article sont d'étudier la validité de ces outils et les principales difficultés méthodologiques rencontrées par les professionnels de terrain dans la construction de leurs indicateurs. Cette expérience montre la faisabilité d'une démarche d'établissement pour élaborer une batterie d'indicateurs alors qu'il n'existait pas de compétence épidémiologique ni métrologique interne. L'encadrement méthodologique, fondé sur des outils jugés valides, semble essentiel pour former les professionnels aux indicateurs et pour les aider à choisir et à améliorer leurs indicateurs.

Goujard, A. (2018). France: improving the efficiency of the health-care system. OECD Economics Department Working Papers ; 1455**:** 51 , tab., graph., fig.
http://d.repec.org/n?u=RePEc:oec:ecoaaa:1455-en&r=age

France's health-care system offers high-quality care. Average health outcomes are good, public satisfaction with the health-care system is high, and average household out-of-pocket expenditures are low. As in other OECD countries, technology is expanding possibilities for

life extension and quality, and spending is rising steadily, while an ageing population requires substantially more and different services. The main challenges are to promote prevention and cost-efficient behaviour by care providers, tackle the high spending on pharmaceuticals, strengthen the role of health insurers as purchasing agents and secure cost containment. Good-quality information and appropriate financing schemes would ensure stronger efficiency incentives. Disparities of coverage across social groups and health services suggest paying greater attention to co-ordination between statutory and complementary insurance provision. Ongoing reforms to improve prevention and co-ordination among care providers are steps in the right direction. However, progress in the development of capitation-based payment schemes, which can reduce the incentives to increase the number of medical acts and encourage health professionals to spend more time with their patients, and performance-based payment schemes in primary care need to be stepped up to respond to the increasing prevalence of chronic diseases and curb supplier-induced demand and social disparities in access to care

Grenier-Sennelier Guillaume, S. et Or, Z. (2016). "La satisfaction des personnes âgées en termes de prise en charge médicale et de coordination des soins : une approche qualitative exploratoire." Questions D'economie De La Sante (Irdes)(214): 1-6.
http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/214-la-satisfaction-des-personnes-agees-en-termes-de-prise-en-charge-medicale-et-de-coordination-des-soins.pdf

Cette enquête qualitative exploratoire vise à identifier les dimensions de la satisfaction des personnes âgées concernant leur prise en charge médicale et la coordination de leurs soins. Réalisée au printemps 2015 à partir d'entretiens semi-directifs, elle porte sur un échantillon de 18 personnes âgées de 72 à 90 ans, vivant à domicile ou en institution, ainsi que sur 4 aidants de patients atteints de pertes de facultés cognitives. Toutes les personnes interrogées, quel que soit leur type d'hébergement, y compris les aidants, s'accordent à dire que la dimension la plus importante dans la prise en charge concerne la qualité de la relation entretenue avec les professionnels de santé. Il semble y avoir une marge de manœuvre importante pour améliorer cette qualité relationnelle et la satisfaction des personnes avec des gestes simples. Les personnes enquêtées évoquent l'importance d'être bien informées sur leur prise en charge, d'avoir la possibilité de s'exprimer et l'importance des échanges ainsi que de la coordination entre les différents professionnels de santé impliqués dans leurs soins.

HAS (2007). Elaboration de critères de qualité pour l'évaluation et l'amélioration des pratiques professionnelles. St Denis HAS**:** 16 , annexes.
http://www.has-sante.fr/portail/upload/docs/application/pdf/criteres_de_qualite_pour_levaluation_et_lamelioration_de.pdf

Ce document propose une méthode d'élaboration et de sélection de critère de qualité pour l'évaluation et l'amélioration des pratiques professionnelles. Il a pour objectif d'aider ces professionnels à s'engager dans ces démarches, la finalité étant d'améliorer le service médical rendu au patient.

HAS (2012). Indicateurs de qualité généralisés en HAD. Analyse descriptive des résultats agrégés et analyse des facteurs associés à la variabilité des résultats. Campagne 2011. Etudes et Rapports. Saint Denis HAS**:** 60.
http://www.has-sante.fr/portail/upload/docs/application/pdf/2012-10/ipaqss-rapport-had-v4.pdf

[BDSP. Notice produite par HAS pAtR0xEB. Diffusion soumise à autorisation]. La Haute Autorité de Sante (HAS) a piloté début 2012 la deuxième campagne nationale des indicateurs généralisés sur le thème du dossier du patient en secteur HAD, (tenue du dossier patient (TDP), délai d'envoi du courrier de fin d'hospitalisation (DEC), évaluation de la douleur (TRD), suivi du poids (DTN), évaluation du risque d'escarre (TRE)). Après chaque campagne de recueil, la HAS rend compte des résultats agrégés dans un rapport d'analyse mis en ligne sur son site internet. Ce rapport présente les principaux constats et faits marquants issus de l'analyse des résultats de la campagne 2011.

HAS (2012). Indicateurs de qualité généralisés en MCO - Campagne 2011 - Analyse descriptive des résultats agrégés et analyse des facteurs associés à la variabilité des résultats. Etudes et Rapports. Saint-Denis HAS**:** 60.
http://www.has-sante.fr/portail/upload/docs/application/pdf/2011-12/ipaqss_rapport_mco_2011.pdf

[BDSP. Notice produite par HAS 8CA8qR0x. Diffusion soumise à autorisation]. En 2011, la HAS a coordonné la quatrième campagne de recueil généralisée des cinq indicateurs du dossier du patient (Qualité de la tenue du dossier patient, délai d'envoi du courrier de fin d'hospitalisation, évaluation de la douleur, dépistage des troubles nutritionnels, évaluation du risque d'escarre) impliquant les établissements ayant une activité de médecine, chirurgie et obstétrique (MCO). Après chaque campagne de recueil, la HAS rend compte des résultats agrégés dans un rapport d'analyse mis en ligne sur son site Internet. Ce rapport présente les principaux constats et faits marquants issus de l'analyse des résultats de la campagne 2011. Il permet notamment d'analyser l'évolution des résultats sur 4 années consécutives.

HAS (2012). Indicateurs de qualité généralisés en santé mentale. Analyse descriptive des résultats agrégés et analyse des facteurs associés à la variabilité des résultats. Campagne 2011. Etudes et Rapports. Saint Denis HAS**:** 48.
http://www.has-sante.fr/portail/upload/docs/application/pdf/2012-10/ipaqss-rapport-psy-v5.pdf

[BDSP. Notice produite par HAS R0xDlsJA. Diffusion soumise à autorisation]. Début 2012, la HAS a coordonné la deuxième campagne nationale de recueil des 3 indicateurs du thème "Qualité du dossier patient en santé mentale" impliquant les établissements ayant une activité en santé mentale (PSY) (Tenue du dossier patient, Délai d'envoi du courrier de fin d'hospitalisation, Dépistage des troubles nutritionnels). Après chaque campagne de recueil, la HAS rend compte des résultats agrégés dans un rapport d'analyse mis en ligne sur son site Internet. Ce rapport présente les principaux constats et faits marquants issus de l'analyse des résultats de la campagne 2011.

HAS (2012). Indicateurs de qualité généralisés en SSR. Analyse descriptive des résultats agrégés et analyse des facteurs associés à la variabilité des résultats. Campagne 2011. Etudes et Rapports. Saint Denis HAS**:** 64.
http://www.has-sante.fr/portail/upload/docs/application/pdf/2012-10/ipaqss-rapport-ssr-v4.pdf

[BDSP. Notice produite par HAS CrR0xCHq. Diffusion soumise à autorisation]. La Haute Autorité de Santé a piloté en 2012 la troisième itération du recueil des indicateurs sur la qualité du dossier du patient dans les établissements de soins de suite et de réadaptation (SSR) s'est déroulée de novembre 2011 à mars 2012. Quatre indicateurs obligatoires et un indicateur optionnel ont été évalués à partir du même tirage au sort de dossiers portant sur le premier semestre 2011. Ces indicateurs répondent à des enjeux prioritaires (tenue du dossier patient (TDP), délai d'envoi du courrier de fin d'hospitalisation (DEC), évaluation de la douleur (TRD), suivi du poids (DTN), évaluation du risque d'escarre (TRE - indicateur

optionnel)). Après chaque campagne de recueil, la HAS rend compte des résultats agrégés dans un rapport d'analyse mis en ligne sur son site internet. Ce rapport présente les principaux constats et faits marquants issus de l'analyse des résultats de la campagne 2011.

HAS (2012). Indicateurs de qualité sur la prise en charge initiale de l'accident vasculaire cérébral. Campagne 2011. Etudes et rapports. Saint Denis HAS**:** 40.
http://www.has-sante.fr/portail/upload/docs/application/pdf/2012-11/ipaqss_rapport-avc-v5.pdf

[BDSP. Notice produite par HAS R0xp8Ep7. Diffusion soumise à autorisation]. Les résultats de cette première campagne de recueil des indicateurs AVC n'ayant pas vocation à être diffusés publiquement, la communication se fait cette année à partir des seuls résultats agrégés présentés dans ce rapport. L'analyse descriptive des données 2011 permet plusieurs constats : - Les résultats moyens nationaux sont variables en fonction des indicateurs, mais la variabilité inter-établissements des résultats est importante pour chacun. - Le délai médian entre l'arrivée dans l'établissement et la réalisation d'une imagerie cérébrale après un AVC est de 1h41 pour les patients admis par le SAU tout type d'établissement confondu. - La date et l'heure de début des symptômes sont retrouvées pour plus de 7 patients sur 10. La connaissance de ces informations est une étape initiale et primordiale dans la mise en ouvre du traitement thrombolytique. En effet, au cours de la phase d'expérimentation, le calcul de l'indicateur "Taux de thrombolyse chez les patients ne présentant pas de contre-indications formelles à la thrombolyse et dont la prise en charge initiale a été effectuée dans les 4 heures suivant le début des symptômes" n'avait pu être réalisé que pour un très faible nombre de dossiers car une part importante de données horaires était manquante, principalement l'heure de début des symptômes. - Sept patients sur dix reçoivent une administration appropriée d'aspirine après un AVC ischémique et en l'absence de traitement fibrinolytique. - En court séjour, 4 patients hospitalisés avec un diagnostic d'AVC sur 10 bénéficient d'une évaluation initiale par un professionnel de la rééducation. En outre, le délai médian entre l'arrivée dans l'établissement et l'évaluation par un professionnel de la rééducation est de 3 jours. - La tenue du dossier patient est de qualité pour au moins 8 patients sur 10. Parmi les 7 critères évalués, 6 ont de très bons résultats (supérieurs à 80%) excepté le score de gravité NIH qui n'est retrouvé qu'une fois sur quatre dans le dossier du patient.

HAS (2012). Indicateurs de qualité. Prévention et prise en charge initiale des hémorragies du post-partum immédiat. Etudes et Rapports.**:** 48.
http://www.has-sante.fr/portail/upload/docs/application/pdf/2012-12/ipaqss-rapport-hpp-v3.pdf

[BDSP. Notice produite par HAS IrsR0x7D. Diffusion soumise à autorisation]. En 2012, dans le cadre des campagnes nationales de recueil des indicateurs de la Haute Autorité de Santé, les maternités françaises ont recueilli pour la première fois [1] des indicateurs de qualité sur la prévention et la prise en charge initiale des hémorragies du post-partum immédiat (HPPI), indicateurs qui permettent la comparaison inter-établissements et le suivi dans le temps. Les indicateurs sont centrés sur deux aspects de la prise en charge [2] : - Deux indicateurs concernent la prévention de l'HPP lors de l'accouchement (un autour de la délivrance, un sur la surveillance minimale en salle de naissance) puisqu'une surveillance attentive et des mesures prophylactiques de l'HPP (cliniques et pharmacologiques) permettent une diminution de son incidence. - Trois indicateurs évaluent la qualité de la prise en charge initiale de l'HPPI (diagnostic (heure et évaluation en ml des pertes sanguines), geste endo-utérin et l'antibioprophylaxie) qui permet de diminuer le risque de complications graves secondaires à l'hémorragie. Les 536 maternités concernées ont audité 60 dossiers d'accouchements et 60 dossiers d'HPPI maximum.

HAS (2013). Indicateur Conformité des demandes d'examens d'imagerie. Campagne 2012. Analyse descriptive des résultats agrégés 2012 et analyse des facteurs associés à la variabilité des résultats. Etudes et Rapports.**:** 24.
http://www.has-sante.fr/portail/jcms/c_1616132/fr/indicateur-conformite-des-demandes-dexamens-dimagerie-campagne-2012-analyse-descriptive-des-resultats-agreges-2012-et-analyse-des-facteurs-associes-a-la-variabilite-des-resultats-juin-2013

[BDSP. Notice produite par HAS sB9sR0xJ. Diffusion soumise à autorisation]. Le taux de participation était de 19% pour le 3e recueil optionnel. En moyenne, une demande d'examen d'imagerie était retrouvée et complète dans 51% des cas. La variabilité observée des résultats (0% - 100%) confirme la pertinence de l'indicateur, et la nécessité de poursuivre des actions d'amélioration. Les critères les moins bien tracés sont la date de la demande (86%) et la finalité de l'examen (75%) ; et les critères les mieux tracés sont l'identité du patient (99%) et la région anatomique (98%). Des analyses complémentaires ont montré que l'informatisation des demandes améliorait la traçabilité des critères administratifs, notamment pour la date de rédaction de la demande (96% pour les demandes informatiques versus 83% pour les demandes manuscrites). La complétude de rédaction est meilleure pour les demandes provenant des services d'hospitalisation (60%) que pour celles provenant des services d'urgences (52%) et de consultations (48%). L'indicateur CDEI étant optionnel, les résultats ne feront l'objet ni d'une diffusion publique nominative, ni d'une prise en compte dans les tableaux de bord des ARS. Le prochain recueil optionnel de l'indicateur CDEI est prévu pour le second semestre 2014. Les établissements disposent ainsi d'une année complète pour mettre en place des plans d'actions d'amélioration entre deux mesures.

HAS(2011). Indicateurs de qualité généralisés. Thème "Infarctus du myocarde après la phase aiguë". Analyse descriptive des résultats agrégés Campagne 2010. Etudes et enquêtes.**:** 50.
http://www.has-sante.fr/portail/jcms/c_1216354/rapport-indicateurs-de-qualite-generalises-theme-infarctus-du-myocarde-apres-la-phase-aigue-analyse-descriptive-des-resultats-agreges-campagne-2010

[BDSP. Notice produite par HAS 8ArR0x8m. Diffusion soumise à autorisation]. En 2010, la HAS a coordonné la troisième campagne de recueil généralisée des indicateurs du thème "Prise en charge de l'infarctus du myocarde après la phase aiguë" impliquant les établissements ayant une activité de médecine, chirurgie et obstétrique (MCO). Après chaque campagne de recueil, la HAS rend compte des résultats agrégés dans un rapport d'analyse mis en ligne sur son site Internet. Ce rapport présente les principaux constats et faits marquants issus de l'analyse des résultats de la campagne 2010. Il permet notamment d'analyser l'évolution des résultats sur 3 années consécutives.

HAS (2011). Rapport : Indicateurs de qualité du dossier du patient généralisés en SSR - Campagne 2010 - Analyse descriptive des résultats agrégés 2010 et analyse des facteurs associés à la variabilité des résultats. Etudes et enquêtes.**:** 62.
http://www.has-sante.fr/portail/upload/docs/application/pdf/2011-12/ipaqss_rapport_ssr_2011.pdf

En 2010, la HAS a coordonné la deuxième campagne de généralisation des cinq indicateurs du dossier du patient (qualité de la tenue du dossier patient, délai d?envoi du courrier de fin d?hospitalisation, évaluation de la douleur, dépistage des troubles nutritionnels, évaluation du risque d?escarre) impliquant les établissements ayant une activité de soins de suite et de réadaptation (SSR). Après chaque campagne de recueil, la HAS rend compte des résultats agrégés dans un rapport d?analyse mis en ligne sur son site Internet. Ce rapport présente les principaux constats et faits marquants issus de l?analyse des résultats de la campagne 2010. Il permet de porter une première appréciation sur l?évolution des résultats entre 2009 et

2010 pour les établissements de santé SSR, et apporte un premier éclairage sur les facteurs associés permettant d?expliquer le résultat des indicateurs. Cette analyse permet plusieurs constats : - une amélioration pour tous les indicateurs du thème "Dossier du patient" entre les campagnes 2009 et 2010 ; - l'informatisation des dossiers améliore le résultat des indicateurs "Tenue du dossier patient", "Délai d'envoi du courrier" et "Évaluation de la douleur" ; - les personnes âgées ont une moins bonne évaluation de la douleur avec une échelle ; - une structure SSR mono-activité obtient de meilleurs scores pour la "Tenue du dossier patient" et l' "Évaluation de la douleur".

HAS (2011). Rapport : Indicateur sur la qualité du dossier d'anesthésie - Campagne 2010 - Analyse descriptive des résultats agrégés 2010. Etudes et enquêtes.**:** 20.
http://www.has-sante.fr/portail/upload/docs/application/pdf/2011-12/ipaqss_rapport_dan_2011.pdf

[BDSP. Notice produite par HAS 9R0x9D9s. Diffusion soumise à autorisation]. Le rapport présente les résultats nationaux et régionaux agrégés. Près de 1000 établissements ont évalué la qualité de leur dossier d'anesthésie. - Depuis 2008, le score national ne cesse de progresser : 17 points en 3 ans : Il atteint le score de 80 en 2010. - Dans 6 établissements sur 10, le dossier, d'au moins 8 patients sur 10, contient les éléments qualitatifs indispensables à la maîtrise du risque anesthésique - Les établissements de santé continuent de progresser grâce à l'implication des professionnels dans l'amélioration de la qualité de leur dossier. Néanmoins certains établissements ont des résultats en baisse. La HAS intégrera ces informations dans la cartographie des risques des établissements afin de cibler les visites de certification. - Les résultats restant tout de même très variables d'un établissement à l'autre confirment la pertinence de la poursuite du recueil de cet indicateur. - Il existe une variabilité de résultats pour certains éléments de la maîtrise du risque anesthésique qui témoignent d'une hétérogénéité des pratiques. La HAS et le Collège Français des Anesthésistes-Réanimateurs (CFAR) se sont engagés dans un travail commun d'analyse des facteurs explicatifs de cette variabilité des résultats, qui complétera les résultats présentés dans ce rapport.

HAS (2011). Rapport : Indicateurs de qualité du dossier du patient généralisés en MCO - Campagne 2010 - Analyse descriptive des résultats agrégés 2010 et analyse des facteurs associés à la variabilité des résultats. Etudes et enquêtes.**:** 60.
http://www.has-sante.fr/portail/upload/docs/application/pdf/2011-12/ipaqss_rapport_mco_2011.pdf

En 2010, la HAS a coordonné la troisième campagne de recueil généralisée des cinq indicateurs du dossier du patient (Qualité de la tenue du dossier patient, délai d?envoi du courrier de fin d?hospitalisation, évaluation de la douleur, dépistage des troubles nutritionnels, évaluation du risque d?escarre) impliquant les établissements ayant une activité de médecine, chirurgie et obstétrique (MCO). Après chaque campagne de recueil, la HAS rend compte des résultats agrégés dans un rapport d?analyse mis en ligne sur son site Internet. Ce rapport présente les principaux constats et faits marquants issus de l?analyse des résultats de la campagne 2010. Il permet notamment d?analyser l?évolution des résultats sur 3 années consécutives. Cette analyse permet plusieurs constats : - une amélioration générale pour tous les indicateurs du thème "Dossier du patient" en 3 ans. - une variabilité inter-établissements et interrégionale, qui témoigne de la persistance d'une hétérogénéité des pratiques. - l'informatisation des dossiers améliore la qualité des prescriptions médicamenteuses. - les personnes âgées ont une moins bonne évaluation de la douleur avec une échelle, et une moins bonne mesure du poids.

HAS(2011). Rapport IMGENI. La généralisation des indicateurs qualité en Aquitaine. Entre contraintes et apprentissages. Une étude sociologique. Etudes et Rapports. Saint Denis HAS**:** 203.

> [BDSP. Notice produite par HAS R0xHEErI. Diffusion soumise à autorisation]. Les indicateurs généralisés de mesure de la qualité et de la sécurité des soins, inscrits dans la démarche de certification des établissements de santé, font aujourd'hui partie du paysage hospitalier. Ils visent notamment, à terme, à engager les établissements dans une logique de comparaison et de benchmarking. Compte tenu de l'investissement dont ces indicateurs font l'objet de la part des acteurs de santé, la Haute Autorité de Santé a souhaité bénéficier d'un éclairage sociologique sur les effets produits par l'introduction des indicateurs qualité généralisés. Le projet "IMGENI" vise ainsi à identifier les éléments susceptibles de favoriser l'usage des indicateurs qualité dans les pratiques cliniques et managériales.

HAS (2011). Rapport : Indicateurs de qualité et de sécurité des soins généralisés en HAD. Campagne 2010. Analyse descriptive des résultats agrégés 2010 et des facteurs associés à la variabilité des résultats. Etudes et Rapports.**:** 44.
http://www.has-sante.fr/portail/upload/docs/application/pdf/2012-04/ipaqss_rapport_had-v4.pdf

> [BDSP. Notice produite par HAS R0xAAo9D. Diffusion soumise à autorisation]. En 2010, la HAS a coordonné la première campagne de généralisation des cinq indicateurs du dossier du patient (qualité de la tenue du dossier patient, délai d'envoi du courrier de fin d'hospitalisation, évaluation de la douleur, dépistage des troubles nutritionnels, évaluation du risque d'escarre) impliquant les établissements ayant une activité d'hospitalisation à domicile (HAD). Après chaque campagne de recueil, la HAS rend compte des résultats agrégés dans un rapport d'analyse mis en ligne sur son site Internet. Ce rapport présente les principaux constats et faits marquants issus de l'analyse des résultats de la campagne 2010. Il apporte un premier éclairage sur les facteurs associés permettant d'expliquer le résultat des indicateurs.

HAS (2011). Rapport : Indicateurs de qualité généralisés en santé mentale - Analyse descriptive des résultats agrégés et analyse des facteurs associés à la variabilité des résultats - Campagne 2010. Etudes et Rapports.**:** 49 , fig., graph.
http://www.has-sante.fr/portail/upload/docs/application/pdf/2012-04/ipaqss_rapport_psy-vf.pdf

> [BDSP. Notice produite par HAS R0xp98Hr. Diffusion soumise à autorisation]. En 2010, la HAS a coordonné la première campagne de recueil généralisée des 3 indicateurs du thème "Qualité du dossier patient en santé mentale" impliquant les établissements ayant une activité en santé mentale (PSY) (Tenue du dossier patient, Délai d'envoi du courrier de fin d'hospitalisation, Dépistage des troubles nutritionnels). Après chaque campagne de recueil, la HAS rend compte des résultats agrégés dans un rapport d'analyse mis en ligne sur son site Internet. Ce rapport présente les principaux constats et faits marquants issus de l'analyse des résultats de la campagne 2010.

HAS (2015). Programme d'actions communes HAS-ANAP. Axe 5 : indicateurs, suivi et évaluation « Développement d'indicateurs de processus et de résultats pour l'amélioration de la qualité et de la sécurité d'éléments clés du parcours du patient en chirurgie ambulatoire ». Saint-Denis HAS**:** 10.
http://www.has-sante.fr/portail/jcms/c_2022569/fr/developpement-dindicateurs-de-processus-et-de-resultats-pour-evaluer-le-parcours-du-patient-en-chirurgie-ambulatoire-note-de-cadrage

> Le développement des indicateurs de qualité et sécurité des soins (IQSS), fondés sur l'analyse du parcours du patient –avant-pendant-après- permet d'accompagner le déploiement sécurisé de la chirurgie ambulatoire. L'objectif pour la HAS est de proposer un tableau de

bord d'IQSS de processus et de résultats qui mesure, dans le cadre d'une démarche d'amélioration fondée sur les indicateurs, la qualité et la sécurité du parcours du patient en chirurgie ambulatoire sur des points critiques de sa prise en charge.

HAS (2015). Programme d'actions communes HAS-ANAP. Axe 5 : indicateurs, suivi et évaluation. « Développement d'indicateurs de processus et de résultats pour l'amélioration de la qualité et de la sécurité d'éléments clés du parcours du patient en chirurgie ambulatoire ». Saint-Denis HAS**:** 10. www.has-sante.fr/portail/jcms/c_2022569/fr/developpement-dindicateurs-de-processus-et-de-resultats-pour-evaluer-le-parcours-du-patient-en-chirurgie-ambulatoire-note-de-cadrage

En décembre 2010, la DGOS et la HAS collaborent pour le développement d'indicateurs de qualité et sécurité des soins (IQSS) en établissements de santé issus de projets de recherche (COMPAQ, CLARTE). La HAS reprend l'ensemble des opérations dans le cadre d'une maitrise d'ouvrage partagée. Dans ce cadre, le développement des IQSS, fondés sur l'analyse du parcours du patient –avant-pendant-après- permet, dans une approche intégrée, d'accompagner le déploiement sécurisé de la chirurgie ambulatoire. L'objectif pour la HAS est de proposer un tableau de bord d'IQSS de processus et de résultats qui mesure, dans le cadre d'une démarche d'amélioration fondée sur les indicateurs, la qualité et la sécurité du parcours du patient en chirurgie ambulatoire sur des points critiques de sa prise en charge. Ce tableau de bord d'indicateurs qualité et sécurité des soins comprendra :Un set d'indicateurs de processus, optimisant des points clés du processus de prise en charge des patients, y compris l'information sur le suivi recommandé après la sortie, des indicateurs mesurant le résultat pour le patient en termes de chirurgie ambulatoire, de réduction des événements indésirables évitables : tels que les conversions en hospitalisation complète et les réadmissions en urgence.

HCSP (2014). Infections associées aux soins : auditions sur les indicateurs de résultats à visée de diffusion publique. Collection Avis et Rapports. Paris HCSP**:** 23. http://www.hcsp.fr/explore.cgi/avisrapportsdomaine?clefr=430

Afin d'améliorer l'information du public sur la performance des établissements de santé dans la lutte contre les infections nosocomiales, le Haut conseil de la santé publique (HCSP) avait sélectionné début 2012 dans un rapport précédent cinq indicateurs, ciblés sur les résultats, susceptibles de faire partie d'un tableau de bord annuel des établissements de santé en complément des indicateurs existants.

Henni, S., et al. (2015). "Mesurer la performance dans les établissements de demain : Regards croisés entre directeurs et médecin hospitalier sur l'utilisation du Balanced ScoredCard." Revue Hospitaliere De France(567): 58-62, fig.

[BDSP. Notice produite par EHESP R0xIr8Bm. Diffusion soumise à autorisation]. La mesure de la performance hospitalière est souvent prise sous l'angle purement financier, alors que les dimensions prospective et stratégique constituent un puissant levier managérial. Cet article, issu d'un travail collégial, promeut une approche globale de la mesure de la performance hospitalière comme point de départ d'actions collectives d'améliorations selon le principe : mesurer pour mieux soigner. Cette approche globale est réalisée au moyen de l'outil d'évaluation Balanced ScoreCard, qui élargit les objectifs au-delà de la seule performance économique, selon quatre axes : financier, usagers/patients, processus interne, apprentissage organisationnel.

Januel, J.-M. (2009). "Développement d'indicateurs de la sécurité des soins (PSI) à partir des bases de données médico-administratives hospitalières : évaluation et validation d'une sélection d'indicateurs." Serie Etudes Et Recherche - Document De Travail - Drees(93): 28. http://www.drees.sante.gouv.fr/IMG/pdf/serieetud93.pdf

[BDSP. Notice produite par MIN-SANTE 8R0xklpH. Diffusion soumise à autorisation]. Les Patient Safety Indicators (PSI) sont des indicateurs de la sécurité des patients construits sur la base d'algorithmes de codes CIM (diagnostics médicaux) et de codes CCAM (actes médicaux) issus de la base du PMSI. Le projet de développement de ces PSI en France repose sur trois objectifs majeurs : - Estimer, dans le cadre d'une collaboration au projet Health Care Quality Indicators (HCQI) de l'OCDE, les PSI dans la base nationale du PMSI en utilisant les codes CIM-10 adaptés par un consortium international ; - Valider selon différentes approches une sélection de ces PSI ; - Adapter au contexte français cette sélection de PSI en améliorant la structure de leurs algorithmes de construction. La première étape d'estimation des PSI dans la base nationale du PMSI pour les années 2005 et 2006 a été réalisée sur l'année 2008. Les résultats ont montré la faisabilité des PSI en utilisant les bases de données médico-administratives hospitalières en France et a mis en évidence un certain nombre de limites à leur utilisation. Aussi, les résultats obtenus ont pu être comparés avec ceux d'autres pays. Avant de proposer leur usage en routine, une étape de validation des PSI demeure néanmoins nécessaire. Cette deuxième partie du projet est en cours. Le projet HCQI a pour ambition de produire un rapport proposant un panorama des systèmes de santé des pays de l'OCDE basé sur la présentation des résultats d'une cinquantaine d'indicateurs collectés (dont les PSI) si possible annuellement par les pays participants.

Januel, J.-M. (2011). "Développement d'Indicateurs de la sécurité des soins (PSI) à partir des bases de données médico-administratives hospitalières : rapport final." Serie Sources Et Methodes - Document De Travail - Drees(20): 87.

[BDSP. Notice produite par MIN-SANTE m7IR0xjo. Diffusion soumise à autorisation]. Le projet de développement des indicateurs PSI a trois objectifs successifs : 1) Estimer les PSI à partir de la base nationale du Programme de Médicalisation des Systèmes d'Information (PMSI) en utilisant les codes de la 10ème version de la Classification internationale des maladies (CIM-10) ; 2) Évaluer la performance (validité et fiabilité, en testant notamment la sensibilité, la spécificité et les valeurs prédictives) des PSI à mesurer la survenue des événements indésirables liés aux soins (EIS) ; 3) Adapter au contexte français cette sélection de PSI en améliorant la structure de leurs algorithmes de construction. Ces objectifs ont été atteints en grande partie.

Januel, J.-M. (2011). "Les méthodes d'ajustement dans les modèles d'évaluation de la mortalité hospitalière : Étude descriptive." Serie Etudes Et Recherche - Document De Travail - Drees(112): 101. http://www.drees.sante.gouv.fr/IMG/pdf/serieetud112-4.pdf

[BDSP. Notice produite par MIN-SANTE R0xnC7I9. Diffusion soumise à autorisation]. Ce rapport décrit les méthodes et modèles d'estimation et d'ajustement de la mortalité hospitalière identifiées dans la littérature. Il en ressort que, d'une manière générale, trois questions méthodologiques majeures préoccupent les épidémiologistes, les chercheurs et les décideurs : premièrement, sur l'opportunité d'établir l'indicateur de mortalité hospitalière à partir de groupes de population de patients homogènes définis par des pathologies et/ou des procédures médicales/chirurgicales cibles ; deuxièmement, sur le type d'approche analytique et de l'intérêt de prendre en compte plusieurs niveaux dans l'analyse statistique ; enfin troisièmement, sur le choix des variables d'ajustement permettant de contrôler les

différences de case-mix entre plusieurs établissements ou groupes de patients pour réaliser des comparaisons.

Januel, J. M., et al. (2011). "Adaptation au codage CIM-10 de 15 indicateurs de la sécurité des patients proposés par l'Agence étasunienne pour la recherche et la qualité des soins de santé (AHRQ)." Revue D'epidemiologie Et De Sante Publique **59**(5): 341-350, tabl., fig.

[BDSP. Notice produite par ORSRA 9R0xBpp9. Diffusion soumise à autorisation]. Position du problème : Aux États-Unis, l'Agence pour la recherche et la qualité des soins de santé (AHRQ) a développé 20 indicateurs de la sécurité des patients afin de mesurer la survenue d'événements indésirables liés aux soins (EIS) à partir des données médico-administratives codées selon la neuvième révision de la classification internationale des maladies (CIM-9-CM). L'adaptation de ces indicateurs de sécurité des patients (Patient Safety Indicators [PSI]) à la version OMS de la CIM-10 du codage des diagnostics a été réalisée par un consortium international. Méthodes : Les codes diagnostiques CIM-9-CM proposés par l'AHRQ ont été transcodés en CIM-10-OMS parallèlement par deux équipes. Un processus Delphi a été utilisé par des experts de six pays qui ont évalué indépendamment chaque code en précisant s'il était "inclus", "exclus" ou "incertain". Les experts se sont ensuite réunis pour discuter les codes qui n'avaient pas obtenu un consensus et les codes additionnels proposés. Résultats : Quinze PSI ont été adaptés. Parmi les 2569 codes diagnostiques proposés, 1775 ont été adoptés unanimement d'emblée. Les 794 codes restants et 2541 codes additionnels ont été discutés. Trois documents ont été préparés : (1) une liste de codes CIM-10-OMS pour les 15 PSI adaptés ; (2) des recommandations destinées à l'AHRQ pour l'amélioration du cadre nosologique et du codage des PSI avec la CIM-9-CM ; (3) des recommandations destinées à l'OMS pour améliorer la CIM-10. Conclusion : Ce travail permet d'envisager des comparaisons internationales des PSI entre les pays qui utilisent la CIM-10. Toutefois ces PSI doivent encore faire l'objet d'une évaluation plus approfondie avant leur utilisation. (résumé d'auteur).

Jeanblanc, G. et Durand, Z. A. L. E. S. K. I. I. (2008). "Évaluation des pratiques professionnelles et indicateurs de performance." Journal D'economie Medicale **26**(4): 218-225, tabl.

[BDSP. Notice produite par ORSRA R0xJH7DH. Diffusion soumise à autorisation]. L'objet de cet article est l'étude des relations entre l'évaluation des pratiques professionnelles (EPP) pour les médecins hospitaliers et l'utilisation des indicateurs de performance hospitaliers, à partir d'expériences étrangères. Les deux exemples choisis sont la Grande-Bretagne et les Etas-Unis qui ont établi des programmes nationaux de recueil de données sur les pratiques professionnelles. Sont abordés successivement : les réformes en cours et leur cohérence, les relations entre qualité d'une pratique individuelle ou d'une équipe hospitalière et performance dans un objectif de régulation, le rôle des incitations financières.

Juven, P.-A. (2013). "Codage de la performance ou performance du codage : Mise en chiffre et optimisation de l'information médicale." Journal De Gestion Et D'economie Medicales **31**(2-3): 75-91, rés.

[BDSP. Notice produite par ORSRA R0xqsHkl. Diffusion soumise à autorisation]. De nombreux travaux se sont d'ores et déjà penchés sur la diffusion d'une logique performantielle à l'hôpital. Pourtant, cette logique peut être envisagée non pas comme une entité existante malgré les acteurs mais produite et négociée par eux. Nous montrons ici que la performance ne va pas de soi, qu'elle doit être définie au travers d'un ensemble d'épreuves, de bricolages institutionnels. Principalement appuyé par des critères quantitatifs, le discours sur la performance doit être étudié à partir de la matière même de ce qui le soutient. Cette matière est produite à partir du codage dans le système d'information des hôpitaux. Or ce

codage, non seulement implique des incertitudes quant à la description de l'activité médicale mais il peut aussi être l'objet de retouches, de valorisation. La performance ne dépend alors plus seulement des mesurés, mais des outils de mesure et de l'action des mesurants.

Kervasdoue, J. d. (2000). La qualité des soins en France, Paris : Fédération Nationale de la Mutualité Française ; Editions de l'Atelier ; Editions ouvrières

Depuis plus de dix ans, le thème de la qualité des soins est au cour de toutes les réflexions et mesures visant à améliorer notre système de santé. Mais en dépit des intentions affichées, la France accuse encore un retard important en la matière, telle en témoigne la mortalité occasionnée à l'hôpital par les infections nosocomiales. Ce livre se veut d'abord un plaidoyer pour la mise en oeuvre des procédures de qualité. Il met cependant en garde contre une certaine conception des politiques de qualité de soins qui pourrait mener à une bureaucratisation et une déshumanisation des pratiques médicales. Il propose des mesures opérationnelles susceptibles d'être développées rapidement. Ecrit par l'un des meilleurs spécialistes de la question, cet ouvrage n'hésite pas à bousculer tous les conservatismes et à avancer des solutions audacieuses.

Kervasdoue, J. de, et al. (1997). "L'accréditation en France : un unanimisme trompeur. Discussion." Gestions Hospitalieres(369): 686-690.

[BDSP. Notice produite par INIST kKR0xYyg. Diffusion soumise à autorisation].

Kimberly, J. et Minvielle, E. (1991). "L'analyse de la qualité des soins et de l'utilisation des ressources à l'hôpital." Revue Francaise Des Affaires Sociales **45**(2): 79-94.

Laflamme, B., et al. (2011). "La qualité des soins, les guides de pratique et les modalités d'organisation." Sante Societe Et Solidarite : Revue De L'observatoire Franco-Quebecois(1/2010): 77-86.

Les intervenants de cet atelier abordent les questions relatives à la qualité des soins, aux guides de pratique et aux modalités d'organisation des services aux patients atteints de cancer dans le but de proposer aux ministres français et québécois des pistes d'action qui orienteront leurs choix en matière de lutte contre le cancer.

Le Barbier, B., Mélina, et al. (2008). "Des indicateurs de qualité et de gestion des risques pour suivre la prise en charge hospitalière des accidents vasculaires cérébraux." Sante Publique(3): 225-237.

[BDSP. Notice produite par EHESP FnFIFR0x. Diffusion soumise à autorisation]. Le pronostic des accidents vasculaires cérébraux (AVC) fait l'objet de recommandations diagnostiques et thérapeutiques. Cette étude vise à déterminer des indicateurs de qualité et de gestion des risques pour suivre leur prise ne charge hospitalière. Il s'agit d'une étude descriptive et prospective des patients présentant un AVC de moins de 12 heures dans l'unité neuro-vasculaire (USINV) du groupe hospitalier Pitié-Salpétrière à travers une série d'items choisis à partir de l'analyse de la littérature et des recommandations existantes. Durant la période étudiée (1er août 2003-30 avril 2005), 310 patients répondaient aux critères d'inclusion. Il s'agissait principalement d'accident ischémique (87,5%) et d'hémorragie cérébrale (10,3%=avec un déficit initial modéré à sévère. Le délai moyen d'arrivée était de 212+-130 minutes. 40% des patients thrombolisés l'ont été dans les trois premières heures. La durée moyenne de séjour était de 17,5 jours. Au décours de leur hospitalisation, 31% sont rentrés à leur domicile, 47% en service de rééducation et 8% sont décédés. Dix indicateurs de qualité et de gestion des risques sont proposés interrogeant sur la filière pré-hospitalière, les

modalités de prise en charge, les évènement indésirables, les durées de séjour, les modes de sortie et le handicap.

Leleu, H., et al. (2011). "Developing and Using Quality Indicators in French Health Care Organisations : A new area of health services and management research. Lessons from the COMPAQ-HPST Project." Journal D'economie Medicale **29**(1-2): 37-46, tabl., fig.

[BDSP. Notice produite par ORSRA Bn7qlR0x. Diffusion soumise à autorisation]. L'objectif de cet article est de décrire le processus d'intégration des indicateurs de qualité des soins dans le domaine du management des organisations de santé.

Leleu, H. et Dervaux, B. (2005). "Les enjeux d'une mesure de la productivité hospitalière dans le cadre de l'évaluation de la tarification à l'activité." Dossiers Solidarite Et Sante(3): 49-66.

La mesure d'un indicateur de productivité hospitalière renvoie à plusieurs problématiques qui ont trait à sa définition, à sa mesure, à son champ d'application et à son utilisation. Cet article tente de mettre en lumière les enjeux d'une mesure de la productivité hospitalière afin d'en dégager une méthodologie de mesure adaptée qui pourrait être utile à l'évaluation de l'impact économique de la tarification à l'activité. Une fois passés en revue les différents concepts de performance économique, les auteurs analysent de manière critique la mesure de la productivité propre au secteur hospitalier qui fait l'objet d'une discussion au travers de l'expérience américaine.

Lepape, A. (2007). "Qualité des soins, gestion des risques et infections nosocomiales." Esprit **Janvier**(1): 88-97.
http://www.cairn.info/revue-esprit-2007-1-page-88.htm

Lombrail, P. (2001). "Lien entre hits-parades, indicateurs de performances et qualité." Actualite Et Dossier En Sante Publique(35): 68-70.

[BDSP. Notice produite par ENSP 3I7ER0xL. Diffusion soumise à autorisation]. Les classements des hôpitaux présentés dans la presse sont basés sur des critères incomplets et controversés. La qualité des établissements repose en grande partie sur l'organisation du travail et la capacité d'adaptation.

Louvel, A. (2008). "Éducation thérapeutique en établissements de santé. Des indicateurs de qualité." Gestions Hospitalieres(479): 549-557, tabl.

[BDSP. Notice produite par EHESP R0x99E7o. Diffusion soumise à autorisation]. Un ensemble d'indicateurs de qualité de l'éducation thérapeutique du patient et son cadre d'évaluation pour les établissements de santé sont proposés dans cet article. La proposition s'inscrit dans le contexte du projet d'évaluation de l'éducation thérapeutique de 2008 : distinction entre disease management, accompagnement du patient et éducation thérapeutique, déploiement de l'éducation thérapeutique, ressources et recommandations disponibles... Les indicateurs se rapportent à quatre dimensions : la participation des patients, la formation des professionnels, le rôle que jouent ces professionnels et leur organisation en équipe et enfin le dossier du patient. L'auteure rapproche ces indicateurs des recommandations émises par la Haute Autorité de santé pour la mise en oeuvre de l'éducation thérapeutique, notamment en 2007. Elle en précise aussi les enjeux d'efficacité, d'éthique et de progrès en se référant à une éducation thérapeutique qui vise à être utile au patient pour gérer sa maladie, sa santé et sa qualité de vie. (R.A.).

Mallot, J. (2010). Rapport d'information sur le fonctionnement de l'hôpital. Paris Assemblée Nationale**:** 171 , ann.
http://www.assemblee-nationale.fr/13/rap-info/i2556.asp

Ce rapport d'information fait la synthèse des travaux de la mission d'évaluation et de contrôle des lois de financement de la sécurité sociale (MECSS) sur « le fonctionnement de l'hôpital » La mission qui a concentré son analyse sur les établissements hospitaliers publics a étudié les voies et moyens de nature à améliorer l'organisation et le fonctionnement interne des établissements afin d'améliorer la qualité du service médical rendu aux usagers et leur efficience médico-économique. Le document comporte 46 propositions visant à réorganiser et à améliorer le fonctionnement des hôpitaux, et donc leur performance. Les pistes tracées portent sur le pilotage de l'efficience médico-économique (fixer des objectifs aux ARS en la matière), l'appui technique aux réorganisations hospitalières et la prise en compte de l'efficience (clarification des missions des multiples structures chargées de l'audit et de l'accompagnement des hôpitaux), la mise en place des pôles (instauration d'audits d'efficience médico-économique obligatoires), les outils de pilotage et de gestion dans les établissements (généralisation de la comptabilité analytique performante dans les deux ans, accélération des dispositifs d'aides à la performance), les évolutions de l'activité hospitalière (lever les freins au développement de la chirurgie et de la médecine ambulatoires, poursuivre le développement de l'HAD), la régulation par la qualité (mise en place et diffusion de référentiels, veiller davantage à la pertinence des interventions et des soins), l'efficience des achats et la sécurité juridique des marchés publics (rendre obligatoire le recours aux groupements d'achats hospitaliers), les rapports avec les usagers (améliorer l'information des usagers), le financement des établissements (généralisation du codage à la source, au lit du malade, des séjours et des actes par les professionnels de santé et généralisation des paiements des patients dès leur entrée à l'hôpital pour la consultation, les actes et examens programmés), la gestion du personnel. Tous ces progrès dans la gestion des hôpitaux français paraissent plus que jamais urgents, alors que ceux-ci vont être amenés à davantage se serrer la ceinture. Déjà cette année, les tarifs de rémunération des actes hospitaliers ont été gelés. Et l'objectif d'un retour à l'équilibre des hôpitaux en 2012 est confirmé

Minvielle, E. (1999). "Les politiques d'amélioration de la qualité des soins à l'hôpital. Quel fondement organisationnel ?." Politiques et management public, **17**(4): 59-84.

Si la recherche de qualité constitue un objectif partagé par l'ensemble des acteurs hospitaliers, les moyens nécessaires pour y parvenir sont sources de controverses. L'histoire de la co-production de la qualité à l'hôpital montre qu'à des formes traditionnelles, attachées au régime de la bureaucratie professionnelle, est venue récemment s'associer une conception prônant une approche organisationnelle centrée sur la prise en charge des patients. La qualité doit-elle alors se concevoir sous le prisme de l'expertise professionnelle, comme la conformité à des règles administratives, ou comme un objectif de rationalisation d'un système productif ? Pour éclairer cette question, cet article s'attache à préciser dans un premier temps les différentes formes existantes de coproduction de la qualité, puis à présenter les grandes lignes d'un cadre d'analyse organisationnel structuré dans lequel s'inscrirait l'objectif de recherche de qualité, et enfin à discuter les modes de régulation entre cette conception et les approches traditionnelles, professionnelles et administratives.

Minvielle, E. (2005). "Classement des hôpitaux : jusqu'où ?" Revue Hospitaliere De France(505): 34-38.

[BDSP. Notice produite par ENSP R0xBvRSo. Diffusion soumise à autorisation]. Le classement des hôpitaux est un sujet sensible et complexe. Sensible car il renvoie à des débats de société souvent médiatisés dans lesquels professionnels, politiques, citoyens/usagers/patients expriment des attentes différentes. Complexe car la notion de classement est elle-même ambiguë : doit-on y voir un rangement du premier au dernier ou des catégories distinguant des "bons" et des "mauvais" ? Doit-on classer l'hôpital dans son ensemble ou distinguer des thèmes spécifiques ? En outre, l'objectif poursuivi n'est pas univoque. Il est fréquent d'associer le classement à une diffusion publique de l'information. Mais un classement peut aussi s'inscrire dans des démarches où seul l'établissement connaît son positionnement. Dans le cas d'une diffusion publique de l'information, il est habituel d'y associer une vertu de transparence. Mais n'y a-t-il pas d'autres effets de cette diffusion publique ?

Minvielle, E. (2006). "COMPAQH. Recherches sur le développement des indicateurs qualité." Revue Hospitaliere De France(513): 19-22.

[BDSP. Notice produite par EHESP H8CR0x8t. Diffusion soumise à autorisation]. Trois années d'existence du programme COMPAQH permettent d'en tirer les premiers enseignements et d'évaluer ses perspectives de développement jusqu'en 2009. Quels indicateurs sont utilisés ? Comment les tester ? Quelles différences de qualité peut-on révéler ? Quel emploi pratique envisager au sein des ES ? Quel équilibre établir entre initiatives propres aux établissements et incitations externes, telles que le développement des classements ou les incitations économiques ? Enfin, quelle cohérence donner à ce mouvement d'évaluation par la mesure de la qualité des soins ? Autant de questions auxquelles ce programme cherche à répondre.

Minvielle, E. (2012). "La régulation de la qualité des soins hospitaliers : avec ou sans les professionnels de santé ?" Gestions Hospitalieres(514): 152-159, tabl.

[BDSP. Notice produite par EHESP 8npnR0xF. Diffusion soumise à autorisation]. Dans le système de soins français, la régulation de la qualité vise à garantir un niveau de qualité égal quelles que soient les conditions d'accès. Fort de ce principe de solidarité, le régulateur ne doit pas contribuer à différencier par la qualité mais, au contraire, l'améliorer, la rendre homogène et subordonner toute concurrence à un objectif de réduction des inégalités. Cet objectif ambitieux se traduit par d'importantes opérations ces dernières années. A leur lumière, des enseignements apparaissent pour le futur, posant la question centrale du rapport de confiance avec le monde professionnel. (intr.).

Minvielle, E. (2013). "Comment évaluer et réguler la performance en matière de qualité de la prise en charge des malades ?" Quaderni(82): 82-98.

Dans le système de santé, la régulation de la qualité des soins vise à garantir un niveau de qualité égal quelles que soient les conditions d'accès. Fortes de ce principe, les vingt dernières années ont été le théâtre d'un développement important de cette régulation, principalement à l'hôpital. L'objectif de cet article est d'établir une mise en perspective historique de ce développement et d'en déduire une analyse critique. Si cette régulation était peu affirmée dans les années 90, essentiellement fondée sur des formes d'autoévaluation menées par les professionnels, le début des années 2000 a marqué un virage avec l'émergence de régulations externes (diffusion publique de l'information, paiement à la qualité, renforcement des normes) fondée sur les indicateurs. Sur cette base, nous tentons de préciser le statut de la régulation de la qualité dans des systèmes professionnels de ce type : entre contrôle et autonomie encadrée.

Minvielle, E. et Grenier-Sennelier, C. (2001). "Une mesure régulière de la performance en matière de qualité de la prise en charge des malades est-elle possible ?" Journal D'economie Medicale **19**(3): 131-146, rés., tabl., fig.

> [BDSP. Notice produite par ORSRA Qs2R0xDK. Diffusion soumise à autorisation]. Dans un premier temps, nous rappelons le caractère forcément multidimensionnel de la "performance hospitalière en matière de qualité du service rendu". Nous dressons également le constat du caractère embryonnaire des travaux menés en France sur le sujet en regard des pays anglo-saxons. Nous restituons ensuite les premiers enseignements d'une recherche engagée dans le domaine en collaboration avec l'Union Hospitalière Privée. Nous y identifions trois écueils à surmonter : des dimensions de la qualité qui ne renvoient à aucun indicateur opérationnel, des indicateurs pour lesquels les moyens nécessaires à une utilisation routinière sont absents, et des indicateurs développés empiriquement, mais sans précaution méthodologique. (R.A.).

Moisdon, J.-C. (2014). "Payer la qualité des soins à l'hôpital ?. Réflexions à propos d'un dispositif innovant : l'expérimentation IFAQ (Incitation Financière à la Qualité)." Quaderni **85**(3): 29-38. http://www.cairn.info/revue-quaderni-2014-3-page-29.htm

> IFAQ (Incitation Financière à la Qualité) est une expérimentation visant à anticiper les effets d'une rémunération des établissements de santé français en fonction de leur performance évaluée à partir d'indicateurs. L'article commente cette opération sous trois aspects : le processus de construction du dispositif, largement coopératif, la complexité du modèle aboutissant à un score global pour tout établissement, et les mécanismes qui y ont conduit, la question de la compatibilité entre un incitatif national construit à partir d'indicateurs de processus et une gestion locale de la qualité par les équipes de soignants elles-mêmes.

Mougeot, F., et al. (2017). "L'émergence de la question de la sécurité des patients en France." Sante Publique **29**(6): 869-877.

> [BDSP. Notice produite par EHESP 9R0x9ErF. Diffusion soumise à autorisation]. L'objectif de cet article est de comprendre les conditions d'émergence de la thématique de la sécurité des soins dans le débat public et les limites de sa mise en oeuvre dans le système de santé actuel. En effet, une revue de la littérature a permis de montrer que la difficile émergence de la sécurité des soins en France est notamment liée à l'euphémisation du problème de la sécurité des patients, à la difficulté du passage au raisonnement systémique, à la carence en leviers de gestion des ressources humaines et à la place ambiguë des patients dans la sécurité des soins.

Mousques, J. et Daniel, F. (2015). "L'impact de l'exercice regroupé pluriprofessionnel sur la qualité des pratiques des médecins généralistes. Résultats de l'évaluation des maisons, pôles et centres de santé participant à l'Expérimentation des nouveaux modes de rémunération (ENMR)." Questions D'economie De La Sante (Irdes)(211): 1-6. http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/211-l-impact-de-l-exercice-regroupe-pluriprofessionnel-sur-la-qualite-des-pratiques-des-medecins-generalistes.pdf

> Quels impacts l'exercice pluriprofessionnel a-t-il dans les maisons, pôles et centres de santé ayant participé aux Expérimentations des nouveaux modes de rémunération (ENMR) entre 2010 et 2014 ? Les médecins généralistes des sites ENMR sont-ils plus actifs et plus productifs que les autres ? La structure de leur activité est-elle similaire ? Leurs patients recourent-ils plus ou moins fréquemment aux différentes catégories de soins ambulatoires ? Leurs dépenses sont-elles moindres ou plus élevées ? Ces résultats sont-ils homogènes ou

hétérogènes entre les différents types de sites participant aux ENMR ? Autant de questions qui sont explorées dans ce cinquième volet de l'évaluation des sites regroupés pluriprofessionnels ayant participé aux ENMR. Les analyses évaluatives quantitatives de mesure de l'impact du regroupement sur l'activité et les soins et services de santé sont effectuées à partir de designs quasi-expérimentaux.

Mulley, A., et al. (1997). "Avantages et limites des recommandations de pratique clinique dans la prise de décision médicale. Discussion." Gestions Hospitalieres(369): 646-652.

[BDSP. Notice produite par INIST R0xV5c4B. Diffusion soumise à autorisation].

Nestrigue, C. et Or, Z. (2011). "Surcoût des événements indésirables associés aux soins à l'hôpital : premières estimations à partir de neuf indicateurs de sécurité des patients." Etudes Et Resultats (Drees)(784): 8.
http://www.drees.sante.gouv.fr/IMG/pdf/er784.pdf

Cette étude fournit de premières estimations nationales du coût de prise en charge d?une partie des événements indésirables associés aux soins qui surviennent à l?hôpital, en exploitant les données hospitalières collectées en routine. Neuf indicateurs de sécurité des patients, permettant d?identifier les événements indésirables nécessitant une attention particulière et sur lesquels il est possible d?intervenir en amont, ont été retenus. Les résultats montrent que 0,5 % des séjours hospitaliers sont associés à l?un ou l?autre de ces neuf événements indésirables. Il existe toutefois de fortes disparités de surcoûts, ceux-ci pouvant varier d?un peu plus de 500 ? pour les traumatismes obstétricaux à environ 20 000 ? pour les septicémies. Ces surcoûts sont étroitement corrélés avec la durée des séjours et l?intensité des soins. En 2007, le coût total de prise en charge de ces neuf événements indésirables est estimé à 700 millions d?euros, concentré à 90 % sur quatre événements indésirables (désordres physiologiques et métaboliques postopératoires, septicémies postopératoires, escarres et embolies pulmonaires postopératoires). Les événements indésirables examinés dans cette étude sont associés à une augmentation significative du coût et de la durée de séjour à l?hôpital. Cette question nécessite donc d?être explorée dans la perspective d?améliorer la qualité des soins tout en renforçant le rapport coût-efficience des établissements.

Nestrigue, C. et Or, Z. (2011). "Surcoût des évènements indésirables associés aux soins à l'hôpital. Premières estimations à partir de neuf indicateurs de sécurité des patients." Questions D'economie De La Sante (Irdes)(171): 8.
http://www.irdes.fr/Publications/2011/Qes171.pdf

Cette étude fournit de premières estimations nationales du coût de prise en charge dune partie des événements indésirables associés aux soins qui surviennent à l'hôpital, en exploitant les données hospitalières collectées en routine. Neuf indicateurs de sécurité des patients, permettant d'identifier les événements indésirables nécessitant une attention particulière et sur lesquels il est possible d'intervenir en amont, ont été retenus. Les résultats montrent que 0,5 % des séjours hospitaliers sont associés à l'un ou l'autre de ces neuf événements indésirables. Il existe toutefois de fortes disparités de surcoûts, ceux-ci pouvant varier d'un peu plus de 500 euros pour les traumatismes obstétricaux à environ 20 000 euros pour les septicémies. Ces surcoûts sont étroitement corrélés avec la durée des séjours et l'intensité des soins. En 2007, le coût total de prise en charge de ces neuf événements indésirables est estimé à 700 millions d'euros, concentré à 90 % sur quatre événements indésirables (désordres physiologiques et métaboliques postopératoires, septicémies postopératoires, escarres et embolies pulmonaires postopératoires). Les événements

indésirables examinés dans cette étude sont associés à une augmentation significative du coût et de la durée de séjour à l'hôpital. Cette question nécessite donc d'être explorée dans la perspective d'améliorer la qualité des soins tout en renforçant le rapport coût-efficience des établissements.

Nestrigue, C. et Or, Z. (2016). "Le surcoût des événements indésirables associés aux soins à l'hôpital." Soins **61**(804): 23-25.
http://www.em-consulte.com/en/article/1048292

La qualité et la sécurité des soins fournis à l'hôpital font l'objet d'une attention croissante dans nombre de pays. Le célèbre rapport de l'Institut de médecine américain précisant que près de 100 000 Américains meurent chaque année à cause d'événements indésirables associés aux soins (EIS) – pour lesquels le coût est estimé à près de 29 milliards de dollars par an – a suscité la volonté de mieux comprendre ces EIS afin d'en réduire l'occurrence.

Or, Z., et al. (2013). Activité, productivité et qualité des soins des hôpitaux avant et après la T2A. Document de travail Irdes ; 56. Paris Irdes**:** 76.
http://www.irdes.fr/EspaceRecherche/DocumentsDeTravail/DT56SoinsHospitaliersT2A.pdf

La tarification à l'activité (T2A), introduite en 2004-2005 pour financer l'activité de court séjour des hôpitaux publics et privés, avait pour but d'améliorer l'efficience des établissements de santé et du secteur hospitalier. Or le suivi de l'impact de la T2A sur l'évolution de l'activité et de la productivité hospitalière reste à ce jour partiel. Cette étude fournit de nouvelles données et analyses quantitatives permettant d'apprécier les effets de la réforme de la T2A sur l'activité, la productivité et la qualité des soins hospitaliers. Au moyen d'une série d'indicateurs estimés annuellement sur la période 2002-2009, nous tentons de répondre aux questions suivantes : produit-on plus ou moins pour chaque euro dépensé pour l'hôpital depuis l'introduction de la T2A ? La structure de la production a-t-elle été modifiée ? Comment la qualité des soins a-t-elle évolué ? (résumé d'auteur).

Or, Z. et Com-Ruelle, L. (2008). "La qualité de soins en France : comment la mesurer pour l'améliorer ?" Journal D'economie Medicale **26**(6-7): 371-385.
http://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales1-2008-6-page-371.htm

Or, Z. et Com-Ruelle, L. (2008). La qualité des soins en France : comment la mesurer pour l'améliorer ? Document de travail Irdes ; 19. Paris Irdes**:** 18.
http://www.irdes.fr/EspaceRecherche/DocumentsDeTravail/DT19QualiteDesSoinsEnFrance.pdf

Définir et évaluer la qualité des soins est une démarche fondamentale si l'on veut améliorer le système de santé. Malgré sa réputation « de meilleur système de santé dans le monde », selon l?OMS, la France est en retard sur l'étude de la qualité des soins. Il n'existe pas à l'heure actuelle de système d'information permanent sur la qualité et la sécurité des soins et les données demeurent partielles, contradictoires et difficilement accessibles. Afin d'obtenir une image globale des problèmes de qualité de soins et développer des stratégies pour l'améliorer, il est important de recueillir des données de manière systématique et sur une base nationale cohérente. Cet article fournit une vue d'ensemble des données disponibles sur la qualité de soins en France en suivant le cadre d'analyse et les recommandations internationales pour mesurer la qualité. En comparant la situation de la France à celles d'autres pays développés, elle vise également à identifier les lacunes et les points forts du système actuel pour améliorer la gestion de la qualité des soins.

Or, Z. et Com-Ruelle, L. (2008). "La qualité des soins en France : comment la mesurer pour l'améliorer ?" Journal D'economie Medicale **26**(6-7): 371-385.

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Or, Z., et al. (2015). "Pour un atlas des variations des pratiques en France." Actualite Et Dossier En Sante Publique(92): 43-45.
http://www.hcsp.fr/Explore.cgi/Adsp?clef=149

> L'information sur les droits des usagers de la santé constitue une priorité pour réduire l'asymétrie d'information entre soignants et soignés et permettre aux usagers de pouvoir contribuer aux décisions de santé et aux patients d'être réellement acteurs de leur prise en charge en choisissant au mieux leur parcours de soins. Cette priorité est entrée dans le Code de santé publique depuis plus de 13 ans avec le vote de la loi du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé (introd.).

Or, Z., et al. (2017). "Variations des pratiques chirurgicales dans la prise en charge des cancers du sein en France." Questions D'economie De La Sante (Irdes)(226): 1-8.
www.irdes.fr/recherche/questions-d-economie-de-la-sante/226-variations-des-pratiques-chirurgicales-dans-la-prise-en-charge-des-cancers-du-sein-en-france.pdf

> En 2015, le cancer du sein est le premier cancer féminin en termes d'incidence (54 000 nouveaux cas) et de mortalité (12 000 décès) [Inca, 2015]. La prise en charge chirurgicale des cancers du sein s'est améliorée à la suite d'évolutions diagnostiques et thérapeutiques, mais également d'une recomposition de l'offre de soins en cancérologie. Le traitement conservateur (tumorectomie) est devenu le traitement de référence avec un taux de recours dépassant 70 % dans une grande majorité d'établissements en 2012. Entre 2005 et 2012, la technique du ganglion sentinelle s'est diffusée dans la plupart des établissements, et le nombre de patientes en ayant bénéficié a triplé sur la période. En revanche, la reconstruction mammaire immédiate après une mastectomie totale reste peu fréquente, bien que le recours à cette technique soit en augmentation. Les taux de recours à ces pratiques varient entre les établissements et entre les départements. Ces variations peuvent être en partie le reflet de l'état de santé et des préférences des patientes. Mais elles illustrent également des différences dans la disponibilité et l'organisation des services et des plateaux techniques, ainsi que des différences de pratiques entre établissements. Toutes choses égales par ailleurs, la probabilité de bénéficier de la technique du ganglion sentinelle ou d'une reconstruction mammaire immédiate est plus élevée dans les Centres de lutte contre le cancer (CLCC), dans les Centres hospitaliers régionaux (CHR) et dans les établissements ayant un volume d'activité élevé.

Or, Z. et Verboux, D. (2014). France : Geographic variations in health care. Geographic Variations in Health Care: What Do We Know and What Can Be Done to Improve Health System Performance?, Paris : OCDE**:** 221-243.
http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/geographic-variations-in-health-care/france-geographic-variations-in-health-care_9789264216594-10-en

In France, awareness about practice variations has been growing in recent years due to the harsh economic context and changes in regional governance. This chapter provides information on variations in the use of eight specific hospital procedures and activities across departments for 2005 and 2011. It then provides an overview of the major policy instruments used in France for tackling variations in medical practice.

Or, Z. et Verboux, D. (2014). La pertinence des pratiques d'hospitalisation : une analyse des écarts départementaux de prostatectomies. Document de travail Irdes ; 59. Paris Irdes**:** 20.
http://www.irdes.fr/recherche/documents-de-travail/059-la-pertinence-des-pratiques-d-hospitalisation-une-analyse-des-ecarts-departementaux-de-prostatectomies.pdf

Cet article analyse les variations territoriales de pratiques de prostatectomies en France. Nous recourons à une modélisation multiniveaux permettant de distinguer la variabilité liée à deux niveaux géographiques : le département et la région. Nos résultats montrent que les taux de prostatectomies standardisés (pour 100 000 hommes) varient de manière significative entre les départements. Les écarts interdépartementaux sont expliqués notamment par la densité d'urologues libéraux dans le département ainsi que par l'offre de soins hospitaliers (disponibilité des lits de chirurgie et de personnels soignants), au niveau régional, une fois contrôlé par le revenu et les taux de mortalité par départements (résumé d'auteur).

Or, Z. et Verboux, D. (2016). "La pertinence des pratiques d'hospitalisation : une analyse des écarts départementaux de prostatectomies." Revue Economique **67**(2): 337-354.
http://www.cairn.info/article.php?ID_ARTICLE=RECO_PR2_0062&WT.mc_id=RECO_672

Cet article analyse les variations territoriales de pratiques de prostatectomies en France. Nous recourons à une modélisation multiniveaux permettant de distinguer la variabilité liée à deux niveaux géographiques : le département et la région. Nos résultats montrent que les taux de prostatectomies standardisés (pour 100 000 hommes) varient de manière significative entre les départements. Les écarts interdépartementaux sont expliqués notamment par la densité d'urologues libéraux dans le département ainsi que par l'offre de soins hospitaliers (disponibilité des lits de chirurgie et de personnels soignants), au niveau régional, une fois contrôlé par le revenu et les taux de mortalité par départements (résumé d'auteur).

Philippe, E., et al. (2015). "Le contrat de bon usage. Suivi des indicateurs générations I et II." Gestions Hospitalieres(547): 353-357.

[BDSP. Notice produite par EHESP JBoR0x88. Diffusion soumise à autorisation]. Le contrat de bon usage engage les établissements de santé soumis à la tarification à l'activité (T2A) dans un processus de sécurisation du circuit des produits pharmaceutiques et d'amélioration des pratiques relatives aux médicaments et dispositifs médicaux. Si sa mise en oeuvre en Bourgogne a permis de renforcer les démarches de qualité et de sécurisation pour les patients, les résultats relatifs au suivi et à l'analyse des pratiques de prescription des produits en sus de la T2A sont les seuls à ne pas témoigner d'une amélioration. Les exigences

renforcées sur ces spécialités, la complexité des interfaces, les problèmes techniques, le manque de réactivité des éditeurs peuvent expliquer les retards dans le déploiement et l'inaccessibilité pour certaines pharmacies à usage intérieur aux données indispensables à l'analyse pharmaceutique, comme pour le déploiement de la dispensation nominative. Si les résultats globaux ont montré une amélioration des indicateurs régionaux, ceux-ci restent globalement en deçà des moyennes nationales. (introd.).

Polton, D., et al. (2008). "Classements d'établissements : pour quoi faire et comment ? : résumé des discussions." Sante Societe Et Solidarite : Revue De L'observatoire Franco-Quebecois(2/2007): 83-85.

Pulcini, C., et al. (2013). "Drug-specific quality indicators assessing outpatient antibiotic use among French general practitioners." The European Journal of Public Health **23**(2): 262-264.

Raynaud, J. et Bailly, A. p. (2015). Inégalités d'accès aux soins : acteurs de santé et territoires, Paris : FBMF ; Paris : Economica
http://www.economica.fr/livre-inegalites-d-acces-aux-soins,fr,4,9782717867954.cfm

L'accès aux soins est devenu l'une des priorités majeures des Français. Souvent étudié à travers la distance géographique ou les difficultés financières, ce concept relève pourtant de multiples dimensions. La prise en compte des perceptions des acteurs de santé est essentielle pour que les décisions politiques soient en adéquation avec le vécu des acteurs. Ainsi, l'ouvrage présente les concepts et les outils nécessaires pour analyser les perceptions des patients (difficultés pour obtenir une consultation) et des médecins (conditions de travail et solutions pour améliorer l'accès aux soins) afin d'identifier les territoires sur lesquels l'offre de soins est insuffisante. D'autre part, le regroupement pluriprofessionnel et la télémédecine sont étudiés pour déterminer les conditions favorables pour le développement d'une offre de soins durable et de qualité sur les territoires grâce à la coopération entre professionnels de santé. L'auteur replace ainsi la géographie au centre d'une réflexion globale et pluridisciplinaire, intégrant l'aménagement du territoire, la sociologie, l'analyse des politiques de santé et l'organisation des professionnels de santé.

Ritter, P. (2008). Mission de préfiguration de l'Agence nationale d'appui à la performance des établissements de santé et médico-sociaux (ANAP). Paris Ministère de la santé, de la Jeunesse, des Sports et de la Vie associative.**:** 46.

Par lettre du 30 juillet 2008, la ministre a confié une mission de préfiguration de l'Agence nationale d?appui de la performance des établissements de santé et médico-sociaux (ANAP). Le présent rapport est issu de la consultation des différents acteurs concernés : plus de 50 entretiens menés, discussion du projet au sein du comité de pilotage de la mission. Le rapport présente : un projet stratégique pour l'agence , une proposition d?organisation , des recommandations pour sa mise en place.

Rococo, E., et al. (2016). "Variation in rates of breast cancer surgery: A national analysis based on French Hospital Episode Statistics." European Journal of Surgical Oncology (Ejso) **42**(1): 51-58.
http://www.ejso.com/article/S0748-7983(15)00795-7/abstract

Aims: Minimum volume thresholds were introduced in France in 2008 to improve the quality of cancer care. We investigated whether/how the quality of treatment decisions in breast cancer surgery had evolved before and after this policy was implemented. Methods: We used Hospital Episode Statistics for all women having undergone breast conserving surgery (BCS) or mastectomy in France in 2005 and 2012. Three surgical procedures considered as

better treatment options were analyzed: BCS, immediate breast reconstruction (IBR) and sentinel lymph node biopsy (SLNB). We studied the mean rates and variation according to the hospital profile and volume.

Saint-Lary, O., et al. (2011). "Adhérer ou pas au CAPI : de quel clivage des généralistes le paiement à la performance est-il révélateur ?" Revue Francaise Des Affaires Sociales(2-3): 180-209.

L'assurance maladie a lancé début 2009 un programme dit de paiement à la performance pour les médecins généralistes : le contrat d'amélioration des pratiques individuelles (CAPI). Il propose aux médecins adhérents de majorer leur rémunération en échange d'une meilleure qualité de leur pratique, mesurée à partir d'une batterie d'indicateurs. L'article cherche à mettre en évidence les facteurs qui déterminent un médecin à y adhérer ou non, à partir d'entretiens collectifs de type focus group, avec des médecins adhérents, d'une part, et non-adhérents, d'autre part. À partir d'une grille construite par une équipe multidisciplinaire, ce travail montre que c'est d'abord le type de positionnement vis-à-vis de l'assurance maladie qui permet de prédire leur choix, mais qu'un second facteur a aussi un rôle propre : le jugement a priori qu'ils portent sur la capacité des indicateurs du CAPI à donner une image valide de la pratique de médecine générale. Les limites de ces résultats sont discutées tout en montrant comment ils permettent d'envisager de coupler au CAPI des incitations non monétaires susceptibles de permettre à des non-adhérents d'améliorer leur pratique (résumé d'auteur).

Saintoyant, V., et al. (2012). "Gestion des risques associés aux soins : état des lieux et perspectives." Pratiques Et Organisation Des Soins(1): 35-45.
http://www.ameli.fr/fileadmin/user_upload/documents/POS1201_Gestion_des_risques_lies_aux_soins__perspectives.pdf

La gestion des risques associés aux soins a fait l'objet de nombreuses actions ces dernières années en France. L'objectif de cet article est double, descriptif, en réalisant une synthèse de ces démarches, et critique. Il s'avère que si la connaissance sur les causes de survenue des évènements indésirables est plus précise, et que le cadre législatif s'est renforcé dans de nombreux domaines, la régulation de la sécurité reste encore à consolider. De nombreuses actions sont désormais mises en œuvre sur le plan de la déclaration des évènements indésirables et du développement des outils d'analyse (revue de morbi-mortalité, check-list, notamment). Par contre, une question persiste sur l'équilibre à trouver entre les interventions demandées par les pouvoirs publics et l'auto-évaluation conduite par les professionnels. Entre le souci de proximité dans l'accompagnement des professionnels à des fins d'amélioration et la quête de transparence sur le sujet, cet article expose des pistes de ce que pourraient être les perspectives de cette régulation.

Salomon, V. (2009). "Les instruments : qualité et sécurité, hygiène hospitalière." Sécurité des patients, sécurité des consommateurs: 161-167.
http://www.cairn.info/securite-des-patients-securite-des-consommateurs--9782130574163-page-161.htm

Salomon, V. et Nadal, J.-M. (2006). "Icalin et les indicateurs de qualité des soins." Revue Hospitaliere De France(513): 29-30.

[BDSP. Notice produite par EHESP R0x8nIB7. Diffusion soumise à autorisation]. Produire et diffuser des indicateurs de qualité relève, pour les pouvoirs publics, d'une démarche à la fois scientifique et pragmatique : il s'agit de transmettre des informations sur la qualité du système de santé pertinentes, valides, de compréhension facile mais non simplistes. En

février 2006 a eu lieu la première diffusion d'un indicateur composite des activités de lutte contre les infections nosocomiales (Icalin). Lui sera associée, prochainement, la mise en ligne d'une plateforme Internet présentant les données issues du PMSI et de la SAE 2004. Cette diffusion, nationale et publique, répond au souci d'une transparence accrue.

Schilte, A. et Minvielle, É. (2008). "Le classement des hôpitaux : une nouvelle manière de rendre des comptes." Annales des Mines - Gérer et comprendre **91**(1): 36-47.
http://www.cairn.info/revue-gerer-et-comprendre1-2008-1-page-36.htm

Silber, D. (2008). Mesurer la qualité des soins. Paris Institut Montaigne**:** 47.
http://www.institutmontaigne.org/medias/documents/note_silber.pdf

Il y a encore quelques années, les Français étaient convaincus de bénéficier du meilleur système de santé au monde. Aujourd'hui, leur sentiment est plus mitigé. En fait, ils sont incapables de se prononcer en toute objectivité. Et pour cause : l'évaluation de la qualité des soins, en France, n'en est encore qu'à ses balbutiements. Or les conséquences en termes de santé publique sont graves : erreurs de soins, prévention mal conçue, suivis négligés, accidents trop nombreux, décès évitables. Dans cette note de l'institut Montaigne, Denise Silber, après avoir dressé un état des lieux aussi complet qu'alarmant de la situation, formule sept propositions concrètes pour mesurer efficacement la qualité des soins en France et pour en diffuser largement les résultats. En gardant à l'esprit que l'objectif n'est pas de clouer au pilori les professionnels de santé mais, au contraire, de les aider à progresser afin de satisfaire à un impératif majeur : soigner les Français le mieux possible.

Studer, N. (2013). "Quelles évolutions récentes de la productivité hospitalière dans le secteur public ?" Economie Et Statistique(455-456): 175-202.
http://www.insee.fr/fr/themes/document.asp?reg_id=0&id=3967

Après plusieurs décennies de forte croissance des dépenses de santé, leur efficacité fait l'objet d'une attention accrue. La description fine de l'activité de court séjour fournie par le Programme de médicalisation du système d'information (PMSI) permet d'analyser l'évolution de la performance économique des établissements de santé. Ce travail se propose ainsi de définir un indice de productivité globale construit à partir de l'estimation sur la période 2003-2007 d'une fonction de production pour le secteur hospitalier public. L'indicateur d'activité retenu est la somme des séjours ou actes par groupe homogène de malades (GHM), pondérés par les coûts observés dans un échantillon hôpitaux en 2002-2003. Il s'agit donc essentiellement d'un indicateur d'activité, à qualité des soins supposée constante. On cherche à rendre compte de cette activité par la composition du personnel, ainsi que d'autres caractéristiques observables des établissements, dont la taille et un indice de plateau technique. L'indice de productivité correspond à la part de l'activité qui n'est pas expliquée par le niveau de ces différents facteurs explicatifs (résumé d'auteur).

Tabet, J., et al. (1997). "De la qualité et de ses perversions." Gestions Hospitalieres(369): 637-642.

[BDSP. Notice produite par INIST 16FR0xMf. Diffusion soumise à autorisation].

Touzet, S. (2008). "Évaluation des pratiques professionnelles (EPP) : un avenir conditionné par sa cohérence avec les différents dispositifs d'amélioration de la qualité des soins." Journal D'economie Medicale **26**(6-7): 361-366.
http://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales1-2008-6-page-361.htm

Tregoat, J. J., et al. (2008). "Maîtrise des dépenses de santé ou qualité : faut-il choisir ? Actes du 2e forum franco-québécois sur la santé. Paris - Mars 2007." Sante Societe Et Solidarite : Revue De L'observatoire Franco-Quebecois(2/2007): 151. http://www.persee.fr/web/revues/home/prescript/issue/oss_1634-8176_2007_num_6_2

Vanlerenberghe, J. M. (2017). Rapport d'information sur la pertinence des soins. Paris Sénat**:** 62. http://www.senat.fr/rap/r16-668/r16-668.html

> Alors que les budgets sont sous tension, les systèmes de santé génèrent, en France comme dans la plupart des pays développés, une part de « gaspillage », notamment sous la forme de soins inutiles ou redondants, d'interventions évitables ou à faible valeur ajoutée. Cela pourrait représenter, d'après l'OCDE, près d'un cinquième de la dépense de santé. Ces constats ne sont pas nouveaux. Ils suscitent néanmoins, chez l'ensemble des acteurs du système de santé, une prise de conscience accrue. Face aux défis de la médecine de demain (vieillissement de la population, poids des maladies chroniques, technicité croissante des soins...), l'amélioration de la pertinence des soins représente en effet un enjeu majeur pour l'avenir et la pérennité de notre système de santé. Renvoyant au « juste soin », approprié, adapté aux besoins des patients, conforme aux meilleurs standards cliniques, la pertinence médicale conduit à conjuguer l'exigence de qualité et de sécurité des soins et l'amélioration de l'efficience de notre système de santé, souvent pensées de manière antagoniste. Si des actions ont été engagées par l'État et l'assurance maladie, leurs résultats plafonnent. De l'avis général, l'organisation cloisonnée de notre système de santé et ses modes de financement peu incitatifs sont un frein à des avancées plus substantielles. Une vision stratégique et des évolutions structurelles, au-delà de la logique de rabot, sont aujourd'hui indispensables.

Waelli, M., et al. (2016). "Keys to successful implementation of a French national quality indicator in health care organizations: a qualitative study." BMC Health Serv Res **16**(1): 553.

> BACKGROUND: Several countries have launched public reporting systems based on quality indicators (QIs) to increase transparency and improve quality in health care organizations (HCOs). However, a prerequisite to quality improvement is successful local QI implementation. The aim of this study was to explore the pathway through which a mandatory QI of the French national public reporting system, namely the quality of the anesthesia file (QAF), was put into practice. METHOD: Seven ethnographic case studies in French HCOs combining in situ observations and 37 semi-structured interviews. RESULTS: A significant proportion of potential QAF users, such as anesthetists or other health professionals were often unaware of quality data. They were, however, involved in improvement actions to meet the QAF criteria. In fact, three intertwined factors influenced QAF appropriation by anesthesia teams and impacted practice. The first factor was the action of clinical managers (chief anesthetists and head of department) who helped translate public policy into local practice largely by providing legitimacy by highlighting the scientific evidence underlying QAF, achieving consensus among team members, and pointing out the value of QAF as a means of work recognition. The two other factors related to the socio-material context, namely the coherence of information systems and the quality of interpersonal ties within the department. CONCLUSIONS: Public policy tends to focus on the metrological validity of QIs and on ranking methods and overlooks QI implementation. However, effective QI implementation depends on local managerial activity that is often invisible, in interaction with socio-material factors. When developing national quality improvement programs, health authorities might do well to specifically target these clinical managers who act as invaluable mediators. Their key role should be acknowledged and they ought to be provided with adequate resources.

Waelli, M. et Minvielle, E. (2013). "Facteurs clés pour une personnalisation du service rendu au patient : élaboration d'un cadre d'analyse." Journal De Gestion Et D'economie Medicales **31**(5): 303-316, rés.

[BDSP. Notice produite par ORSRA CkHR0xED. Diffusion soumise à autorisation]. Dans un contexte de contraintes financières accrues et d'engouement pour les questions de personnalisation de la prise en charge des patients, cet article interroge la mise en oeuvre d'un service sur mesure en santé. En prenant appui sur une revue de littérature réalisée à la fois dans le champ de la santé et du management général, il propose un cadre d'analyse tenant compte des spécificités de la santé. Ce cadre permet de distinguer 6 facteurs clés de mise en oeuvre d'un service personnalisé et de souligner leurs interdépendances.

Waelli, M. et Minvielle, E. (2016). "Personnaliser la prise en charge des usagers en santé. Oui, mais comment ?" Revue Hospitaliere De France(568): 49-53.

[BDSP. Notice produite par EHESP 99r9GR0x. Diffusion soumise à autorisation]. "L'AP-HP proche de vous", "My Hospifriends", "Une cuisine qui s'adapte à votre goût à l'hôpital". Alors que les contraintes budgétaires en santé augmentent, le renforcement du droit des usagers et la complexification des parcours favorisent le développement d'innovations pour un service public personnalisé à coût contenu. Oui, mais comment organiser la gestion de la singularité à grande échelle ? Mathias Waelli et Étienne Minvielle ont élaboré un cadre d'analyse dédié à cette dimension organisationnelle de la personnalisation : la "care customization".

Wang, S., et al. (2015). "Inventory of antibiotic stewardship programs in general practice in France and abroad." Med Mal Infect **45**(4): 111-123.

OBJECTIVES: The authors conducted a survey of measures implemented in France and abroad for a better use of antibiotics in general practice. METHODS: A literature review was conducted from January 2000 to July 2014. Emails were sent to every infectious diseases department, to all regional health authorities (ARS), to the health insurance offices (CPAM) with the highest and lowest antibiotic use, and to the ministry of health to make an inventory of all antibiotic stewardship programs. The ministry of health, the board of general practitioners, infectious diseases specialists, pharmacists, and the medical and pharmacy schools of the nation's capital were contacted in 17 countries of Europe and North America. RESULTS: The main measures implemented in France were training of healthcare professionals, publishing guidelines, feedback to the practitioners on their prescriptions, and availability of rapid diagnostic tests. Telephone networks were created in some regions, such as Antibiolor or Medqual, to help physicians with antibiotic prescription. Many foreign countries issued pedagogical material to physicians, for patients to explain what to do in case of viral infection or delayed prescription. In Alberta (Canada), the government introduced an optional authorization for quinolones. In Denmark, the government temporarily suspended the reimbursement of some agents to preserve them according to bacterial ecology. In the United-Kingdom, the antibiotic susceptibility test report must include less than 5 agents. CONCLUSIONS: The measures implemented in France and abroad were usually more persuasive than restrictive. But the bacterial resistance crisis should lead to implementing more restrictive measures.

Weckert, E. et Bertillot, H. (2014). "La régulation de la qualité dans le secteur de la santé?" Quaderni **85**(3): 39-52.
http://www.cairn.info/revue-quaderni-2014-3-page-39.htm

Longtemps, la nature des savoirs médicaux et l'organisation de leur profession ont permis aux médecins d'échapper, dans une large mesure, à toute forme de contrôle extérieur. Pourtant, au cours des deux dernières décennies, l'évaluation de la qualité des soins, en s'institutionnalisant, est venue progressivement remettre en question cette autonomie médicale. Au tournant des années 2000, de nombreux pays industrialisés ont franchi une nouvelle étape en ce sens, en introduisant des indicateurs pour évaluer la qualité des pratiques médicales. À partir d'une enquête qualitative permettant de comparer les formes prises par cette dynamique dans deux contextes institutionnels bien différents (Allemagne et France), cet article s'attache à qualifier les ressorts de la diffusion de tels dispositifs d'évaluation, et leurs effets sur l'autonomie professionnelle des médecins.

Weeks, W. B., et al. (2016). "Without explicit targets, does France meet minimum volume thresholds for hip and knee replacement and bariatric surgeries ?" International Journal of Health Policy and Management **5**(10): 613-614.
http://www.ijhpm.com/article_3249_31da161a9cda932ed4eeaede7c4204d5.pdf
http://www.ijhpm.com/article_3249.html

Persistent findings of a relationship between higher volumes of surgical care and better outcomes1 have caused 3 large US healthcare systems to refer surgical cases when they do not meet minimum volume thresholds for bariatric surgery (where the minimum threshold is 40 surgeries per year) and total hip or total knee replacement surgeries (where it is 50 surgeries per year) (Extrait).

Weider, M.-C., et al. (2015). "Contrôle de l'indicateur de charge en soins SIIPS." Gestions Hospitalieres(550): 531-535, tabl.

[BDSP. Notice produite par EHESP 9R0xp8Do. Diffusion soumise à autorisation]. La méthode des soins infirmiers individualisés à la personne soignée (SIIPS) est actuellement une des seules méthodes d'évaluation de la charge de travail couvrant les secteurs médecine/chirurgie/obstétrique, soins de suite/réadaptation et hospitalisation à domicile. Elle comprend la mesure des SIIPS, qui permet d'évaluer la charge en soins à partir de la demande du patient, et la mesure des activités afférentes aux soins, qui a pour finalité d'apprécier la charge liée à l'organisation de l'unité. L'association des deux mesures donne la charge de travail du personnel infirmier et aide-soignant. Les auteurs présentent ici le dispositif actuel du contrôle qualité des SIIPS. (introd.).

Zaugg, V., et al. (2014). "Améliorer les pratiques et l'organisation des soins : méthodologie des études d'interventions." Sante Publique **26**(4): 519-529.
http://www.cairn.info/revue-sante-publique-2014-4-page-519.htm

ÉTUDES INTERNATIONALES

Aeyels, D., et al. (2017). "Key interventions and quality indicators for quality improvement of STEMI care: a RAND Delphi survey." Acta Cardiol: 1-10.

OBJECTIVE: Identification, selection and validation of key interventions and quality indicators for improvement of in hospital quality of care for ST-elevated myocardial infarction (STEMI) patients. METHODS AND RESULTS: A structured literature review was followed by a RAND Delphi Survey. A purposively selected multidisciplinary expert panel of cardiologists, nurse managers and quality managers selected and validated key interventions and quality

indicators prior for quality improvement for STEMI. First, 34 experts (76% response rate) individually assessed the appropriateness of items to quality improvement on a nine point Likert scale. Twenty-seven key interventions, 16 quality indicators at patient level and 27 quality indicators at STEMI care programme level were selected. Eighteen additional items were suggested. Experts received personal feedback, benchmarking their score with group results (response rate, mean, median and content validity index). Consequently, 32 experts (71% response rate) openly discussed items with an item-content validity index above 75%. By consensus, the expert panel validated a final set of 25 key interventions, 13 quality indicators at patient level and 20 quality indicators at care programme level prior for improvement of in hospital care for STEMI. CONCLUSIONS: A structured literature review and multidisciplinary expertise was combined to validate a set of key interventions and quality indicators prior for improvement of care for STEMI. The results allow researchers and hospital staff to evaluate and support quality improvement interventions in a large cohort within the context of a health care system.

AHRQ (2017). National Healthcare Quality and disparities, 2016. Rockville AHRQ**:** 25 , tabl., fig., cartes.
https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/nhqdr16/2016qdr.pdf

The annual National Healthcare Quality and Disparities Report (QDR) is mandated by Congress to provide a comprehensive overview of the quality of health care received by the general U.S. population and disparities in care experienced by different racial and socioeconomic groups. The report assesses the performance of our health care system and identifies areas of strengths and weaknesses, as well as disparities, for access to health care and quality of health care. Quality is described in terms of the National Quality Strategy priorities, which include patient safety, person-centered care, care coordination, effective treatment, healthy living, and care affordability. The report is based on more than 250 measures of quality and disparities covering a broad array of health care services and settings. Selected findings in each priority area are shown in this report, as are examples of large disparities, disparities worsening over time, and disparities showing improvement.

AIHW (2009). Towards national indicators of safety and quality in health care. Canberra Australian Institute of Health and Welfare**:** 276 , fig., tabl., annexes.
http://www.aihw.gov.au/publications/hse/hse-75-10792/hse-75-10792.pdf

This report sets out recommendations for a set of 55 national indicators of safety and quality in health care. The report concludes the National Indicators Project, a major project funded by the Australian Commission on Safety and Quality in Health Care (the Commission) and undertaken by the Australian Institute of Health and Welfare (AIHW) in close consultation with the Commission and a wide range of clinical and other stakeholders.

Almeida, A. et Fique, J. P. (2011). Evaluating Hospital Efficiency Adjusting for Quality Indicators: an Application to Portuguese NHS Hospitals. Porto Universidade do Porto, Faculdade de Economia do Porto.**:** 20 , tabl., fig.
http://www.fep.up.pt/investigacao/workingpapers/11.11.02_wp435.pdfhttp://www.fep.up.pt/investigacao/workingpapers/11.11.02_wp435.pdf

The objective of this paper is to develop a methodology to incorporate measures of hospital quality in efficiency analysis, applied to Portuguese NHS hospitals, in order to assess whether there is a trade-off between efficiency and quality in Portuguese hospitals. We develop and compare two methodologies to compute DEA technical efficiency scores adjusted for output quality, for a sample of Portuguese NHS hospitals in 2009. When DEA efficiency scores are

adjusted for output quality, the decision making units that lie on the technical efficiency frontier remain largely unaltered, even if a great weight is given to quality indicators over quantity indicators of output. Nevertheless, we find that outside of the frontier adjusting for quality does have an impact in efficiency scores.We conclude that the empirical evidence is not sufficient to identify a clear trade-off between efficiency and quality in the hospitals under review, implying the possibility that efficiency gains may achieved without a significant sacrifice of service quality. Nevertheless, there is enough evidence to conclude that analyzing hospital efficiency without consideration of differences in quality of service will generate biased results. When perceived quality is brought to the analysis, the gap between efficient and inefficient units tends to widen.

Anell, A. et Glenngard, A. H. (2014). "The use of outcome and process indicators to incentivize integrated care for frail older people: a case study of primary care services in Sweden." International Journal of Integrated Care **14**: 11 , tabl.

Background: A number of reforms have been implemented in Swedish health care to support integrated care for frail older people and to reduce utilization of hospital care by this group. Outcomes and process indicators have been used in pay-for-performance (P4P) schemes by both national and local governments to support developments. Objective: To analyse limitations in the use of outcome and process indicators to incentivize integrated care for elderly patients with significant health care needs in the context of primary care. Method: Data were collected from the Region Skåne county council. Eight primary care providers and associated community services were compared in a ranking exercise based on information from interviews and registered data. Registered data from 150 primary care providers were analysed in regression models. Results and conclusion: Both the ranking exercise and regression models revealed important problems related to risk-adjustment, attribution, randomness and measurement fixation when using indicators in P4P schemes and for external accountability purposes. Instead of using indicators in incentive schemes targeting individual providers, indicators may be used for diagnostic purposes and to support development of new knowledge, targeting local systems that move beyond organizational boundaries.

Anema, H. A., et al. (2014). "Influences of definition ambiguity on hospital performance indicator scores: examples from The Netherlands." Eur J Public Health **24**(1): 73-78.
PM:23543677

Research objective: Reliable and unambiguously defined performance indicators are fundamental to objective and comparable measurements of hospitals' quality of care. In two separate case studies (intensive care and breast cancer care), we investigated if differences in definition interpretation of performance indicators affected the indicator scores. Design: Information about possible definition interpretations was obtained by a short telephone survey and a Web survey. We quantified the interpretation differences using a patient-level dataset from a national clinical registry (Case I) and a hospital's local database (Case II). In Case II, there was additional textual information available about the patients' status, which was reviewed to get more insight into the origin of the differences. Participants: For Case I, we investigated 15 596 admissions of 33 intensive care units in 2009. Case II consisted of 144 admitted patients with a breast tumour surgically treated in one hospital in 2009. RESULTS: In both cases, hospitals reported different interpretations of the indicators, which lead to significant differences in the indicator values. Case II revealed that these differences could be explained by patient-related factors such as severe comorbidity and patients' individual preference in surgery date. Conclusions: With this article, we hope to increase the awareness on pitfalls regarding the indicator definitions and the quality of the underlying data. To

enable objective and comparable measurements of hospitals' quality of care, organizations that request performance information should formalize the indicators they use, including standardization of all data elements of which the indicator is composed (procedures, diagnoses)

Angelis, J., et al. (2017). Management Practices and the Quality of Primary Care. IFN Working Paper ; 1114. Stochkolm IFN**:** 18.
http://www.ifn.se/wfiles/wp/wp1174.pdf

Using the World Management Survey method, we map and analyse management quality in Swedish primary care centres. On average, private providers have higher management quality than public ones. We also find that centres with a high overall social deprivation among enrolled patients tend to have higher management quality. Regarding quality of care, we find that management quality is positively associated with accessibility, but not with patient reported experience.

Arah, O. A. et Westert, G. P. (2005). "Correlates of health and healthcare performance : applying the Canadian health indicators framework at the provincial-territorial level." Bmc Health Services Research **76**(5): 13.

Puisqu'il n'existe peu de recherche, au niveau du système de santé, sur les possibles relations entre les indicateurs de santé, la performance des soins de santé, les déterminants non-médicaux de la santé et les caractéristiques de la communauté et des systèmes de santé, les auteurs de cet article ont mené une étude pour explorer ce type de relations en utilisant le cadre d'indicateur de santé développé au Canada.

Ashworth, M. et Armstrong, D. (2006). "The relationship between general practice characteristics and quality of care: a national survey of quality indicators used in the UK Quality and Outcomes Framework, 2004-5." Bmc Family Practice **7**(68): 1-8.
http://www.biomedcentral.com/content/pdf/1471-2296-7-68.pdf

L'information descriptive maintenant disponible sur les soins de santé primaires au Royaume-Uni est unique à l?échelle internationale. Sous le Quality and Outcomes Framework (QOF), des données sont disponibles sur 147 indicateurs de performance pour chaque pratique générale. Les auteurs ont cherché à déterminer les relations entre la qualité des soins primaires, le manque de contacts sociaux et les caractéristiques de la pratique.

Ashworth, M., et al. (2007). "The relationship between social deprivation and the quality of primary care: a national survey using indicators from the UK Quality and Outcomes Framework." Br J Gen Pract **57**(539): 441-448.

BACKGROUND: The existence of health inequalities between least and most socially deprived areas is now well established. AIM: To use Quality and Outcomes Framework (QOF) indicators to explore the characteristics of primary care in deprived communities. DESIGN OF STUDY: Two-year study. SETTING: Primary care in England. METHOD: QOF data were obtained for each practice in England in 2004-2005 and 2005-2006 and linked with census derived social deprivation data (Index of Multiple Deprivation scores 2004), national urbanicity scores and a database of practice characteristics. Data were available for 8480 practices in 2004-2005 and 8264 practices in 2005-2006. Comparisons were made between practices in the least and most deprived quintiles. RESULTS: The difference in mean total QOF score between practices in least and most deprived quintiles was 64.5 points in 2004-2005 (mean score, all practices, 959.9) and 30.4 in 2005-2006 (mean, 1012.6). In 2005-2006,

the QOF indicators displaying the largest differences between least and most deprived quintiles were: recall of patients not attending appointments for injectable neuroleptics (79 versus 58%, respectively), practices opening > or =45 hours/week (90 versus 74%), practices conducting > or = 12 significant event audits in previous 3 years (93 versus 81%), proportion of epileptics who were seizure free > or = 12 months (77 versus 65%) and proportion of patients taking lithium with serum lithium within therapeutic range (90 versus 78%). Geographical differences were less in group and training practices. CONCLUSIONS: Overall differences between primary care quality indicators in deprived and prosperous communities were small. However, shortfalls in specific indicators, both clinical and non-clinical, suggest that focused interventions could be applied to improve the quality of primary care in deprived areas.

Baars, I. J., et al. (2010). "Performance measurement in mental health care: present situation and future possibilities." International Journal of Health Planning and Management **25**(3): 198-214, fig.

This paper describes performance measurement and its indicators for mental health care services. Performance measurement can serve several goals such as accountability, quality improvement and performance management. For all three purposes structure, process and outcome indicators should be measured. Literature was retrieved from Medline and PsychInfo in order to see which performance indicators were used for the three purposes of performance measurement in mental health care. The indicators were classified in structure, process and outcome indicators. The results show no big differences in the indicators used among studies. Performance management is the performance measurement purpose most referred to, followed by accountability, and quality improvement. Outcome and process indicators are used most, structure indicators are in the minority. Several levels of measurement, that is national or service level, came forward in the literature review. To overcome misinterpretation of data and to be able to improve quality and manage performances, performance indicator sets should refer to structure, process and outcome. Indicators should be chosen carefully with the aim of the measurement taken into mind. Based on this review, a conceptual framework is presented to support managers in their decisions about which indictors can best be used for performance measurement. Additionally, a model that provides an understanding of the use of information gained by performance measurement is given.

Ballard, D. J. (2003). "Indicators to improve clinical quality across an integrated health care system." Int J Qual Health Care **15 Suppl 1**: i13-23.

PURPOSE: To describe key historical and operational elements of change that may assist an organization to develop quality indicators for implementing a strategic plan to improve care, align health care improvement efforts with national directions, and examine the types of medication indicators used to assess these changes. SETTING: The Baylor Health Care System (BHCS) is an integrated health care delivery organization in Dallas-Fort Worth, Texas. It includes 11 hospitals with 83 000 admissions per year and 47 primary care and senior centers with more than 500 000 visits annually. INTERVENTION: Following a charter by the BHCS Board of Trustees to develop a health care quality improvement strategic plan, BHCS undertook a system-wide effort to improve care supported by the use of clinical quality indicators. RESULTS: Consistent with the direction of the US Institute of Medicine, BHCS has implemented a clinical indicator system focused on measures of health care underuse, overuse, and misuse. These indicators demonstrated the accomplishments of specific process of care improvements throughout BHCS. Despite implementing Web-enabled error reporting systems and pilot work with an adverse drug event hospital medical record abstraction tool, BHCS indicators of medication misuse continue to be in a formative stage,

much like the national consensus. CONCLUSION: Organizational, compensatory, and cultural commitments may be important for successful implementation of clinical indicator initiatives by health care systems. Using clinical indicators to establish baseline performance and to assess the effectiveness of proposed quality improvements provides quantitative and qualitative means to identify and disseminate best care practices. Although indicators to measure underuse of clinically necessary care are well established, there remains a need to achieve consensus regarding practicable medication quality indicators for overuse, misuse, and adverse drug events.

Barber, R. M., et al. (2017). "Healthcare Access and Quality Index based on mortality from causes amenable to personal health care in 195 countries and territories, 1990–2015: a novel analysis from the Global Burden of Disease Study 2015." The Lancet(on line): 36 , tabl., cartes. www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736%2817%2930818-8.pdf

National levels of personal health-care access and quality can be approximated by measuring mortality rates from causes that should not be fatal in the presence of effective medical care (ie, amenable mortality). Previous analyses of mortality amenable to health care only focused on high-income countries and faced several methodological challenges. In the present analysis, we use the highly standardised cause of death and risk factor estimates generated through the Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) to improve and expand the quantification of personal health-care access and quality for 195 countries and territories from 1990 to 2015.

Basger, B. J., et al. (2008). "Inappropriate medication use and prescribing indicators in elderly Australians: development of a prescribing indicators tool." Drugs Aging **25**(9): 777-793.

Batbaatar, E., et al. (2017). "Determinants of patient satisfaction: a systematic review." Perspect Public Health **137**(2): 89-101.

AIM: A large number of studies have addressed the detection of patient satisfaction determinants, and the results are still inconclusive. Furthermore, it is known that contradicting evidence exists across patient satisfaction studies. This article is the second part of a two-part series of research with a goal to review a current conceptual framework of patient satisfaction for further operationalisation procedures. The aim of this work was to systematically identify and review evidence regarding determinants of patient satisfaction between 1980 and 2014, and to seek the reasons for contradicting results in relationships between determinants and patient satisfaction in the literature to design a further robust measurement system for patient satisfaction. METHOD: This systematic review followed the guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) statement. The search was conducted in PubMed, CINAHL, and Scopus in October 2014. Studies published in full in peer reviewed journals between January 1980 and August 2014 and in the English language were included. We included 109 articles for the synthesis. RESULTS: We found several number of determinants of patient satisfaction investigated in a wide diversity of studies. However, study results were varied due to no globally accepted formulation of patient satisfaction and measurement system. CONCLUSIONS: Health care service quality indicators were the most influential determinants of patient satisfaction across the studies. Among them, health providers' interpersonal care quality was the essential determinant of patient satisfaction. Sociodemographic characteristics were the most varied in the review. The strength and directions of associations with patient satisfaction were found inconsistent. Therefore, person-related characteristics should be considered to be the potential determinants and confounders simultaneously. The selected studies were not able to show all potential characteristics which may have had effects on

satisfaction. There is a need for more studies on how cultural, behavioural, and socio-demographic differences affect patient satisfaction, using a standardised questionnaire.

Becker, M., et al. (2018). "Guideline-based quality indicators-a systematic comparison of German and international clinical practice guidelines: protocol for a systematic review." Syst Rev **7**(1): 5.

BACKGROUND: Quality indicators (QIs) are used in assessing the quality of healthcare. Evidence-based clinical practice guidelines (CPGs) are relevant sources for generating QIs. In this context, QIs are important tools to assess the implementation of guideline recommendations. However, the methodological approaches to guideline-based QI development vary considerably. In Germany, the guideline classification scheme of the AWMF (German Association of the Scientific Medical Societies) differentiates between S1-, S2k-, S2e-, and S3-CPGs depending on the methodological approach. Thus, S3-CPGs are consensus- and evidence-based CPGs and have the highest methodological standard in Germany. An analysis of the status quo of reported QIs in S3-CPGs found 35 current S3-CPGs, which report 372 different QIs. Currently, there is no gold standard for the development of guideline-based QIs. To our knowledge, no studies have investigated to what extent guideline-based QIs from different CPGs that are related to the same topic are consistent. The objective of this study is to compare guideline-based QIs and their underlying methodological approaches of German S3-CPGs with those of topic-related international CPGs. METHODS: Based on the previous identified German S3-CPGs (n = 35), which report quality indicators, we will conduct systematic searches in the guidelines databases of G-I-N (Guidelines International Network) and NGC (National Guideline Clearinghouse) to identify international CPGs matching the topics of the S3-CPGs. If necessary, we will search additionally the websites of the particular CPG providers for separate documents with regard to QIs. We will include evidence-based CPGs which report QIs. Reported QIs as well as methods of development and the rationale for QIs will be extracted and compared with those of the S3-CPGs. DISCUSSION: This study will be part of the project "Systematic analysis of the translation of guideline recommendations into quality indicators and development of an evidence- and consensus-based standard," supported by the German Research Association (DFG). The results of this analysis will feed into a subsequent qualitative study, which will consist of structured interviews with developers of international CPGs. Further, the results will be considered in a consensus study on standards of the translation of guideline recommendations into quality indicators in Germany.

Belicza, E. et Takacs, E. (2007). "[The objective assessment of the quality of hospital care: dream or reality?]." Orv Hetil **148**(43): 2033-2041.

One of the hottest topics of the international journals is the question: what is the effect of the public indicator-based quality assessment on the quality of care and on the decision of stakeholders, and which criteria should be applied for development of public quality assessment system. According to the international literature the paper discusses 6 topics: (1) the ability of indicators to distinguish providers from the point of view of quality; (2) the appropriateness of outcome indicators to assess providers; (3) the ability of league tables to rank providers; (4) the people's behaviour during choosing providers; (5) the impact of indicator-based public report; (6) recommendations for developing quality assessment system. Based on the literature review, the ability of indicators in distinguishing providers from the point of view of quality is doubtful primarily because of risk-adjustment problems. Other reasons are: the outcomes of care do not definitely refer to the quality of care process; the rankings of providers (league tables) based on more indicators are not reliable; people take into account mainly distance and the opinions of acquaintance when they choose providers; as a result of public reports the overall quality of care is declining. The publication

of the results of measurement to assess providers has to be considered as a tool. For the purpose of helping people in choosing providers, the publication of patient satisfaction survey designed according to their preferences could achieve the desired effect. The quality improvement aims are definitely helped by the direct feedback to providers about the indicator values. Furthermore, much finer picture can be made if the standardized audits of care and organisational processes are inserted into external assessment procedures.

Benjamin G. Druss, et al. (1999). "Patient Satisfaction and Administrative Measures as Indicators of the Quality of Mental Health Care." Psychiatric Services **50**(8): 1053-1058. http://ps.psychiatryonline.org/doi/abs/10.1176/ps.50.8.1053

OBJECTIVE: Although measures of consumer satisfaction are increasingly used to supplement administrative measures in assessing quality of care, little is known about the association between these two types of indicators. This study examined the association between these measures at both an individual and a hospital level. METHODS: A satisfaction questionnaire was mailed to veterans discharged during a three-month period from 121 Veterans Administration inpatient psychiatric units; 5,542 responded, for a 37 percent response rate. These data were merged with data from administrative utilization files. Random regression analysis was used to determine the association between satisfaction and administrative measures of quality for subsequent outpatient follow-up. RESULTS: At the patient level, satisfaction with several aspects of service delivery was associated with fewer readmissions and fewer days readmitted. Better alliance with inpatient staff was associated with higher administrative measures of rates of follow-up, promptness of follow-up, and continuity of outpatient care, as well as with longer stay for the initial hospitalization. At the hospital level, only one association between satisfaction and administrative measures was statistically significant. Hospitals where patients expressed greater satisfaction with their alliance with outpatient staff had higher scores on administrative measures of promptness and continuity of follow-up. CONCLUSIONS: The associations between patient satisfaction and administrative measures of quality at the individual level support the idea that these measures address a common underlying construct. The attenuation of the associations at the hospital level suggests that neither type can stand alone as a measure of quality across institutions.

Berenson, R. A. et Rice, T. (2015). "Beyond Measurement and Reward: Methods of Motivating Quality Improvement and Accountability." Health Serv Res **50 Suppl 2**: 2155-2186.

OBJECTIVE: The article examines public policies designed to improve quality and accountability that do not rely on financial incentives and public reporting of provider performance. PRINCIPAL FINDINGS: Payment policy should help temper the current "more is better" attitude of physicians and provider organizations. Incentive neutrality would better support health professionals' intrinsic motivation to act in their patients' best interests to improve overall quality than would pay-for-performance plans targeted to specific areas of clinical care. Public policy can support clinicians' intrinsic motivation through approaches that support systematic feedback to clinicians and provide concrete opportunities to collaborate to improve care. Some programs administered by the Centers for Medicare & Medicaid Services, including Partnership for Patients and Conditions of Participation, deserve more attention; they represent available, but largely ignored, approaches to support providers to improve quality and protect beneficiaries against substandard care. CONCLUSIONS: Public policies related to quality improvement should focus more on methods of enhancing professional intrinsic motivation, while recognizing the potential role of organizations to actively promote and facilitate that motivation. Actually achieving improvement, however, will require a reexamination of the role played by financial incentives embedded in payments

and the unrealistic expectations placed on marginal incentives in pay-for-performance schemes.

Bijlsma, M., et al. (2010). The effect of competition on process and outcome quality of hospital care; An empirical analysis for the Netherlands. CPB Discussion Paper; 157. La Hague CPB**:** 46 , tabl. http://www.cpb.nl/sites/default/files/publicaties/download/disc157.pdf

The paper focuses on the relationship between competition and quality in the Dutch hospital sector. We analyse the period of 2004-2008, in which a healthcare reform took place in the Netherlands, introducing competition in the healthcare sector. The increased attention to hospital quality and its growing importance in a new institutional environment have resulted in a gradual increase of the voluntary disclosure of quality indicators by Dutch hospitals. We use panel data on Dutch general and academic hospitals in 2004-2008, including both process indicators (e.g., share of operation cancellations on short notice and share of diagnoses within 5 days) and outcome indicators (e.g., mortality rates) of hospital quality. We take the correlation between the disclosure decision and the level of the disclosed quality indicators explicitly into account by estimating a bivariate model. We find that competition explains differences in performance on process indicators, but not on outcome indicators.

Bishop, S. R. (2015). Accélérer la transformation du système de santé en Saskatchewan : Leçons tirées de l'Initiative pour les soins chirurgicaux. Ottawa Fondation Canadienne pour l'Amélioration des Services de Santé**:** vii+54 , fig.
http://www.fcass-cfhi.ca/sf-docs/default-source/reports/sask-report-f.pdf

En 2010, le gouvernement de la Saskatchewan a entrepris de mettre en œuvre une stratégie pluriannuelle agressive à l'échelle du système afin de « transformer l'expérience chirurgicale des patients ». Bien que l'Initiative pour des soins chirurgicaux de la Saskatchewan (SkSI) ait fortement mis l'accent sur la réduction des temps d'attente pour une chirurgie élective, elle vise également, par son ampleur, la qualité, la sécurité et la viabilité des soins, ainsi que l'expérience du patient. La présente recherche, publiée par la Fondation canadienne pour l'amélioration des services de santé, étudie de façon systématique une seule politique – la SkSI – et détermine les facteurs critiques qui facilitent ou freinent des changements d'envergure du système de santé.

Blank, J. L. T., et al. (2002). "Hospital efficiency : a matter of output measurement." Journal D'economie Medicale **20**(3-4): 189-200, res., tabl., fig., ann.

[BDSP. Notice produite par ORSRA R0x7HSjg. Diffusion soumise à autorisation]. Traditionnellement, deux approches sont utilisées pour modéliser la production de services hospitaliers : l'approche par la production finale dans laquelle les "cas traités" constituent l'indicateur de service rendu, et l'approche par les productions intermédiaires dans laquelle le "nombre de journées" et les "procédures" tels les examens radiologiques ou les tests de laboratoires sont les indicateurs de production. Le corps médical transforme ces dernières en "cas traités". Dans cet article, nous analysons l'impact du choix des indicateurs d'activité sur la mesure de l'efficacité. A cet égard, nous comparons deux modèles d'estimation d'une fonction de coût qui relient, respectivement, les ressources mobilisées aux productions finale et intermédiaire. Nous montrons également comment les différences entre ces deux approches peuvent être pertinemment interprétées. (résumé d'auteur).

Boeckxstaens, P., et al. (2011). "The equity dimension in evaluations of the quality and outcomes framework: a systematic review." BMC Health Serv Res **11**: 209.

BACKGROUND: Pay-for-performance systems raise concerns regarding inequity in health care because providers might select patients for whom targets can easily be reached. This paper aims to describe the evolution of pre-existing (in)equity in health care in the period after the introduction of the Quality and Outcomes Framework (QOF) in the UK and to describe (in)equities in exception reporting. In this evaluation, a theory-based framework conceptualising equity in terms of equal access, equal treatment and equal treatment outcomes for people in equal need is used to guide the work. METHODS: A systematic MEDLINE and Econlit search identified 317 studies. Of these, 290 were excluded because they were not related to the evaluation of QOF, they lacked an equity dimension in the evaluation, their qualitative research focused on experiences or on the nature of the consultation, or unsuitable methodology was used to pronounce upon equity after the introduction of QOF. RESULTS: None of the publications (n = 27) assessed equity in access to health care. Concerning equity in treatment and (intermediate) treatment outcomes, overall quality scores generally improved. For the majority of the observed indicators, all citizens benefit from this improvement, yet the extent to which different patient groups benefit tends to vary and to be highly dependent on the type and complexity of the indicator(s) under study, the observed patient group(s) and the characteristics of the study. In general, the introduction of QOF was favourable for the aged and for males. Total QOF scores did not seem to vary according to ethnicity. For deprivation, small but significant residual differences were observed after the introduction of QOF favouring less deprived groups. These differences are mainly due to differences at the practice level. The variance in exception reporting according to gender and socio-economic position is low. CONCLUSIONS: Although QOF seems not to be socially selective at first glance, this does not mean QOF does not contribute to the inverse care law. Introducing different targets for specific patient groups and including appropriate, non-disease specific and patient-centred indicators that grasp the complexity of primary care might refine the equity dimension of the evaluation of QOF. Also, information on the actual uptake of care, information at the patient level and monitoring of individuals' health care utilisation tracks could make large contributions to an in-depth evaluation. Finally, evaluating pay-for-quality initiatives in a broader health systems impact assessment strategy with equity as a full assessment criterion is of utmost importance.

Bogh, S. B., et al. (2015). "Accreditation and improvement in process quality of care: a nationwide study." Int J Qual Health Care **27**(5): 336-343.

OBJECTIVE: To examine whether performance measures improve more in accredited hospitals than in non-accredited hospital. DESIGN AND SETTING: A historical follow-up study was performed using process of care data from all public Danish hospitals in order to examine the development over time in performance measures according to participation in accreditation programs. PARTICIPANTS: All patients admitted for acute stroke, heart failure or ulcer at Danish hospitals. INTERVENTION: Hospital accreditation by either The Joint Commission International or The Health Quality Service. MEASUREMENTS: The primary outcome was a change in opportunity-based composite score and the secondary outcome was a change in all-or-none scores, both measures were based on the individual processes of care. These processes included seven processes related to stroke, six processes to heart failure, four to bleeding ulcer and four to perforated ulcer. RESULTS: A total of 27 273 patients were included. The overall opportunity-based composite score improved for both non-accredited and accredited hospitals (13.7% [95% CI 10.6; 16.8] and 9.9% [95% 5.4; 14.4], respectively), but the improvements were significantly higher for non-accredited hospitals (absolute difference: 3.8% [95% 0.8; 8.3]). No significant differences were found at disease level. The overall all-or-none score increased significantly for non-accredited hospitals, but not for accredited hospitals. The absolute difference between improvements in the all-or-

none score at non-accredited and accredited hospitals was not significant (3.2% [95% -3.6:9.9]). CONCLUSIONS: Participating in accreditation was not associated with larger improvement in performance measures for acute stroke, heart failure or ulcer.

Bojke, C., et al. (2015). Productivity of the English NHS: 2012/13 update. CHE Research Paper Series ; 110. York University of York**:** 49 , tabl., fig.
http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP110_NHS_productivity_update_2012-13.pdf

The National Health Service (NHS) provides care to millions of patients every year, with almost everyone having at least some form of contact with the health service annually. The NHS is also the single largest employer in England, accounting for 1 out of 18 in the workforce (Office for National Statistics 2015). In 2012/13 health spending (including spending by central government departments) amounted to £104 billion and accounted for 7.9 per cent of GDP.1 As such an important part of the economy, it is essential to understand what the NHS achieves from the resources devoted to it.

Boulkedid, R., et al. (2011). "Using and reporting the Delphi method for selecting healthcare quality indicators: a systematic review." Plos One **6**(6): e20476.

OBJECTIVE: Delphi technique is a structured process commonly used to developed healthcare quality indicators, but there is a little recommendation for researchers who wish to use it. This study aimed 1) to describe reporting of the Delphi method to develop quality indicators, 2) to discuss specific methodological skills for quality indicators selection 3) to give guidance about this practice. METHODOLOGY AND MAIN FINDING: Three electronic data bases were searched over a 30 years period (1978-2009). All articles that used the Delphi method to select quality indicators were identified. A standardized data extraction form was developed. Four domains (questionnaire preparation, expert panel, progress of the survey and Delphi results) were assessed. Of 80 included studies, quality of reporting varied significantly between items (9% for year's number of experience of the experts to 98% for the type of Delphi used). Reporting of methodological aspects needed to evaluate the reliability of the survey was insufficient: only 39% (31/80) of studies reported response rates for all rounds, 60% (48/80) that feedback was given between rounds, 77% (62/80) the method used to achieve consensus and 57% (48/80) listed quality indicators selected at the end of the survey. A modified Delphi procedure was used in 49/78 (63%) with a physical meeting of the panel members, usually between Delphi rounds. Median number of panel members was 17(Q1:11; Q3:31). In 40/70 (57%) studies, the panel included multiple stakeholders, who were healthcare professionals in 95% (38/40) of cases. Among 75 studies describing criteria to select quality indicators, 28 (37%) used validity and 17(23%) feasibility. CONCLUSION: The use and reporting of the Delphi method for quality indicators selection need to be improved. We provide some guidance to the investigators to improve the using and reporting of the method in future surveys.

Boyce, T., et al. (2010). Choosing a high-quality hospital. The role of nudges, scorecard design and information. Londres King's Fund Institute**:** 76 , fig., tabl.
http://www.kingsfund.org.uk/publications/choosing_a.html

Patient choice, particularly the choice of hospital, has been at the heart of health policy for a number of years. The aim of this policy is to create competition, which in turn drives improvements in quality; for this to work effectively, patients have to make their choices on the basis of clinical quality. Significant resources have been devoted to offering patients more information to help them make their choices. But do people use the information that is

available? This report explores how information can help patients to make informed choices. It is based on a research study, which began with a series of focus group discussions, the results of which informed the design of an online experiment. People were presented with information using a number of different ?scorecards? comparing the performance of hospital, and different ?nudges? were used to influence their choices. The research aimed to answer the following questions: What information do patients use when choosing a hospital? What is important to patients when choosing a hospital? How does the design of information influence the choices that patients make, and in particular, how can they be guided ? using ?nudges? ? to make better decisions? Do people make better choices as they become more practised in making decisions (ie, do they learn to make better choices)?

Brubakk, K., et al. (2015). "A systematic review of hospital accreditation: the challenges of measuring complex intervention effects." BMC Health Serv Res **15**: 280.

BACKGROUND: The increased international focus on improving patient outcomes, safety and quality of care has led stakeholders, policy makers and healthcare provider organizations to adopt standardized processes for evaluating healthcare organizations. Accreditation and certification have been proposed as interventions to support patient safety and high quality healthcare. Guidelines recommend accreditation but are cautious about the evidence, judged as inconclusive. The push for accreditation continues despite sparse evidence to support its efficiency or effectiveness. METHODS: We searched MEDLINE, EMBASE and The Cochrane Library using Medical Subject Headings (MeSH) indexes and keyword searches in any language. Studies were assessed using the Cochrane Risk of Bias Tool and AMSTAR framework. 915 abstracts were screened and 20 papers were reviewed in full in January 2013. Inclusion criteria included studies addressing the effect of hospital accreditation and certification using systematic reviews, randomized controlled trials, observational studies with a control group, or interrupted time series. Outcomes included both clinical outcomes and process measures. An updated literature search in July 2014 identified no new studies. RESULTS: The literature review uncovered three systematic reviews and one randomized controlled trial. The lone study assessed the effects of accreditation on hospital outcomes and reported inconsistent results. Excluded studies were reviewed and their findings summarized. CONCLUSION: Accreditation continues to grow internationally but due to scant evidence, no conclusions could be reached to support its effectiveness. Our review did not find evidence to support accreditation and certification of hospitals being linked to measurable changes in quality of care as measured by quality metrics and standards. Most studies did not report intervention context, implementation, or cost. This might reflect the challenges in assessing complex, heterogeneous interventions such as accreditation and certification. It is also may be magnified by the impact of how accreditation is managed and executed, and the varied financial and organizational healthcare constraints. The strategies hospitals should impelment to improve patient safety and organizational outcomes related to accreditation and certification components remains unclear.

Buja, A., et al. (2015). "Are hospital process quality indicators influenced by socio-demographic health determinants." The European Journal of Public Health **25**(5): 759-765. http://eurpub.oxfordjournals.org/eurpub/25/5/759.full.pdf

Background: This population-level health service study aimed to address whether hospitals assure the same quality of care to people in equal need, i.e. to see if any associations exist between social determinants and adherence to four hospital process indicators clearly identified as being linked to better health outcomes for patients. Participants: This was a retrospective cohort study based on administrative data collected in the Veneto Region (northeast Italy). We included residents of the Veneto Region hospitalized for ST-segment

elevation myocardial infarction (STEMI) or acute myocardial infarction (AMI), hip fracture, or cholecystitis, and women giving birth, who were discharged from any hospital operating under the Veneto Regional Health Service between January 2012 and December 2012. Method: The following quality indicator rates were calculated: patients with STEMI-AMI treated with percutaneous coronary intervention, elderly patients with hip fractures who underwent surgery within 48 h of admission, laparoscopic cholecystectomies and women who underwent cesarean section. A multilevel, multivariable logistic regression analyses were conducted to test the association between age, gender, formal education or citizenship and the quality of hospital care processes. Results: All the inpatient hospital care process quality indicators measured were associated with an undesirable number of disparities concerning the social determinants. Conclusion: Monitoring the evidence-based hospital health care process indicators reveals undesirable disparities. Administrative data sets are of considerable practical value in broad-based quality assessments and as a screening tool, also in the health disparities domain.

Bunnings, C., et al. (2015). How Health Plan Enrollees Value Prices Relative to Supplemental Benefits and Service Quality. SOEP Papers ; 541. Berlin DIW**:** 31 , tabl., fig. http://www.diw-berlin.de/documents/publikationen/73/diw_01.c.498507.de/diw_sp0741.pdf

This paper empirically assesses the relative role of health plan prices, service quality and optional benefits in the decision to choose a health plan. We link representative German SOEP panel data from 2007 to 2010 to (i) health plan service quality indicators, (ii) measures of voluntary benefit provision on top of federally mandated benefits, and (iii) health plan prices for almost all German health plans. Mixed logit models incorporate a total of 1,700 health plan choices with more than 50 choice sets for each individual. The findings suggest that, compared to prices, health plan service quality and supplemental benefits play a minor role in making a health plan choice.

Burge, F. I., et al. (2007). "Quality indicators for cardiovascular primary care." Canadian Journal of Cardiology **23**(5): 383-388.

The Canadian Cardiovascular Outcomes Research Team was established in 2001 to improve the quality of cardiovascular care for Canadians. Initially, quality indicators (QIs) for hospital-based care for those with acute myocardial infarctions and congestive heart failure were developed and measured. Qualitative research on the acceptability of those indicators concluded that indicators were needed for ambulatory primary care practice, where the bulk of cardiovascular disease care occurs. To systematically develop QIs for primary care practice for the primary prevention and chronic disease management of ischemic heart disease, hypertension, hyperlipidemia and heart failure. A four-stage modified Delphi approach was used and included a literature review of evidence-based practice guidelines and previously developed QIs; the development and circulation of a survey tool with proposed QIs, asking respondents to rate each indicator for validity, necessity to record and feasibility to collect; an in-person meeting of respondents to resolve rating and content discrepancies, and suggest additional QIs; and recirculation of the survey tool for rating of additional QIs. Participants from across Canada included family physicians, primary care nurses, an emergency room family physician and cardiologists 31 QIs were agreed on, nine of which were for primary prevention and 22 of which were for chronic disease management. A core set of QIs for ambulatory primary care practice has been developed as a tool for practitioners to evaluate the quality of cardiovascular disease care. While the participants rated the indicators as feasible to collect, the next step will be to conduct field validation.

Burstin, H., et al. (2016). "The evolution of healthcare quality measurement in the United States." J Intern Med **279**(2): 154-159.

> Quality measurement is fundamental to systematic improvement of the healthcare system. Whilst the United States has made significant investments in healthcare quality measurement and improvement, progress has been somewhat limited. Public and private payers in the United States increasingly mandate measurement and reporting as part of pay-for-performance programmes. Numerous issues have limited improvement, including lack of alignment in the use of measures and improvement strategies, the fragmentation of the U.S. healthcare system, and the lack of national electronic systems for measurement, reporting, benchmarking and improvement. Here, we provide an overview of the evolution of U.S. quality measurement efforts, including the role of the National Quality Forum. Important contextual changes such as the growing shift towards electronic data sources and clinical registries are discussed together with international comparisons. In future, the U.S. healthcare system needs to focus greater attention on the development and use of measures that matter. The three-part aim of effective care, affordable care and healthy communities in the U.S. National Quality Strategy focuses attention on population health and reduction in healthcare disparities. To make significant improvements in U.S. health care, a closer connection between measurement and both evolving national data systems and evidence-based improvement strategies is needed.

Busse, R., et al. (2013). "Diagnosis-related groups in Europe : moving towards transparency, efficiency, and quality in hospitals ?" British Medical Journal **En ligne**: 1-7.

Campbell, S. M., et al. (2002). "Research methods used in developing and applying quality indicators in primary care." Quality and Safety in Health Care **11**(4): 358-364.
http://qualitysafety.bmj.com/content/11/4/358.abstract

> Quality indicators have been developed throughout Europe primarily for use in hospitals, but also increasingly for primary care. Both development and application are important but there has been less research on the application of indicators. Three issues are important when developing or applying indicators: (1) which stakeholder perspective(s) are the indicators intended to reflect; (2) what aspects of health care are being measured; and (3) what evidence is available? The information required to develop quality indicators can be derived using systematic or non-systematic methods. Non-systematic methods such as case studies play an important role but they do not tap in to available evidence. Systematic methods can be based directly on scientific evidence by combining available evidence with expert opinion, or they can be based on clinical guidelines. While it may never be possible to produce an error free measure of quality, measures should adhere, as far as possible, to some fundamental a priori characteristics (acceptability, feasibility, reliability, sensitivity to change, and validity). Adherence to these characteristics will help maximise the effectiveness of quality indicators in quality improvement strategies. It is also necessary to consider what the results of applying indicators tell us about quality of care.

Campbell, S. M., et al. (2000). "Defining quality of care." Social Science & Medicine **51**(11): 1611-1625.
http://www.sciencedirect.com/science/article/pii/S0277953600000575

> This paper defines quality of health care. We suggest that there are two principal dimensions of quality of care for individual patients; access and effectiveness. In essence, do users get the care they need, and is the care effective when they get it? Within effectiveness, we define two key components — effectiveness of clinical care and effectiveness of inter-

personal care. These elements are discussed in terms of the structure of the health care system, processes of care, and outcomes resulting from care. The framework relates quality of care to individual patients and we suggest that quality of care is a concept that is at its most meaningful when applied to the individual user of health care. However, care for individuals must placed in the context of providing health care for populations which introduces additional notions of equity and efficiency. We show how this framework can be of practical value by applying the concepts to a set of quality indicators contained within the UK National Performance Assessment Framework and to a set of widely used indicators in the US (HEDIS). In so doing we emphasise the differences between US and UK measures of quality. Using a conceptual framework to describe the totality of quality of care shows which aspects of care any set of quality indicators actually includes and measures and, and which are not included.

Chandra, A. et Staiger, D. O. (2017). Identifying Sources of Inefficiency in Health Care. NBER Working Paper Series ; 24035. Cambridge NBER**:** 48 ,tabl., fig.
http://www.nber.org/papers/w24035.pdf

In medicine, the reasons for variation in treatment rates across hospitals serving similar patients are not well understood. Some interpret this variation as unwarranted, and push standardization of care as a way of reducing allocative inefficiency. However, an alternative interpretation is that hospitals with greater expertise in a treatment use it more because of their comparative advantage, suggesting that standardization is misguided. We develop a simple economic model that provides an empirical framework to separate these explanations. Estimating this model with data on treatments for heart attack patients, we find evidence of substantial variation across hospitals in both allocative inefficiency and comparative advantage, with most hospitals overusing treatment in part because of incorrect beliefs about their comparative advantage. A stylized welfare-calculation suggests that eliminating allocative inefficiency would increase the total benefits from this treatment by about a third.

Charlesworth, A., et al. (2016). Efficiency measurement for policy formation and evaluation. Health system efficiency: How to make measurement matter for policy and management., Copenhague : OMS Bureau régional del'Europe**:** 167-202.
http://www.euro.who.int/__data/assets/pdf_file/0004/324283/Health-System-Efficiency-How-make-measurement-matter-policy-management.pdf

Ce chapitre examine le rôle que peuvent jouer les mesures de l'efficience dans l'élaboration et l'évaluation des choix de politique dans les pays à revenu intermédiaire et à revenu élevé, en utilisant un cadre conceptuel de développement de politiques contre lequel un certain nombre d'exemples de pays sont évalués.

CIHI (2014). Comparaisons internationales :regard sur la qualité des soins. Ottawa C.I.H.I.**:** 31 , tabl., fig.
https://secure.cihi.ca/free_products/OECD_AFocusOnQualityOfCareAiB_FR.pdf

L'OCDE est une source fiable et exhaustive de données internationales touchant divers secteurs économiques et sociaux, dont les soins de santé. Elle a créé des indicateurs qui peuvent servir à comparer les politiques de différents pays, à s'inspirer des bonnes performances et à coordonner la réalisation d'analyses comparatives entre les pays. En 2001, l'OCDE a lancé un projet visant à élaborer une série d'indicateurs de la qualité des soins qui seraient comparables à l'échelle internationalei. En 2013, la liste s'est enrichie de plus de 30 indicateurs mesurant dans quelle mesure les soins de santé sont efficaces, sécuritaires et

axés sur le patient. Les résultats pour bon nombre de ces indicateurs sont présentés dans le rapport bisannuel Panorama de la santé de l'OCDE, dont la plus récente édition a été publiée en novembre 2013. Au même moment, l'Institut canadien d'information sur la santé (ICIS) a publié le rapport Analyse comparative du système de santé du Canada : comparaisons internationales, qui porte sur la performance du Canada par rapport aux pays de l'OCDE pour quatre groupes d'indicateurs : l'état de santé, les déterminants non médicaux de la santé, l'accès aux soins et la qualité des soins. Le présent rapport analyse en profondeur quelques-uns des indicateurs de la qualité des soins recueillis par l'OCDE. Les comparaisons peuvent nous aider à comprendre et fixer les points de référence et les objectifs (que pourrait viser le Canada), ainsi qu'à déceler les meilleures performances (les pays ayant atteint les meilleurs résultats et la nature de leurs réalisations).

CIHI (2014). Measuring the Level and Determinants of Health System Efficiency in Canada. Ottawa C.I.H.I.**:** 37 , tabl., fig.
https://secure.cihi.ca/free_products/HSE_TechnicalReport_EN_web.pdf

Cette étude portant sur l'efficacité du système de santé canadien présente les facteurs qui permettent d'expliquer les écarts sur le plan de l'efficacité entre les régions sanitaires. Elle s'appuie sur les résultats d'un autre rapport de l'ICIS, Vers un modèle de mesure de l'efficacité du système de santé au Canada, pour répondre à diverses questions, notamment pourquoi certaines régions sanitaires canadiennes sont plus efficaces que d'autres.

CIHI (2015). Cadres de mesure de la performance du système de santé : harmonisation des cadres relatifs aux secteurs et aux organismes à celui du système de santé. Ottawa C.I.H.I.**:** 80 , tabl., fig.
https://secure.cihi.ca/free_products/Harmonisation_des_cadres_relatifs_aux_secteurs_et_aux_organismes_celui_du_systeme_de_sante.pdf

Ce rapport vise à stimuler et à simplifier la création de cadres de mesure de la performance. Le secteur hospitalier et le secteur des soins de longue durée ont servi d'exemples pour illustrer comment le cadre de mesure de la performance du système de santé peut servir à divers échelons du système.

Cleary, P. D. et Edgman-Levitan, S. (1997). "Health care quality. Incorporating consumer perspectives." Jama **278**(19): 1608-1612.

The goal of this article is to address, from the perspective of users of the health care system (consumers), the following questions: What are the most important health care quality gaps and/or challenges; what major changes should we anticipate in this area in the near future; and what should be the role of federal and state agencies, accreditation organizations, and philanthropic foundations in addressing these challenges? We discuss the needs, challenges, and potential action steps for increasing the prominence of the user's perspective in 3 areas: (1) the conceptualization and definition of quality; (2) the measurement of quality; and (3) routine quality assessment and improvement. The article concludes by making recommendations about the role that different agencies and organizations can and should play in meeting these challenges.

CommissionEuropéenne (2008). Quality in and Equality of Access to Healthcare Services. Bruxelles Commission européenne**:** 359 , tabl., ann.
http://www.euro.centre.org/data/1237457784_41597.pdf

This study reviews barriers of access to health care that persist in European Union countries and presents an analysis of what policies countries have adopted to mitigate these barriers.

It has a focus on the situation of migrants, older people with functional limitations, and people with mental disorders. What are the barriers to accessing high quality health care for people at risk of social exclusion? What are the interdependencies between poverty, social exclusion and problems of accessing health care? What policies have EU Member States put in place to improve access and quality of health care for vulnerable groups of the population? The study is based on eight country reports: Finland, Germany, Greece, the Netherlands, Poland, Romania, Spain, and the United Kingdom. This was complemented with findings from the literature and European comparisons. Ensuring equitable access to high-quality healthcare constitutes a key challenge for health systems throughout Europe. Despite differences in health system size, structure and financing, evidence suggests that across Europe particular sections of the population are disproportionately affected by barriers to accessing healthcare. Studies have also shown that difficulties in accessing healthcare are compounded by poverty and social exclusion, and that poverty and social exclusion compound difficulties in accessing healthcare.

CommonWealthFund (2004). First report and recommendations of the Commonwealth Fund's International Working Group on Quality Indicators : a report to Health Ministers of Australia, Canada, New Zealand, The United Kingdom, and the United States. New York Commonwealth Fund**:** 118 , graph., tabl.

Ce rapport a été réalisé par le groupe de travail international des fonds du Commonwealth aux ministres de la santé de l'Australie, du Canada, de la Nouvelle-Zélande, du Royaume uni et des Etats-Unis. Il fournit des données détaillées sur 40 indicateurs principaux de qualité des soins de ces cinq pays afin de comparer les performances de leurs systèmes de santé.

CommonwealthFund (2011). Why Not the Best ? Results from the National Scorecard on U.S. Health System Performance, 2011. New York The Commonwealth Fund**:** 80 , tabl., graph.
http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2011/Oct/1500_WNTB_Natl_Scorecard_2011_web.pdf

The National Scorecard on U.S. Health System Performance, 2011, updates a series of comprehensive assessments of U.S. population health and health care quality, access, efficiency, and equity. It finds substantial improvement on quality-of-care indicators that have been the focus of public reporting and collaborative initiatives. However, U.S. health system performance continues to fall far short of what is attainable, especially given the enormity of public and private resources devoted nationally to health. Across 42 performance indicators, the U.S. achieves a total score of 64 out of a possible 100, when comparing national rates with domestic and international benchmarks. Overall, the U.S. failed to improve relative to these benchmarks, which in many cases rose. Costs were up sharply, access to care deteriorated, health system efficiency remained low, disparities persisted, and health outcomes failed to keep pace with benchmarks. The Affordable Care Act targets many of the gaps identified by the Scorecard

Communauté Européenne (2016). So What? Strategies across Europe to assess quality of care. Luxembourg Publications Office of the European Union**:** 157 , fig., tabl.
http://ec.europa.eu/health/systems_performance_assessment/docs/sowhat_en.pdf

Today, the expert group on health systems performance assessment (HSPA) composed of European countries health authorities and international organisations, and co-chaired by Sweden and the Commission, publishes its first report.The HSPA expert group, set up in 2014, provides participating countries with a forum to exchange experience on the use of HSPA at national level. It also aims to support national policy-makers by identifying tools and

methodologies for developing HSPA. The overarching aim of this work is to build better health systems that help people remain healthy and ensure access to good quality healthcare for those in need. This first report focuses on quality of care. It is based on the exchange of experiences and knowledge among countries and with international organisations between 2014 and 2015. It sets out a selection of country cases, analyses them and draws general conclusions. The aim is to provide useful recommendations for policy makers who want to design, set up, run and evaluate a system to assess quality of care.

Communauté Européenne (2018). Tools and methodologies for assessing the performance of primary care. Report of the Expert Panel on effective ways of investing in Health (EXPH). Luxembourg Publications Office of the European Union**:** 68 , tabl.
https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/docsdir/opinion_primarycare_performance_en.pdf

Ce rapport produit par un groupe d'experts mandaté par l'Union européenne discute des outils et des méthodes d'évaluation de la performance en contexte de soins de santé primaires. Il identifie 10 principaux domaines organisationnels, ce qui inclut la coordination et l'intégration des soins, et propose des indicateurs qui pourraient être utilisés à des fins de comparaison. Les étapes requises pour la mise en place d'un système d'évaluation de la performance sont explorées, de même que les expériences récentes de pays européens.

ConseilCanadiendelaSanté (2012). Measuring and reporting on health system performance in Canada: Opportunities for improvement. Toronto Conseil Canadien de la Santé**:** 33 , tabl., fig.
http://healthcouncilcanada.ca/tree/HCC_Health_Indicators_WP_EN_WEB.PDF

Cette étude met en relief la nécessité pour les gouvernements de définir des buts de politique précis, accompagnés de résultats de santé mesurables et d'indicateurs de santé connexes, afin de rendre les dirigeants du système de santé responsables de sa performance. Ce document soumet des recommandations aux gouvernements, et en même temps attire l'attention sur des pratiques novatrices appliquées au Canada, au Royaume-Uni et en Australie, qui pourraient ouvrir des perspectives d'avenir.

Corriol, C. (2007). "Indicateurs nationaux pour utilisation régionale. L'exemple de l'Allemagne." Gestions Hospitalieres(471): 709-713, tabl., graph.

[BDSP. Notice produite par EHESP qm99R0xs. Diffusion soumise à autorisation]. Cela fait environ une dizaine d'années que la mesure de la qualité et de la performance est un sujet important dans l'organisation des systèmes de santé des pays de l'OCDE, que ceux-ci soient régulés par le marché ou par l'Etat. Aux États-Unis, par exemple, on ne compte plus le nombre de programmes qui développent, utilisent et publient des indicateurs de qualité. En Angleterre ou en Allemagne, les initiatives sont sans doute aussi anciennes, moins nombreuses, mais coordonnées par les pouvoirs publics qui ont la responsabilité du système de santé.

CRICH (2009). Measuring Equity of Care in Hospital Settings: From Concepts to Indicators. Toronto C.RI.C.H.**:** 39.
http://www.stmichaelshospital.com/pdf/crich/measuring_equity.pdf

Measuring equity in hospitals is a relatively new practice in Canada. Knowledge of the health indicators that matter most for equity in hospitals, and how to best measure and take action relative to these indicators, is only just developing. The Centre for Research on Inner City Health (CRICH) partnered with the TC-LHIN Hospital Collaborative on Marginalized

Populations to complete a review of scholarly and grey literature concerning existing approaches for measuring and operationalizing equity of care in the hospital setting. This report presents the findings of our review. First, we provide background information on equity and its relationship to the hospital setting. We then review our methods, describing how the literature was collected and analyzed. This is followed by a presentation of results describing a set of indicators, both for general use and for current TC-LHIN priority populations. These indicators were chosen based on criteria that will be discussed in detail below, and represent a starting point for Toronto hospitals to begin measuring equity. We conclude by providing recommendations for the identification and monitoring of health inequalities in hospitals within the TC-LHIN. Ultimately, while measuring an inequality in itself does not lead to change, it is a crucial step in informing change. This study builds on the history and cumulative experience of work conducted on the development and use of hospital-based indicators. It also brings a systematic approach to the selection of equity indicators that may best fit the current needs and priorities of hospitals within the TC-LHIN, and that may be utilized immediately.

Cylus, J., et al. (2017). How to make sense of health system efficiency comparisons? Copenhague OMS Bureau régional de l'Europe**:** 24 , fig., tabl.
http://www.euro.who.int/en/about-us/partners/observatory/publications/policy-briefs-and-summaries/how-to-make-sense-of-health-system-efficiency-comparisons

Improving health system efficiency is a compelling policy goal, especially in systems facing serious resource constraints. However, in order to improve efficiency we must know how to properly measure it. This new policy brief therefore proposes an analytic framework for understanding and interpreting many of the most common health care efficiency indicators.

Cylus, J. et al. (2016). Health system efficiency: How to make measurement matter for policy and management. Paris OMS Bureau régional del'Europe**:** xxii+244 , tabl., graph., fig.
http://www.euro.who.int/fr/about-us/partners/observatory/publications/studies/health-system-efficiency-how-to-make-measurement-matter-for-policy-and-management

Efficiency is one of the central preoccupations of health policy-makers and managers, and justifiably so. Inefficient care can lead to unnecessarily poor outcomes for patients, either in terms of their health, or in their experience of the health system. What is more, inefficiency anywhere in the system is likely to deny health improvement to patients who might have been treated if resources had been used better. Improving efficiency is therefore a compelling policy goal, especially in systems facing serious resource constraints. The desire for greater efficiency motivates a great deal of decision-making, but the routine use of efficiency metrics to guide decisions is severely lacking.To improve efficiency in the health system we must first be able to measure it and must therefore ensure that our metrics are relevant and useful for policy-makers and managers. In this book the authors explore the state of the art on efficiency measurement in health systems and international experts offer insights into the pitfalls and potential associated with various measurement techniques

Damberg, C. L., et al. (2011). An Evaluation of the Use of Performance Measures in Health Care. Santa Monica Rand corporation**:** 46 , tabl., annexes.
http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR1148.pdf

This report presents the results of an evaluation conducted for the U.S. National Quality Forum (NQF), which has established a portfolio of quality and efficiency measures for the Department of Health and Human Services. The report describes how performance measures

are being used by different organizations, the types of measures being used for different purposes, and summarizes key barriers and facilitators to the use of these measures.

Dandi, R., et al. (2012). Long-term care quality insurance policies in European countries. ENEPRI Research Reports, n°111. Bruxelles ENEPRI**:** 85 , tabl., fig.
http://www.ancien-longtermcare.eu/sites/default/files/Quality%20Assurance%20Policies%20for%20LTC%20in%20in%20the%20EU.pdf

Ce rapport analyse les politiques d?assurance qualité pour les soins de longue durée (SLD) dans les pays suivants : Allemagne, Autriche, Espagne, Estonie, Finlande, France, Hongrie, Italie, Lettonie, Pays-Bas, Pologne, Royaume-Uni, Slovaquie, Slovénie et Suède . Il étudie les dimensions de la qualité dans chaque pays ainsi que leur cadre politique. Ce document compare les pays et formule des recommandations politiques. Le rapport a été réalisé en vertu du projet ANCIEN (Assessing Needs of Care in European Nations).

Davies, A., et al. (2016). Focus on : public health and prevention : has the quality of services changed over recent years? QualityWatch. Londres Health Foundation, Londres The Nuffield Trust**:** 60.

This report provides an overview of public health outcomes in recent years. The report also considers the opportunities and challenges presented as efforts are made to maintain the quality of services in the light of these recent reforms and financial pressures. It examines trends in 20 indicators across sexual and reproductive health (SRH) and HIV, substance misuse, smoking, childhood obesity and immunisations. In order to provide a more nuanced view it also gathered reflections from senior public health professionals (37 responses to a survey and 11 interviews), and other provider and advocacy organisations (11 interviews)..

Davies, H. T. O., et al. (2000). "Organisational culture and quality of health care." Quality in Health Care **9**(2): 111-119.
http://qualitysafety.bmj.com/content/9/2/111.short

De Silva, D. et Bamber, J. (2014). Improving quality in general practice. Evidence Scan; 24. Londres Health Foundation**:** 61 , fig., tabl.
http://www.health.org.uk/public/cms/75/76/313/5090/Improving%20quality%20in%20general%20practice.pdf

This evidence scan was initially commissioned to inform attendees at the National Summit on Quality in General Practice, held on 31 July 2014. The theme of the day was Sustaining and improving the quality of general practice. The scan is divided into three parts: Part 1 explores how quality could be defined, drawing upon literature from leading thinkers and organisations in health care and quality improvement. Part 2 summarises empirical evidence on what people using services think of general practice, and the features they think are important in good quality general practice care. Part 3 compiles empirical research about interventions that have been tested to improve the quality of general practice care. Although the research covered is disparate and does not provide a simple solution to improving quality, it shows that a great deal has been published on the topic and that there is much scope to use the existing knowledge base to promote, inspire and engage with improvement (résumé de l'éditeur).

de Vos, M., et al. (2009). "Using quality indicators to improve hospital care: a review of the literature." Int J Qual Health Care **21**(2): 119-129.

PURPOSE: To review the literature concerning strategies for implementing quality indicators in hospital care, and their effectiveness in improving the quality of care. DATA SOURCES: A systematic literature study was carried out using MEDLINE and the Cochrane Library (January 1994 to January 2008). STUDY SELECTION: Hospital-based trials studying the effects of using quality indicators as a tool to improve quality of care. DATA EXTRACTION: Two reviewers independently assessed studies for inclusion, and extracted information from the studies included regarding the health care setting, type of implementation strategy and their effectiveness as a tool to improve quality of hospital care. RESULTS: A total of 21 studies were included. The most frequently used implementation strategies were audit and feedback. The majority of these studies focused on care processes rather than patient outcomes. Six studies evaluated the effects of the implementation of quality indicators on patient outcomes. In four studies, quality indicator implementation was found to be ineffective, in one partially effective and in one it was found to be effective. Twenty studies focused on care processes, and most reported significant improvement with respect to part of the measured process indicators. The implementation of quality indicators in hospitals is most effective if feedback reports are given in combination with an educational implementation strategy and/or the development of a quality improvement plan. CONCLUSION: Effective strategies to implement quality indicators in daily practice in order to improve hospital care do exist, but there is considerable variation in the methods used and the level of change achieved. Feedback reports combined with another implementation strategy seem to be most effective.

DepartmentofHealth (2009). Improving Quality in Primary Care. Londres Department of Health**:** 135. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106575.pdf

This is a practical guide to support PCTs as commissioners of primary care, in working with local clinicians and other stakeholders - including patients - to promote continuous quality and productivity improvement in primary care services.

Doherty, S. (2006). "Evidence-based implementation of evidence-based guidelines." Int J Health Care Qual Assur Inc Leadersh Health Serv **19**(1): 32-41.

PURPOSE: There is evidence that some strategies for guideline implementation are more successful than others. This paper aims to describe the process of developing an evidence-based guideline implementation strategy for use in rural emergency departments. DESIGN/METHODOLOGY/APPROACH: Participation in a nationally funded, research fellowship program involved attendance at workshops run by internationally renowned experts in the field of knowledge translation. Attendance at these workshops, associated reading and a literature review allowed those implementation strategies with the most supportive evidence of effectiveness to be determined. FINDINGS: A multi-faceted implementation strategy was developed. This strategy involved the use of an implementation team as well as addressing issues surrounding individual clinicians, the "emergency department team", the physical structure and processes of the ED and the culture of the department as a whole. Reminders, audit and feedback, education, the use of opinion leaders, and evidence-based formatting of guidelines were all integral to the process. PRACTICAL IMPLICATIONS: It is postulated that an evidence-based implementation strategy will lead to greater changes in clinician behaviour than other strategies used in quality improvement projects. ORIGINALITY/VALUE: This is an important article as it describes the concept and development of evidence-based interventions, which, if tailored to the individual hospital (as evidence-based medicine is tailored to the individual patient), has the

potential to improve compliance with clinical guidelines beyond that achieved with most QI projects.

Dor, A., et al. (2013). Impact of Mortality-Based Performance Measures on Hospital Pricing: the Case of Colon Cancer Surgeries. NBER Working Paper Series ; n° 19447. Cambridge NBER**:** 32 , tabl., fig. http://www.nber.org/papers/w19447

We estimate price regressions for surgical procedures used to treat colon cancer, a leading cause of cancer mortality. Using a claims database for self-insured employers, we focus on transaction prices, rather than more commonly available billing data that do not reflect actual payments made. Although the responsiveness of prices to hospital performance depends on the impact of quality on the slope of the quantity-demand of the payers, which are not known a priory, it is often assumed that higher performing hospitals are able to command higher prices. To test this hypothesis we construct performance rankings, based on hospital excess-mortality and incorporate them into our price models. We are interested in the type information available to large payers who negotiate prices on behalf of their members. To get a cancer-specific index we emulate the widely-reported risk-adjustment methodology used in the federal Hospital Compare reporting system for ranking cardiac performance. The effects were consistently negative in all models (adverse quality reduces price), though not significant. However, we observe a rational pricing structure whereby higher treatment complexity is reflected in higher price differentials, controlling for patient characteristics and market structure.

Dozol, A., et al. (2017). Mission d'étude sur l'expérimentation par le NHS anglais de nouveaux modèles d'organisation et de financement intégrés. Paris DGOS**:** 21 , fig., ill., annexes. http://social-sante.gouv.fr/IMG/pdf/ipep_mission_uk_rapport_vd_word_dgos_08-12-2016.pdf

Le système de santé britannique est confronté aux mêmes enjeux que le système de santé français : contexte budgétaire contraignant avec des enjeux épidémiologiques de vieillissement. Pour y faire face, la solution privilégiée par le système britannique repose sur la mise en place de nouvellesorganisations entre acteurs, « les news care models », favorisant la coordination entre les secteurs sanitaires, social et médico-social. En effet, dans la mesure où les principaux besoins de demain relèvent davantage des secteurs médico-social et social que du secteur sanitaire, une prise en charge intégrant ces secteurs devient une nécessité. Ainsi, contrairement aux objectifs recherchés par la réforme de financement à la tarification à l'activité mise en place dans les années 2000, l'objectif principal recherché par le NHS n'est pas celui de l'efficience économique par la concurrence entre les acteurs mais celui de la performance par une collaboration et une atteinte collective des indicateurs d'accès, de continuité et de coordination de la prise en charge.

Drosler, S., et al. (2009). Health Care Quality Indicators Project: Patient Safety Indicators Report 2009. OECD Health Working Paper; 47. Paris OCDE**:** 105 , tabl., graph. http://www.olis.oecd.org/olis/2009doc.nsf/LinkTo/NT00006F0A/$FILE/JT03274823.PDF

Ce document présente l?état d?avancement de la recherche et du développement d?un ensemble d?indicateurs en matière de sécurité des patients dans le cadre du projet sur les indicateurs de la qualité des soins (HCQI). Un groupe d?experts a recommandé l?utilisation des indicateurs présentés ici pour les comparaisons internationales sur une dimension clé de la qualité des soins : la sécurité. Les indicateurs ont été sélectionnés par un consensus d?experts, leur validité et leur comparabilité ont été testées. Bien qu?il reste quelques problèmes quant aux différences de codage et de déclaration venant des bases de données administratives hospitalières, la rigueur du travail sur les indicateurs a permis d?améliorer la

capacité des pays à rendre compte de la qualité des soins. Le développement des indicateurs de la sécurité des patients met l?accent sur les progrès techniques réalisés dans la construction de mesures et le besoin récurrent d?améliorer la méthodologie. Les indicateurs présentés ici ne doivent pas donner lieu à des conclusions quant à la situation de la sécurité des patients dans les pays, mais visent plutôt à poser des questions pour une meilleure compréhension des différences observées.

Elixhauser, A., et al. (2005). "Using the AHRQ quality indicators to improve health care quality." Jt Comm J Qual Patient Saf **31**(9): 533-538.

In summary, the AHRQ QIs are a set of readily available programs that can be downloaded without charge from the AHRQ Web site. The methodology is completely open and accessible to all users. The QI software can be applied to hospital administrative data that is available within individual institutions or from state data organizations and hospital associations and can provide valuable insights into health care quality at extremely low cost. The QIs have been incorporated into numerous quality assessment reports, including hospital-specific reports, with the aim of improving health care quality at a reasonable cost. With enhancements currently underway, the QIs will be an even more valuable part of the toolkit to improve health care quality in the United States.

Elliot-Smith, A. et Morgan, M. A. J. (2010). "How do we compare? Applying UK pay for performance indicators to an Australian general practice." Australian Family Physician **39**(1-2): 43-48, 44 tabl. http://www.racgp.org.au/afp/201001/201001elliot-smith.pdf

Falconi, M., et al. (2016). "A scoping review to explore the suitability of interactive voice response to conduct automated performance measurement of the patient's experience in primary care." Prim Health Care Res Dev **17**(3): 209-225.

INTRODUCTION: Practice-based performance measurement is fundamental for improvement and accountability in primary care. Traditional performance measurement of the patient's experience is often too costly and cumbersome for most practices. OBJECTIVE/METHODS: This scoping review explores the literature on the use of interactive voice response (IVR) telephone surveys to identify lessons for its use for collecting data on patient-reported outcome measures at the primary care practice level. RESULTS: The literature suggests IVR could potentially increase the capacity to reach more representative patient samples and those traditionally most difficult to engage. There is potential for long-term cost effectiveness and significant decrease of the burden on practices involved in collecting patient survey data. Challenges such as low response rates, mode effects, high initial set-up costs and maintenance fees, are also reported and require careful attention. CONCLUSION: This review suggests IVR may be a feasible alternative to traditional patient data collection methods, which should be further explored.

Fermon, B. et Joel, M. E. (2012). Quality Assurance Policies and Indicators for Long-Term Care in the European Union, Country Report: France. ENEPRI Research Reports, n°107. Bruxelles ENEPRI**:** 18. http://www.ceps.eu/book/informal-care-provision-europe-regulation-and-profile-providers

Quality assurance policies for long-term care in France are founded on a law passed in 2002, but the organisation of the system is still underway. It is principally based on a legal framework that sets out requirements for quality monitoring and quality improvement. Quality assessment is related to outcomes, indicators and guidelines. It pertains to formal care and is related to administrative authorisation and financial conditions. In the public sector, the aim is to develop continuous quality assurance in a system differentiated by

internal and external quality assessment. In the private sector, the aim is mainly to check conformity with quality standards, as internal and external quality assurance may be replaced by a certification procedure. A central agency is in charge of enhancing quality through the production of new guidelines but quality supervision is the role of the funding institution and qualitative results are not publicly available. To date, not many organisations or units have conducted the entire quality assurance process, as the quality of long-term care is ensured by an institutional system that is in the final stages of being structured.

Filistrucchi, L. et Ozbugday, F. C. (2012). Mandatory Quality Disclosure and Quality Supply: Evidence from German Hospitals. Working paper; 16/2012. Firenze Università degli Studi di Firenze**:** 86 , fig., tabl.
http://www.dse.unifi.it/upload/sub/WP16_2012.pdf

Using a newly constructed dataset on German hospitals, which includes 24 process and outcome indicators of clinical quality, we test whether quality has increased in various clinical areas since the introduction of mandatory quality reports and the online publication of part of the collected quality measures. Our results suggest that process indicators of clinical quality have increased significantly in 2008 compared to 2006. In addition, the hospitals underperforming in 2006 appear to have increased their clinical quality relatively more than the other hospitals. When instead quality is measured by outcome indicators, average clinical quality is estimated to have increased for underperforming hospitals and decreased for the best performing hospitals in 2006, so that on average across all hospitals the changes in outcome indicators are insignificant for just more than half of the outcome quality measures. We further show that the best performing hospitals in 2006 in terms of outcome quality measures experienced an increase in their share of patients in 2008, thus providing indirect evidence that patients react to disclosed quality. Interestingly, the best performing hospitals in 2006 in terms of process quality measures did not experience a significant change in their share of patients in 2008, thus suggesting that patients react more to output than to process measures of quality. Finally, for the subset of hospitals who offer services in obstetrics, we find that higher competitive pressure, measured as the number of competitors in a given radius, is associated with a higher increase in quality following quality disclosure. We argue that the latter effect is unlikely to be due to selection of patients by hospitals.

Fisher, C. E., et al. (2013). "Developing mental health-care quality indicators : toward a common framework." International Journal for Quality in Health Care **25**(1): 75-80.

Fisher, C. E., et al. (2013). "Developing mental health-care quality indicators: toward a common framework." International Journal for Quality in Health Care **25**(1): 75-80.
http://intqhc.oxfordjournals.org/content/25/1/75.abstract

Objective Inconsistent performance measurement schemes hinder attempts to make international comparisons about mental health-care quality. This report describes a project undertaken by an international collaborative group that aims to develop a common framework of measures that will allow for international comparisons of mental health system performance.Design Representatives from each country submitted reports of quality measurement initiatives in mental health. Indicators were reviewed, and all measurable indicators were compiled and organized.Sample Twenty-nine programs from 11 countries and two cross-national programs submitted reports.Methods Indicators were evaluated according to measurable inclusion criteria.Results These methods yielded 656 total measures that were organized into 17 domains and 80 subdomains.Conclusions No single program contained indicators in all domains, highlighting the need for a comprehensive, shared

scheme for international measurement. By collecting and organizing measures through an inductive compilation of existing programs, the present study has generated a maximally inclusive basis for the creation of a common framework of international mental health quality indicators

Foot, C., et al. (2010). How do quality accounts measure up? Findings from the first year. Londres King's Fund Institute**:** 36 , fig., tabl.
http://www.kingsfund.org.uk/publications/mental_health_and.html

In 2010, for the first time, many providers of NHS services have been required to produce quality accounts, which are public reports of the quality of their services and their plans for improvement. We have analysed a sample of these, reviewing their compliance with statutory requirements and published guidance and assessing how well they meet principles of good practice in publishing information on quality. We looked in particular at: how they present and use quality measures to report on performance; how they have reported on data quality; their participation in clinical audit and national confidential enquiries; how providers have reported patient and public feedback; how they have involved local stakeholders, and what the external comments have focused on. Across all dimensions, there were examples of both good and poor practice, and many very different approaches to style, content and intended audience. Based on these findings, we have made a series of recommendations to providers about how their quality accounts could be improved. However, we also raise policy questions about quality accounts, in the context of the new government?s policy agenda on information. We conclude that, fundamentally, quality accounts are so varied because they are having to provide commentary on a wide range of services, are serving a broad range of audiences and are also attempting to meet two related, but different, goals of local quality improvement and public accountability. The future for public accountability needs to focus more on the centralised provision of standard, consistent and comparable measures, published in forms that enable interpretation and comparison. Individual quality accounts can then both draw on these measures and select local priorities and measures, as long as those measures can be given with benchmark or trend information to provide some context for interpretation.

Foot, C., et al. (2014). Managing quality in community health care services. Londres The King's Fund**:** 44 ,fig.
http://www.kingsfund.org.uk/publications/managing-quality-community-health-care-services

Community health services provide vital care for millions of people. Children, families, people with injuries or long-term conditions, older people, and people in their last years of life all use this huge range of services. Demand for community services is growing as more and more people are cared for closer to home. These community services are a key component of our health and care system, but they have been too often overlooked by the national focus on quality. This report uses surveys, interviews and document analysis to gauge how community providers are defining, measuring, managing and improving quality. Our findings show that: there are many examples of local innovation in measuring quality and some robust systems of quality governance in place; community service providers feel that poor availability of information is constraining quality improvement; staff shortages and workforce concerns pose serious risks to delivering quality care as do growing financial, demand and capacity pressures. At a national level, our lack of knowledge about quality in community services is a dangerous blind spot. If policy-makers are truly committed to quality and transparency – and to bringing more care closer to home – then action (résumé de l'éditeur).

Forbes, L. J., et al. (2017). "The role of the Quality and Outcomes Framework in the care of long-term conditions: a systematic review." Br J Gen Pract **67**(664): e775-e784.

> BACKGROUND: Improving care for people with long-term conditions is central to NHS policy. It has been suggested that the Quality and Outcomes Framework (QOF), a primary care pay-for-performance scheme that rewards practices for delivering effective interventions in long-term conditions, does not encourage high-quality care for this group of patients. AIM: To examine the evidence that the QOF has improved quality of care for patients with long-term conditions. DESIGN AND SETTING: This was a systematic review of research on the effectiveness of the QOF in the UK. METHOD: The authors searched electronic databases for peer-reviewed empirical quantitative research studying the effect of the QOF on a broad range of processes and outcomes of care, including coordination and integration of care, holistic and personalised care, self-care, patient experience, physiological and biochemical outcomes, health service utilisation, and mortality. Because the studies were heterogeneous, a narrative synthesis was carried out. RESULTS: The authors identified three systematic reviews and five primary research studies that met the inclusion criteria. The QOF was associated with a modest slowing of both the increase in emergency admissions and the increase in consultations in severe mental illness (SMI), and modest improvements in diabetes care. The nature of the evidence means that the authors cannot be sure that any of these associations is causal. No clear effect on mortality was found. The authors found no evidence that the QOF influences integration or coordination of care, holistic care, self-care, or patient experience. CONCLUSION: The NHS should consider more broadly what constitutes high-quality primary care for people with long-term conditions, and consider other ways of motivating primary care to deliver it.

Foury, C. (2017). "La High Value Healthcare collaborative américaine : Un modèle pour l'Europe et la France." Revue Hospitaliere De France(579): 51-55.

> [BDSP. Notice produite par EHESP nR0xn9lF. Diffusion soumise à autorisation]. Afin de stimuler l'amélioration continue de leur efficience clinique et organisationnelle, les responsables de dix-neuf systèmes de santé et d'assurance maladie américains ont créé la High Value Healthcare Collaborative (HVHC). Cet article présente l'historique, les caractéristiques et certaines réalisations de ce qui pourrait constituer une inspiration pour l'Europe et la France. (R.A.).

Freeman, T. (2002). "Using performance indicators to improve health care quality in the public sector: a review of the literature." Health Serv Manage Res **15**(2): 126-137.

> Given the increasing importance of performance indicators in current UK health policy, this paper provides a systematic review of empirical and theoretical writings concerning their use to improve health care quality. The paper outlines potential problems and explores how best to derive, implement and use performance indicator data, presenting results thematically. The two principal uses of indicator systems are as summative mechanisms for external accountability and verification, and as formative mechanisms for internal quality improvement. In the UK, the use of performance indicators in assurance and performance management systems has heavily influenced debate over their value. Major problems reported include the potential to undermine the conditions required for quality improvement, perverse incentives and the difficulty of using data to promote change. Technical problems include indicator selection; the availability, validity and reliability of data; confounding; and problems with robustness, sensitivity and specificity. Factors that help in the derivation, implementation and use of indicator systems include clear objectives, involvement of stakeholders in development, and use of 'soft' data to aid interpretation.

Frigola-Capell, E., et al. (2015). "Quality indicators for patient safety in primary care. A review and Delphi-survey by the LINNEAUS collaboration on patient safety in primary care." Eur J Gen Pract **21 Suppl**: 31-34.

BACKGROUND: Quality indicators are measured aspects of healthcare, reflecting the performance of a healthcare provider or healthcare system. They have a crucial role in programmes to assess and improve healthcare. Many performance measures for primary care have been developed. Only the Catalan model for patient safety in primary care identifies key domains of patient safety in primary care. OBJECTIVE: To present an international framework for patient safety indicators in primary care. METHODS: Literature review and online Delphi-survey, starting from the Catalan model. RESULTS: A set of 30 topics is presented, identified by an international panel and organized according to the Catalan model for patient safety in primary care. Most topic areas referred to specific clinical processes; additional topics were leadership, people management, partnership and resources. CONCLUSION: The framework can be used to organize indicator development and guide further work in the field.

Frijters, D., et al. (2013). "The calculation of quality indicators for long term care facilities in 8 countries (SHELTER project)." Bmc Health Services Research **13**(138): (19), fig., tabl. http://www.biomedcentral.com/content/pdf/1472-6963-13-138.pdf

Performance indicators in the long term care sector are important to evaluate the efficiency and quality of care delivery. We are, however, still far from being able to refer to a common set of indicators at the European level.We therefore demonstrate the calculation of Long Term Care Facility Quality Indicators (LTCFQIs) from data of the European Services and Health for Elderly in Long TERm Care (SHELTER) project. We explain how risk factors are taken into account and show how LTC facilities at facility and country level can be compared on quality of care using thresholds and a Quality Indicator sum measure. The indicators of Long Term Care Facility quality of care are calculated based on methods that have been developed in the US. The values of these Quality Indicators (QIs) are risk adjusted on the basis of covariates resulting from logistic regression analysis on each of the QIs. To enhance the comparison of QIs between facilities and countries we have used the method of percentile thresholds and developed a QI sum measure based on percentile outcomes. In SHELTER data have been collected with the interRAI Long Term Care Facility instrument (interRAI-LTCF). The data came from LTC facilities in 7 European countries and Israel. The unadjusted values of the LTCF Quality Indicators differ considerably between facilities in the 8 countries. After risk adjustment the differences are less, but still considerable. Our QI sum measure facilitates the overall comparison of quality of care between facilities and countries. With quality indicators based on assessments with the interRAI LTCF instrument quality of care between LTC facilities in and across nations can be adequately compared.

Gache, K., et al. (2014). "Main barriers to effective implementation of stroke care pathways in France: a qualitative study." Bmc Health Services Research **14**(95): 1-10. http://www.biomedcentral.com/1472-6963/14/95

Stroke Care Pathways (SCPs) aim to improve quality of care by providing better access to stroke units, rehabilitation centres, and home care for dependent patients. The objective of this study was to identify the main barriers to effective implementation of SCPs in France.

Gallaher, G., et al. (2009). Measuring equity of care in hospital settings: from concepts to indicators. Toronto Centre for Research on Inner City Health**:** 40. http://www.stmichaelshospital.com/pdf/crich/measuring_equity.pdf

Ce rapport du Centre for Research on Inner City Health examine des indicateurs d'équité des soins en milieu hospitalier pour les populations prioritaires : les personnes âgées, les personnes atteintes de maladie mentale et de toxicomanie et les personnes atteintes de diabète sucré.10 indicateurs apparaissent appropriés pour être utilisés dans les hôpitaux de Toronto.

GAO (2011). Value in Health Care : Key Information for Policymakers to Assess Efforts to Improve Quality While Reducing Costs. Washington GAO**:** 52 , tabl., ann.
http://www.gao.gov/new.items/d11445.pdf

The U.S. has devoted an increasing proportion of its economy and federal budget to the provision of health care services, but high levels of spending do not guarantee good care. Policymakers, health practitioners, and others have implemented numerous health care interventions that make discrete changes in the organization of health care services in order to enhance the value of health care?that is, improve the quality of care while reducing costs. This report examines the availability of evidence on the effect of selected interventions on quality of care and costs; identifies key dimensions for assessing the strength of such evidence; and examines factors that can facilitate the implementation and replication of health care interventions. The Government Accountability Office (GAO) identified a broad and diverse set of health care interventions using published and unpublished sources. For 127 of those interventions, GAO analyzed responses to a questionnaire that it sent to persons knowledgeable about available information on the effect of that particular intervention on quality of care and costs. GAO?s questionnaire also asked respondents to assess the relative importance of seven factors in the implementation and potential replication of the health care intervention. In addition, GAO consulted the methodological literature and experts on assessing evidence on the effects of health care interventions.

GAO (2017). Medicaid Managed Care: CMS Should Improve Oversight of Access and Quality in States' Long-Term Services and Supports Programs. Washington GAO**:** 44 , tab., graph., fig.
https://www.gao.gov/assets/690/686550.pdf

Medicaid beneficiaries who need long-term care can get it in their homes, community settings, or an institution such as a nursing home. Many states contract with managed care organizations to provide this care. The 6 states reviewed in this report used various methods (e.g., beneficiary surveys) to monitor access and quality in managed long-term care programs. However, the Centers for Medicare & Medicaid Services did not always require the states to report information it needs for oversight, such as beneficiary concerns or whether there are enough providers. We recommended that CMS improve its oversight.

Garcia, A. r., S. (2006). Health care quality indicators project. Patient safety data systems in the OECD : a report of a joint irish department of health - OECD conference. Paris OCDE**:** 35 , tabl., fig.
http://www.oecd.org/dataoecd/12/4/38705981.pdf

Dans ce rapport sont présentées les conclusions de la première réunion du sous-groupe sur la sécurité des patients du Projet de l?OCDE sur les indicateurs de la qualité des soins de santé (HCQI), qui a eu lieu les 29 et 30 juin à Dublin (Irlande). Cette conférence a été organisée conjointement par le ministère irlandais de la Santé et de l?Enfance et l?OCDE. Elle a rassemblé des représentants des administrations nationales et des experts internationaux qui ont examiné et analysé la situation actuelle concernant les systèmes de données sur la sécurité des patients dans l?ensemble de la zone de l?OCDE, et les obstacles qui s?opposent à leur amélioration (Résumé d'auteur).

Garcia, A., et al. (2007). Health care quality indicators project. 2006 data collection update report. OCDE Health Working Papers; 29. Paris OCDE**:** 157 , tabl. http://www.oecd.org/dataoecd/57/22/39447928.pdf

> Le présent rapport est une version actualisée du document de travail de l?OCDE sur la santé n°22 intitulé Health Care Quality Indicators Project : Initial Indicators Report, établi sur la base des données rassemblées en 2003/2005 et publié en 2006. Ce rapport présentait les travaux initiaux de l?OCDE concernant l?élaboration d?une série d?indicateurs sur la qualité des soins de santé qui pourraient être utilisés pour tenter d?expliquer les différences en matière de qualité de soins entre les pays. Le rapport 2006 portait sur 21 « indicateurs initiaux » pour lesquels 24 pays avaient communiqué des données ; il a été estimé que 17 de ces indicateurs se prêtaient à des comparaisons internationales et que quatre d?entre eux nécessitaient des travaux approfondis. A la suite de la publication du rapport en mars 2006, l?OCDE a entamé un deuxième cycle de collecte de données relatives à la série initiale d?indicateurs et a entrepris de recueillir pour la première fois des données sur de nouveaux indicateurs par le biais d?un questionnaire adressé aux pays participants au projet HCQI. Le présent rapport fait état des résultats du deuxième cycle de collecte de données. Il contient des données sur la série élargie d?indicateurs considérés comme se prêtant à des comparaisons internationales, soit des données portant sur 19 indicateurs (17 indicateurs existants et 2 nouveaux). Il présente également les données fournies en ce qui concerne 7 autres indicateurs dont on estime qu?ils ne se prêtent pas encore à des comparaisons internationales. Les données communiquées émanent cette fois de 32 pays (des pays de l?UE qui ne sont pas membres de l?OCDE ont été invités à participer au projet).

Gibberd, R., et al. (2004). "Using indicators to quantify the potential to improve the quality of health care." Int J Qual Health Care **16 Suppl 1**: i37-43.

> PURPOSE: Although clinical indicators allow individual providers to monitor and improve their own performance and quality of care, another important role for the indicators is to provide comparative information across all providers. We show that the 'league table' approach is ineffective, and provide an alternative method that uses the comparative rates to quantify the potential for improvement at both the provider and the national level. DATA SOURCES: The methods are applied to English and Australian hospital clinical indicators. METHODS: The key is to regard clinical indicators as screening tools that measure performance in one or more dimensions. All screening processes require explicit tests to determine whether the result should be classified as either positive (requires further investigation) or negative (requires continued monitoring). A clinical indicator will be defined as positive if any of the three following criteria are met: (1) large variation between all areas or hospitals, as defined by the 20th centile gains: requires improvement in the health care system; (2) large variation between strata (rural/urban, teaching/non-teaching, public/private, State): requires action in the relevant stratum; (3) outlier hospitals: requires quality improvement in the individual hospitals. Two techniques are used to determine whether any of the three criteria are positive: (1) empirical Bayesian estimation to calculate 'shrunken' rates; and (2) use of the 20th centile to quantify the potential gains or improvement. RESULTS: For 185 Australian indicators, 55 clinical indicators had system gains involving better outcomes for at least 1000 patients per indicator. Using a set of criteria and subjective judgement, we identified some key areas for quality improvement in Australia. CONCLUSION: Ranking of hospitals does not quantify the potential gains that could be achieved. Indicators that measure health care processes should be reported by quantifying the potential gains, thus encouraging action. Estimating the gains across many indicators allows priorities to be established, such as identifying the areas with the greatest potential

for improvement. The main tasks are to then provide the tools and resources to tackle those areas with the most gains.

Giles, S., et al. (2015). "Contributory factors to patient safety incidents in primary care: protocol for a systematic review." Syst Rev **4**: 63.

BACKGROUND: Organisations need to systematically identify contributory factors (or causes) which impact on patient safety in order to effectively learn from error. Investigations of error have tended to focus on taking a reactive approach to learning from error, mainly relying on incident-reporting systems. Existing frameworks which aim to identify latent causes of error rely almost exclusively on evidence from non-healthcare settings. In view of this, the Yorkshire Contributory Factors Framework (YCFF) was developed in the hospital setting. Eighty-five percent of healthcare contacts occur in primary care. As a result, this review will build on the work that produced the YCFF, by examining the empirical evidence that relates to the contributory factors of error within a primary care setting. METHODS/DESIGN: Four electronic bibliographic databases will be searched: MEDLINE, Embase, PsycInfo and CINAHL. The database search will be supplemented by additional search methodologies including citation searching and snowballing strategies which include reviewing reference lists and reviewing relevant journal table of contents, that is, BMJ Quality and Safety. Our search strategy will include search combinations of three key blocks of terms. Studies will not be excluded based on design. Included studies will be empirical studies conducted in a primary care setting. They will include some description of the factors that contribute to patient safety. One reviewer (SG) will screen all the titles and abstracts, whilst a second reviewer will screen 50% of the abstracts. Two reviewers (SG and AH) will perform study selection, quality assessment and data extraction using standard forms. Disagreements will be resolved through discussion or third party adjudication. Data to be collected include study characteristics (year, objective, research method, setting, country), participant characteristics (number, age, gender, diagnoses), patient safety incident type and characteristics, practice characteristics and study outcomes. DISCUSSION: The review will summarise the literature relating to contributory factors to patient safety incidents in primary care. The findings from this review will provide an evidence-based contributory factors framework for use in the primary care setting. It will increase understanding of factors that contribute to patient safety incidents and ultimately improve quality of health care.

Gillam, S. é. et Siriwardena, A. N. é. (2011). The Quality and Outcomes Framework (QOF) : tranforming general practice, Oxon : Radcliffe Publishing
http://www.amazon.co.uk/Quality-Outcomes-Framework-Transforming-Practice/dp/1846194563

The Quality and Outcomes Framework has deeply divided UK general practitioners. I commend this book and applaud its determination to scrutinise every aspect of the Quality and Outcomes Framework - good and bad and in-between. - From the Foreword by Iona Heath General practice in the UK faces transformation following the introduction of the Quality & Outcomes Framework (QOF), a pay-for-performance scheme unprecedented in the NHS, and the most comprehensive scheme of its kind in the world. Champions claim the QOF advances the quality of primary care; detractors fear the end of general practice as we know it. The introduction of the QOF provides a unique opportunity for research, analysis and reflection. This book is the first comprehensive analysis of the impact of the QOF, examining the claims and counter-claims in depth through the experience of those delivering QOF, comparisons with other countries, and analysis of the wealth of research evidence emerging. Assessments of the true impact of QOF will influence the development of health services in the UK and beyond. This book is essential reading for anyone with an interest in the future of

general practice and primary care, including health professionals, trainers, students, MRCGP candidates and researchers, managers, and policy-makers and shapers (4e de couverture).

Glance, L. G., et al. (2008). "Impact of the Present-on-Admission Indicator on Hospital Quality Measurement: Experience With the Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators." Medical Care **46**(2): 112-119.
http://journals.lww.com/lww-medicalcare/Fulltext/2008/02000/Impact_of_the_Present_on_Admission_Indicator_on.3.aspx

Background: The Agency for Healthcare Research and Quality (AHRQ) has constructed Inpatient Quality Indicator (IQI) mortality measures to measure hospital quality using routinely available administrative data. With the exception of California, New York State, and Wisconsin, administrative data do not include a present-on-admission (POA) indicator to distinguish between preexisting conditions and complications. The extent to which the lack of a POA indicator biases quality assessment based on the AHRQ mortality measures is unknown. Objective: To examine the impact of the POA indicator on hospital quality assessment based on the AHRQ mortality measures using enhanced administrative data from California, which includes a POA indicator. Methods: Retrospective cohort study based on 2.07 million inpatient admissions between 1998 and 2000 in the California State Inpatient Database. The AHRQ IQI software was used to calculate risk-adjusted mortality rates using either (1) routine administrative data that included all the International Classification of Diseases (ICD)-9-CM codes or (2) enhanced administrative data that included only the ICD-9-CM codes representing preexisting conditions. Results: The inclusion of the POA indicator frequently results in changes in the quality ranking of hospitals classified as high-quality or low-quality using routine administrative data. Twenty-seven percent (stroke) to 94% (coronary artery bypass graft) of hospitals classified as high-quality using routine administrative data were reclassified as intermediate- or low-quality hospitals using the enhanced administrative data. Twenty-five percent (congestive heart failure) to 76% (percutaneous coronary intervention) of hospitals classified as low-quality hospitals using enhanced administrative data were misclassified as intermediate-quality hospitals using routine administrative data. Conclusions: Despite the fact that the AHRQ IQIs were primarily intended to serve as a screening tool, they are being increasingly used to publicly report hospital quality. Our findings emphasize the need to improve the “quality” of administrative data by including a POA indicator if these data are to serve as the information infrastructure for quality reporting.

Godichal, M., et al. (2007). "Recommandation d'indicateurs pour la gestion de quartier opératoire. Le projet Path de l'OMS." Gestions Hospitalieres(465): 255-260, graph.,tabl.

[BDSP. Notice produite par ENSP ER0xnXP0. Diffusion soumise à autorisation]. Est présentée ici la réflexion menée par un groupe de travail multi hospitalier belge dans le cadre du projet international Path (Performance Assessment Tool for quality improvement in Hospitals). L'objectif est d'offrir aux hôpitaux participants une évaluation de leur performance et une analyse de leurs résultats, suivies de la traduction de ceux-ci en actions d'amélioration. Le quartier opératoire s'inscrit dans la dimension "efficience" du modèle de mesure de la performance hospitalière de l'Organisation mondiale de la santé. Le groupe de travail s'est attelé à la construction d'un ensemble d'indicateurs articulé autour de trois objectifs considérés : offrir des processus efficaces de prise en charge du patient, optimiser l'activité du quartier opératoire, garantir des ressources humaines de qualité.

Goodwin, N., et al. (2011). Improving the quality of care in general practice. Report of an independent inquiry commissioned by The King's Fund. Londres King's Fund Institute**:** xiv+155 , fig. http://www.kingsfund.org.uk/publications/gp_inquiry_report.html

> The King's Fund set up, in April 2009, an independent inquiry into the quality of general practice in England. The aim of the inquiry, which was conducted by an independent panel of experts and chaired by Sir Ian Kennedy, was to help to support the work of general practice and to provide a guide to ensure that quality is at the heart of the service that it offers to patients.

Gort, M., et al. (2013). "How teams use indicators for quality improvement - a multiple-case study on the use of multiple indicators in multidisciplinary breast cancer teams." Soc Sci Med **96**: 69-77. PM:24034953

> A crucial issue in healthcare is how multidisciplinary teams can use indicators for quality improvement. Such teams have increasingly become the core component in both care delivery and in many quality improvement methods. This study aims to investigate the relationships between (1) team factors and the way multidisciplinary teams use indicators for quality improvement, and (2) both team and process factors and the intended results. An in-depth, multiple-case study was conducted in the Netherlands in 2008 involving four breast cancer teams using six structure, process and outcome indicators. The results indicated that the process of using indicators involves several stages and activities. Two teams applied a more intensive, active and interactive approach as they passed through these stages. These teams were perceived to have achieved good results through indicator use compared to the other two teams who applied a simple control approach. All teams experienced some difficulty in integrating the new formal control structure, i.e. measuring and managing performance, in their operational task, and in using their 'new' managerial task to decide as a team what and how to improve. Our findings indicate the presence of a network of relationships between team factors, the controllability and actionability of indicators, the indicator-use process, and the intended results

Gratacos, J., et al. (2018). "Standards of care and quality indicators for multidisciplinary care models for psoriatic arthritis in Spain." Rheumatol Int.

> To define and give priority to standards of care and quality indicators of multidisciplinary care for patients with psoriatic arthritis (PsA). A systematic literature review on PsA standards of care and quality indicators was performed. An expert panel of rheumatologists and dermatologists who provide multidisciplinary care was established. In a consensus meeting group, the experts discussed and developed the standards of care and quality indicators and graded their priority, agreement and also the feasibility (only for quality indicators) following qualitative methodology and a Delphi process. Afterwards, these results were discussed with 2 focus groups, 1 with patients, another with health managers. A descriptive analysis is presented. We obtained 25 standards of care (9 of structure, 9 of process, 7 of results) and 24 quality indicators (2 of structure, 5 of process, 17 of results). Standards of care include relevant aspects in the multidisciplinary care of PsA patients like an appropriate physical infrastructure and technical equipment, the access to nursing care, labs and imaging techniques, other health professionals and treatments, or the development of care plans. Regarding quality indicators, the definition of multidisciplinary care model objectives and referral criteria, the establishment of responsibilities and coordination among professionals and the active evaluation of patients and data collection were given a high priority. Patients considered all of them as important. This set of standards of care and

quality indicators for the multidisciplinary care of patients with PsA should help improve quality of care in these patients.

Gravelle, H., et al. (2002). Comparing the efficiency of national health systems: a sensitivity analysis of the WHO approach. CHE Technical Paper Series ; 25. York CHE**:** 19 , 14 tabl. www.york.ac.uk/inst/che/tech.htm - http://www.york.ac.uk/inst/che/tp25.pdf

Les auteurs de cette étude s'étaient donné pour objectif d'évaluer la robustesse des méthodes économétriques utilisées par l'Organisation Mondiale de la Santé (OMS) pour mesurer l'efficience des systèmes de santé. Pour cela, ils ont utilisé les mêmes données que l'OMS, sur la période 1997 pour 50 pays, et 1993-1997 pour 141 pays. L'efficience de chaque pays concernant la promotion de la santé auprès des populations a été estimée après avoir pris en compte les dépenses de santé, et tous les autres niveaux de dépenses et d'éducation. Les scores d'efficience ont été comparés selon différentes définitions de l'efficience et différentes méthodes d'estimation. Les résultats montrent que les classements des pays et les scores d'efficience sont sensibles aux définitions de l'efficience et du choix des modèles.

Gravelle, H., et al. (2018). Spatial Competition and Quality: Evidence from the English Family Doctor Market. CHE Research Paper Series ;151. York University of York**:** 33 , tabl., cartes, annexes. https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP151_spatial_competition_quality_family_doctor_market.pdf

We examine whether family doctor firms in England respond to local competition by increasing their quality. We measure quality in terms of clinical performance and patient-reported satisfaction to capture its multi-dimensional nature. We use a panel covering 8 years for over 8000 English general practices, allowing us to control for unobserved local area effects. We measure competition by the number of rival doctors within a small distance. We find that increases in local competition are associated with increases in clinical quality and patient satisfaction, particularly for firms with lower quality. However, the magnitude of the effect is small.

Gravelle, H., et al. (2012). Hospital Quality Competition Under Fixed Prices. CHE Research Paper Series ; 80. York University of York**:** 45 , tabl., fig. http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP80_hospital_quality_competition_fixedprices.pdf

The relationship between the quality of health care and the extent of competition amongst providers has been the subject of intense policy interest and debate. As part of the ESHCRU (Economics of social and Health Care research Unit) programme this study is undertaking a set of related investigations into this relationship in the hospital sector, in primary care (general practices) and in social care. This initial report on competition amongst hospitals reviews the theoretical economics literature on competition and quality, briefly describes the relevant empirical literature on : whether choice of hospital is influenced by quality; whether greater competition is associated with higher quality report on preliminary empirical analyses of the correlations amongst 16 hospital quality measures; the association between distance based measures of competition and these quality measures. It concludes by describing our future research suggested by the theoretical and empirical literature reviews and our initial empirical analyses.

Gravelle, H., et al. (2013). Does a hospital's quality depend on the quality of other hospitals? A spatial econometrics approach to investigating hospital quality competition. CHE Research Paper Series ; 82. York University of York**:** 27 , tabl.

http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP82_Hospital_competition_quality_spatial_econometrics.pdf

This paper examines whether a hospital's quality is affected by the quality provided by other hospitals in the same market. It first sets out a theoretical model with regulated prices which specifies conditions on demand and cost functions which determine whether a hospital will have higher quality when its rivals have higher quality. It then applies spatial econometric methods to a sample of English hospitals in 2009-10 and a set of 16 quality measures including mortality rates, readmission, revision and redo rates and three patient reported indicators to examine to examine the relationship between the quality of hospitals. It finds that a hospital?s quality is positively associated with the quality of its rivals for seven out of the sixteen quality measures and that in no case is there a negative association. In those cases where there is a positive association, an increase in rivals? quality by 10% increases a hospital's quality by 1.7% to 2.9%.

Gravelle, H., et al. (2000). Waiting times and waiting lists : a model of the market for elective surgery. CHE Technical Paper Series ; 18. York CHE**:** 21.
www.york.ac.uk/inst/che/tech.htm

Les auteurs présentent un modèle dynamique simple de la demande et de l'offre de chirurgie non urgente dans le NHS et le testent en utilisant un panel de données trimestrielles de 123 autorités de santé anglaises, du second trimestre 1987 au premier trimestre 1993. L'objectif de ce document est d'introduire l'utilisation de données d'attente du NHS dans la mesure de la performance dans le contexte d'un modèle économique de demande et d'offre de soins hospitaliers.

Gravelle, H., et al. (2007). Doctor behaviour under a pay for performance contract : evidence from the quality and outcomes framework. CHE Research Paper Series ; 28. York University of York**:** 26 , tabl., ann.
http://www.york.ac.uk/inst/che/pdf/rp28.pdf

Since 2003, 25% of UK general practitioners? income has been determined by the quality of their care. The 65 clinical quality indicators in this scheme (the Quality and Outcomes Framework) are in the form of ratios, with financial reward increasing linearly with the ratio between a lower and upper threshold. The numerator is the number of patients for whom an indicator is achieved and the denominator is the number of patients the practices declares are suitable for the indicator. The number declared suitable is the number of patients with the relevant condition less the number exception reported by the practice for a specified range of reasons. Exception reporting is designed to avoid harmful treatment resulting from the application of quality targets to patients for whom they were not intended. However, exception reporting also gives GPs the opportunity to exclude patients who should in fact be treated in order to achieve higher financial rewards. This is inappropriate use of exception reporting or ?gaming?. Practices can also increase income if they are below the upper threshold by reducing the number of patients declared with a condition (prevalence), or by increasing reported prevalence if they were above the upper threshold. This study examines the factors affecting delivered quality (the proportion of prevalent patients for indicators were achieved) and tests for gaming of exceptions and for prevalence reporting being responsive to financial incentives.

Greenfield, S., et al. (2004). Selecting indicators for the quality of diabetes at the Health Systems Level in OECD countries. OECD Health Technical Papers ; n° 15. Paris OCDE**:** 18 , tab.
http://www.oecd.org/dataoecd/28/34/33865546.pdf

Ce rapport présente les recommandations consensuelles d'un groupe d'experts internationaux sur les indicateurs relatifs au diabète. Les experts se sont basés sur un examen des indicateurs existants et ont répertorié les carences d'informations des indicateurs existants pour sélectionner des indicateurs devant couvrir des processus cliniques pour le diabète ainsi que des résultats de soins proximaux et distaux. L'examen a conduit à une recommandation de neuf indicateurs.

Groene, O., et al. (2013). "A systematic review of instruments that assess the implementation of hospital quality management systems." Int J Qual Health Care **25**(5): 525-541.

PURPOSE: Health-care providers invest substantial resources to establish and implement hospital quality management systems. Nevertheless, few tools are available to assess implementation efforts and their effect on quality and safety outcomes. This review aims to (i) identify instruments to assess the implementation of hospital quality management systems, (ii) describe their measurement properties and (iii) assess the effects of quality management on quality improvement and quality of care outcomes. DATA SOURCES: We performed a systematic literature search from 1990 to 2011 in PubMed, CINAHL, EMBASE, Cochrane Library and Web of Science. In addition, we used snowball strategies, screened the reference lists of eligible papers, reviewed grey literature and contacted experts in the field. STUDY SELECTION: and data extraction Two reviewers screened eligible papers based on pre-defined inclusion and exclusion criteria and all authors extracted data. Eligible papers are described in terms of general characteristics (settings, type and level of respondents, mode of data collection), methodological properties (sampling strategy, item derivation, conceptualization of quality management, assessment of reliability and validity, scoring) and application/implementation (accounting for context, organizational adaptations, sensitivity to change, deployment and effect size). RESULTS: Eighteen papers were deemed eligible for inclusion. While some common domains emerged in measurement conceptualization, substantial differences in scope persist. The instruments' measurement properties were insufficiently described and only few instruments assessed links between the implementation of quality management systems (QMS) and improvement strategies or outcomes. CONCLUSIONS: There is currently no well-established measure to assess the implementation and effectiveness of quality management systems. Future research should address this gap.

Hakkinen, U., et al. (2014). "Quality, cost, and their trade-off in treating AMI and stroke patients in European hospitals." Health Policy (Amsterdam, Netherlands) **117**(1): 15-27.
http://www.healthpolicyjrnl.com/article/S0168-8510(14)00130-4/abstract

OBJECTIVES : This study compared the cost and in-hospital mortality of hospital care for two major diseases, acute myocardial infarction (AMI) and stroke, by pooling patient-level data from five European countries (Finland, France, Germany, Spain, and Sweden). We examined whether a cost-quality trade-off existed in these countries by comparing hospital-level costs and survival rates, and whether hospitals which performed well in terms of cost or quality in treating one patient group (AMI) performed well also in treating the other patient group (stroke). METHODS : A fixed-effect probit regression model for survival and the linear model for log costs were used to calculate indicators for hospital quality and cost, which were plotted against each other. FINDINGS : Both with AMI and stroke there were remarkable differences between hospitals and countries in (both crude and adjusted) rates of patients discharged alive. Swedish and French hospitals had lower mortality than hospitals in Germany, Finland and Spain in the care of AMI patients. However, a longer length of stay in Spanish and German hospitals may bias the results in the two countries. The Finnish hospitals

seemed to have lower mortality than the other countries' hospitals in the care of stroke patients. There was no correlation at either the national or hospital level in the quality of treatment of these two diseases. We did not find a clear cost-quality trade-off. The only notable exception was Sweden, where the costs for AMI patients were higher in hospitals with the highest quality of care. CONCLUSIONS : Countries should identify the best performing hospitals both in terms of cost and quality in order to learn from hospitals that demonstrate better practice. It is equally important to better understand the reasons behind the observed differences between hospitals in costs and quality.

Ham, C., et al. (2016). Improving quality in the English NHS: a strategy for action. London The King's Fund**:** 38 , tab., graph., fig.
https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Improving-quality-Kings-Fund-February-2016.pdf

The NHS in England faces the immense challenge of bringing about improvements in patient care at a time of growing financial and workload pressures. It is expected to deliver productivity improvements of £22 billion by 2020/21 as well as implement new commitments such as seven-day working. It is doing so in the context of workforce shortages among key clinical groups and evidence of high levels of work-related stress among staff (Health and Safety Executive 2015). The Spending Review has committed additional resources to the NHS yet, even so, health care spending as a share of GDP is forecast to fall by the end of this parliament (Appleby 2015). The purpose of this paper is not to reopen debate about the adequacy of planned funding, challenging as that is. Rather, its aim is to argue that the English NHS cannot hope to meet the health care needs of the population without a coherent, comprehensive, unifying and sustained commitment to quality improvement as its principal strategy.

Hardcastle, A. C., et al. (2015). "The dynamics of quality: a national panel study of evidence-based standards." Health Services and Delivery Research **3**(11): 126 , tabl., annexes.
http://www.journalslibrary.nihr.ac.uk/hsdr/volume-3/issue-11

People with long-term health conditions do not always receive the health care they need, and so may suffer avoidable poor health. We aimed to find out if the quality of health care received by people in England had improved over 6 years, for four common long-term health conditions: cardiovascular disease (including heart disease and high blood pressure treatment), depression, diabetes and osteoarthritis. We wanted to know if some people got better care than others, and if this was related to things such as their wealth, education or social context. We used information collected by interviewer and nurse visits to the homes of 16,773 people aged 50 years or older who had agreed to take part in a national survey called the English Longitudinal Study of Ageing. They were asked questions about their health, disability, health care, education, employment, money, social lives and well-being in 2004–5, 2006–7, 2008–9 and 2010–11. We found that many people were still not receiving the care they needed, with little change over 6 years. The percentage of good care received for osteoarthritis was only 32%, compared with 83% for cardiovascular disease, 65% for depression and 76% for diabetes. There were no types of people who consistently missed out on care, although people with cognitive impairment received worse care for diabetes. Poorer people with specific illness burden may be less likely than wealthier people to receive a diagnosis, but people with a diagnosis were generally equally likely to get good-quality care.

Hartveit, M., et al. (2017). "Quality indicators for the referral process from primary to specialised mental health care: an explorative study in accordance with the RAND appropriateness method." BMC Health Serv Res **17**(1): 4.

BACKGROUND: Communication between involved parties is essential to ensure coordinated and safe health care delivery. However, existing literature reveals that the information relayed in the referral process is seen as insufficient by the receivers. It is unknown how this insufficiency affects the quality of care, and valid performance measures to explore it are lacking. The aim of the present study was to develop quality indicators to detect the impact that the quality of referral letters from primary care to specialised mental health care has on the quality of mental health services. METHODS: Using a modified version of the RAND/UCLA appropriateness method, a systematic literature review and focus group interviews were conducted to define quality indicators for mental health care expected to be affected by the quality of referral information. Focus group participants included psychiatrists, psychologists, general practitioners, patient representatives and managers. The existing evidence and suggested indicators were presented to expert panels, who assessed the indicators by their validity, reliability, sensitivity and feasibility. RESULTS: Sixteen preliminary indicators emerged during the focus group interviews and literature review. The expert panels recommended four of the 16 indicators. The recommended indicators measure a) timely access, b) delay in the process of assessing the referral, c) delay in the onset of care and d) the appropriateness of the referral. Adjustment was necessary for five other indicators, and seven indicators were rejected because of expected confounding factors reducing their validity and sensitivity. CONCLUSIONS: The quality of information relayed in the referral process from primary care to specialised mental health care is expected to affect a wide range of dimensions defining high quality care. The expected importance of the referral process for ensuring 'timely access'-one of the six aims of high-quality health care defined by the Institute of Medicine-is highlighted. Exploring the underlying mechanisms for the potential impact of referral information on patient outcomes is recommended to enhance quality of care. TRIAL REGISTRATION: ClinicalTrials.gov: NCT01374035 (28 April 2011).

HealthConsumerPowerHouse (2016). Euro Health consumer index 2015. Danderyd Health Consumer Powerhouse**:** 115 , tabl., fig.
http://www.healthpowerhouse.com/files/EHCI_2015/EHCI_2015_report.pdf

European healthcare is steadily improving, in spite of alarm bells about financial crisis austerity measures, aging population and migration turmoil. Survival rates of heart disease, stroke and cancer are all increasing. Infant mortality, perhaps the most descriptive single indicator, keeps going down. This is a main conclusion from the 2015 Euro Health Consumer Index (EHCI), published today by the Health Consumer Powerhouse (HCP) Ltd. The EHCI, started in 2005, is the leading comparison for assessing the performance of national healthcare systems in 35 countries. The EHCI analyses national healthcare on 48 indicators, looking into areas such as Patient Rights and Information, Access to Care, Treatment Outcomes, Range and Reach of Services, Prevention and use of Pharmaceuticals.

Hegger, I., et al. (2016). "Enhancing the contribution of research to health care policy-making: a case study of the Dutch Health Care Performance Report." J Health Serv Res Policy **21**(1): 29-35.

OBJECTIVES: The Dutch Health Care Performance Report, issued by the National Institute of Public Health and the Environment, aims to monitor health care performance in The Netherlands. Both the National Institute and the Ministry of Health wish to increase the contribution of the Report to health care policy-making. Our aim was to identify ways to achieve that. METHOD: We used contribution mapping as a theoretical framework that recognizes alignment of research as crucial to managing contributions to policy-making. To investigate which areas need alignment efforts by researchers and/or policy-makers, we interviewed National Institute researchers and policy-makers from the Ministry of Health and

assessed the process for developing the 2010 Report. RESULTS: We identified six areas where alignment is specifically relevant for enhancing the contributions of future versions of the Dutch Health Care Performance Report: well-balanced information for different ministerial directorates; backstage work; double role actors; reports of other knowledge institutes; data collection/generation and presentation forms. CONCLUSION: The contribution of health care performance reporting to policy-making is complex and requires continuous alignment efforts between researchers and policy-makers. These efforts should form an inseparable part of health care performance reporting and although this demands considerable resources, it is worth considering since it may pay back in better contributions to policy-making.

Hermann, R. C., et al. (2006). "Quality indicators for international benchmarking of mental health care." International Journal for Quality in Health Care: 31-38.

Hernaes, K. H. (2005). Measuring the Quality of Hospital Services. Hospital Specific Factors and Individual Evaluations. Working paper 2005; 10. Oslo HERO**:** 46 , tabl., fig. http://www.hero.uio.no/publicat/2005/HERO2005_10.pdf

Is an increase in the quality of health services, as perceived by the hospital, appreciated by the consumers? If so, patients should respond positively to an increase in the quality of hospital services. Using two indicators to capture the quality of hospital services I investigate the relationship between these indicators and inpatients? experiences. The health sector has increased substantially in most OECD countries over the last few decades. In Norway, total health care expenditures as a percentage share of the GDP, has grown from 2.9 % in 1960 to 8.7 % in 2002. In 2002 the state took over ownership of the Norwegian hospital sector and organized it through five regional semiautonomous companies. The motivation behind this was more efficient use of hospital resources, equal access despite geographical differences, and a higher quality of health services. Cost efficiency, measured as total activity relative to total costs, decreased during the 1990s. Part of the decrease can be explained by increased labour costs. It is often assumed that decreasing costs lead to lower quality. If this is the case in the health sector, one would expect to see a higher level of quality when costs per patient increase. Health services are paid for by taxpayers who are also the users of these services. For this reason, and especially since costs have increased, they should be able to evaluate the quality of the services they receive. This leads to an important question: What aspects of quality are important to consumers of health services? Do quality indicators, such as readmission rates and waiting time, capture the quality that consumers demand? This thesis is an attempt to answer these questions.

Hesselink, G., et al. (2012). "Improving patient handovers from hospital to primary care: a systematic review." Ann Intern Med **157**(6): 417-428.

BACKGROUND: Evidence shows that suboptimum handovers at hospital discharge lead to increased rehospitalizations and decreased quality of health care. PURPOSE: To systematically review interventions that aim to improve patient discharge from hospital to primary care. DATA SOURCES: PubMed, CINAHL, PsycInfo, the Cochrane Library, and EMBASE were searched for studies published between January 1990 and March 2011. STUDY SELECTION: Randomized, controlled trials of interventions that aimed to improve handovers between hospital and primary care providers at hospital discharge. DATA EXTRACTION: Two reviewers independently abstracted data on study objectives, setting and design, intervention characteristics, and outcomes. Studies were categorized according to methodological quality, sample size, intervention characteristics, outcome, statistical significance, and direction of effects. DATA SYNTHESIS: Of the 36 included studies, 25 (69.4%)

had statistically significant effects in favor of the intervention group and 34 (94.4%) described multicomponent interventions. Effective interventions included medication reconciliation; electronic tools to facilitate quick, clear, and structured summary generation; discharge planning; shared involvement in follow-up by hospital and community care providers; use of electronic discharge notifications; and Web-based access to discharge information for general practitioners. Statistically significant effects were mostly found in reducing hospital use (for example, rehospitalizations), improvement of continuity of care (for example, accurate discharge information), and improvement of patient status after discharge (for example, satisfaction). LIMITATIONS: Heterogeneity of the interventions and study characteristics made meta-analysis impossible. Most studies had diffuse aims and poor descriptions of the specific intervention components. CONCLUSION: Many interventions have positive effects on patient care. However, given the complexity of interventions and outcome measures, the literature does not permit firm conclusions about which interventions have these effects. PRIMARY FUNDING SOURCE: The European Union, the Framework Programme of the European Commission.

Hofmann, S. et Muhlenweg, A. M. (2016). Gatekeeping in German Primary Health Care : Impacts on Coordination of Care, Quality Indicators and Ambulatory Costs. CINCH Working Paper; 1605. Essen Universität Duisbourg - Essen**:** 25 , tabl., fig.
http://econpapers.repec.org/paper/duhwpaper/1605.htm

Evaluation studies on gatekeeping in primary care exist for a variety of countries but provide mixed evidence on utilization and quality of care as well as costs. Our study evaluates the German gatekeeping program, based on claims data of a major statutory health insurance company. The panel structure of the data allows controlling for patients' characteristics in the year before opting (or not opting) for a GP contract. In contrast to previous studies we are able to draw on multiple identification strategies. We exploit variation in the regional provision of gatekeeping in an instrumental variable (IV) framework. We also analyze GP fixed effects based on the observation of patients opting for one of two different contracts within the same GP office. We find that the gatekeeping contract yields a somewhat higher coordination of care, improved quality (regarding prevention and avoidance of hospitalization) but also higher ambulatory costs. The effects are largely robust between our identification strategies.

Howard, I., et al. (2018). "Quality Indicators for Evaluating Prehospital Emergency Care: A Scoping Review." Prehosp Disaster Med **33**(1): 43-52.

Introduction Historically, the quality and performance of prehospital emergency care (PEC) has been assessed largely based on surrogate, non-clinical endpoints such as response time intervals or other crude measures of care (eg, stakeholder satisfaction). However, advances in Emergency Medical Services (EMS) systems and services world-wide have seen their scope and reach continue to expand. This has dictated that novel measures of performance be implemented to compliment this growth. Significant progress has been made in this area, largely in the form of the development of evidence-informed quality indicators (QIs) of PEC. Problem Quality indicators represent an increasingly popular component of health care quality and performance measurement. However, little is known about the development of QIs in the PEC environment. The purpose of this study was to assess the development and characteristics of PEC-specific QIs in the literature. METHODS: A scoping review was conducted through a search of PubMed (National Center for Biotechnology Information, National Institutes of Health; Bethesda, Maryland USA); EMBase (Elsevier; Amsterdam, Netherlands); CINAHL (EBSCO Information Services; Ipswich, Massachusetts USA); Web of Science (Thomson Reuters; New York, New York USA); and the Cochrane Library (The

Cochrane Collaboration; Oxford, United Kingdom). To increase the sensitivity of the literature, a search of the grey literature and review of select websites was additionally conducted. Articles were selected that proposed at least one PEC QI and whose aim was to discuss, analyze, or promote quality measurement in the PEC environment. RESULTS: The majority of research (n=25 articles) was published within the last decade (68.0%) and largely originated within the USA (68.0%). Delphi and observational methodologies were the most commonly employed for QI development (28.0%). A total of 331 QIs were identified via the article review, with an additional 15 QIs identified via the website review. Of all, 42.8% were categorized as primarily Clinical, with Out-of-Hospital Cardiac Arrest contributing the highest number within this domain (30.4%). Of the QIs categorized as Non-Clinical (57.2%), Time-Based Intervals contributed the greatest number (28.8%). Population on Whom the Data Collection was Constructed made up the most commonly reported QI component (79.8%), followed by a Descriptive Statement (63.6%). Least reported were Timing of Data Collection (12.1%) and Timing of Reporting (12.1%). Pilot testing of the QIs was reported on 34.7% of QIs identified in the review. CONCLUSION: Overall, there is considerable interest in the understanding and development of PEC quality measurement. However, closer attention to the details and reporting of QIs is required for research of this type to be more easily extrapolated and generalized. Howard I , Cameron P , Wallis L , Castren M , Lindstrom V . Quality indicators for evaluating prehospital emergency care: a scoping review. Prehosp Disaster Med. 2018;33(1):43-52.

Hu, J., et al. (2016). "Correlations Among Hospital Quality Measures: What "Hospital Compare" Data Tell Us." Am J Med Qual: 1062860616684012.
http://www.ncbi.nlm.nih.gov/pubmed/28693332

A number of quality rating systems to rank health care providers have been developed over the years with the intention of helping consumers make informed health care purchasing decisions. Many use sets of individual quality measures to calculate a global rating. The utility of a global rating for consumer choice hinges on the relationships among included measures and the extent to which they jointly reflect an underlying dimension of quality. Publicly reported data on 4 quality domains-complication, mortality, readmission, and patient safety-from Centers for Medicare & Medicaid Services' Hospital Compare website were used to examine correlations among individual measures within each measure group (within-group correlations) and correlations between pairs of measures across different measure groups (between-group correlations). Modest within-group correlations were found in only 2 domains (mortality and readmission), and there were no meaningful between-group associations. These findings raise questions about whether consumers can reliably depend on global quality ratings to make informed decisions.

Hussey, P. S., et al. (2009). "A systematic review of health care efficiency measures." Health Serv Res **44**(3): 784-805.

OBJECTIVE: To review and characterize existing health care efficiency measures in order to facilitate a common understanding about the adequacy of these methods. DATA SOURCES: Review of the MedLine and EconLit databases for articles published from 1990 to 2008, as well as search of the "gray" literature for additional measures developed by private organizations. STUDY DESIGN: We performed a systematic review for existing efficiency measures. We classified the efficiency measures by perspective, outputs, inputs, methods used, and reporting of scientific soundness. PRINCIPAL FINDINGS: We identified 265 measures in the peer-reviewed literature and eight measures in the gray literature, with little overlap between the two sets of measures. Almost all of the measures did not explicitly consider the quality of care. Thus, if quality varies substantially across groups, which is likely

in some cases, the measures reflect only the costs of care, not efficiency. Evidence on the measures' scientific soundness was mostly lacking: evidence on reliability or validity was reported for six measures (2.3 percent) and sensitivity analyses were reported for 67 measures (25.3 percent). CONCLUSIONS: Efficiency measures have been subjected to few rigorous evaluations of reliability and validity, and methods of accounting for quality of care in efficiency measurement are not well developed at this time. Use of these measures without greater understanding of these issues is likely to engender resistance from providers and could lead to unintended consequences.

IAPO (2012). Patient-Centred Healthcare Indicators Review. Londres International Alliance of Patients Organization.**:** 23 , tabl.
http://www.patientsorganizations.org/attach.pl/1441/1484/IAPO%20Patient-Centred%20Healthcare%20Indicators%20Review.pdf

Cette étude de l'International Alliance of Patients' Organizations (IAPO) fait partie d'un projet qui cherche à construire des indicateurs servant à mesurer jusqu'à quel point les prestataires de services de santé se préoccupent des patients. Après une évaluation de la littérature, les auteurs concluent que très peu d'indicateurs fiables existent actuellement. Ils préconisent une approche qui combinerait des indicateurs quantitatifs et qualitatifs.

Jabbarpou, Y., et al. (2017). The Impact of Primary Care Practice Transformation on Cost, Quality, and Utilization : a systematic review of research published in 2016. Washington PCPCC**:** 40 , tab., graph., fig.
https://www.milbank.org/wp-content/uploads/2017/08/pcmh_evidence_report_08-1-17-FINAL.pdf

Ce rapport de la Patient-Centered Primary Care Collaborative (PCPCC) présente les résultats de 45 nouveaux rapports revus par les pairs et d'autres évaluations gouvernementales et étatiques sur la transformation des pratiques de soins de santé primaires. Il trouve que dans de nombreuses études, le « patient-centred medical home » et d'autres formes avancées de soins primaires démontrent des impacts importants.

Jacobs, R., et al. (2004). Measuring performance : An examination of composite performance indicators. CHE Technical Papers Series; 29. York University of York**:** 112 , tabl., fig., ann.
http://www.york.ac.uk/inst/che/pdf/tp29.pdf

It is widely acknowledged that the performance of health care systems is multidimensional, implying that measurement of performance requires a number of different scales to capture each element. Given the increasing interest worldwide in combining disparate indicators of healthcare performance into a single composite measure, this report examines the economic and technical issues involved in the creation of composite indicators. There are many arguments for and against the use of composite indicators and while they are increasingly being used as a political tool in a number of different policy areas, they can potentially suffer from a number of methodological difficulties. The publication of composite performance indicators might generate both positive and negative behavioural responses depending on the incentives which they produce. A number of different examples are given of the creation and use of composite indices in health care and in other sectors, both in the UK and internationally. One example, is the introduction of the annual "star ratings" of NHS hospitals in the UK aimed to create a rounded picture of performance by combining several dimensions of hospital output. This report uses this example of hospital data for English acute hospitals to examine the methodological challenges of creating composite measures. The creation of a composite comprises a number of important steps, each of which requires careful judgement. These include the specification of the choice of indicators, the

transformation of measured performance on individual indicators, combining the indicators using some decision rules and the specification of a set of weights that reflect societal preferences for health system outputs. The report examines these issues by developing a composite index and using Monte Carlo simulations to examine the robustness of performance judgements to these different technical choices. Model uncertainty is explored by changing assumptions about random variation in the indicators and then examining the impact this has on hospital rankings. The analysis suggests that the technical choices that have to be made in the construction of the composite can have a significant impact on the resulting score. In particular, changing the weights, thresholds and decision rules of combining individual performance indicators materially affects the score and rank correlations of hospitals. Technical and analytical issues in the design of composite indicators clearly have important policy implications. This report highlights the issues which need to be taken into account in the construction of robust composite indicators so that they can be designed in ways which will minimise the potential for producing misleading performance information which may fail to deliver the expected improvements or even induce unwanted side-effects (résumé d'auteur).

JanlÖV, N. (2007). Swedish health care performance, quantity versus quality. Lund Lund University**:** 27 , 27 tab.
http://www.nek.lu.se/publications/workpap/Papers/WP07_17.pdf

The Swedish health care system is characterized by its far-reaching decentralization, with 21 politically, economically and administratively independent county councils responsible for financing, delivering and organizing health care for their citizens on the basis of need. This paper investigates the relative efficiency of 21 Swedish county councils through two efficiency models; one focusing on a traditional productivity measure (activity model) in terms of the production of intermediate outputs, and the other on quality outputs in the form .of health-related outcomes (outcome model).

Joling, K. J., et al. (2018). "Quality indicators for community care for older people: A systematic review." Plos One **13**(1): e0190298.

BACKGROUND: Health care systems that succeed in preventing long term care and hospital admissions of frail older people may substantially save on their public spending. The key might be found in high-quality care in the community. Quality Indicators (QIs) of a sufficient methodological level are a prerequisite to monitor, compare, and improve care quality. This systematic review identified existing QIs for community care for older people and assessed their methodological quality. METHODS: Relevant studies were identified by searches in electronic reference databases and selected by two reviewers independently. Eligible publications described the development or application of QIs to assess the quality of community care for older people. Information about the QIs, the study sample, and specific setting was extracted. The methodological quality of the QI sets was assessed with the Appraisal of Indicators through Research and Evaluation (AIRE) instrument. A score of 50% or higher on a domain was considered to indicate high methodological quality. RESULTS: Searches resulted in 25 included articles, describing 17 QI sets with 567 QIs. Most indicators referred to care processes (80%) and measured clinical issues (63%), mainly about follow-up, monitoring, examinations and treatment. About two-third of the QIs focussed on specific disease groups. The methodological quality of the indicator sets varied considerably. The highest overall level was achieved on the domain 'Additional evidence, formulation and usage' (51%), followed by 'Scientific evidence' (39%) and 'Stakeholder involvement' (28%). CONCLUSION: A substantial number of QIs is available to assess the quality of community care for older people. However, generic QIs, measuring care outcomes and non-clinical

aspects are relatively scarce and most QI sets do not meet standards of high methodological quality. This study can support policy makers and clinicians to navigate through a large number of QIs and select QIs for their purposes. PROSPERO Registration: 2014:CRD42014007199.

Jolley, R. J., et al. (2017). "Protocol for a scoping review study to identify and classify patient-centred quality indicators." BMJ Open **7**(1): e013632.

INTRODUCTION: The concept of patient-centred care (PCC) is changing the way healthcare is understood, accepted and delivered. The Institute of Medicine has defined PCC as 1 of its 6 aims to improve healthcare quality. However, in Canada, there are currently no nationwide standards in place for measuring and evaluating healthcare from a patient-centred approach. In this paper, we outline our scoping review protocol to systematically review published and unpublished literature specific to patient-centred quality indicators that have been implemented and evaluated across various care settings. METHODS AND ANALYSIS: Arksey and O'Malley's scoping review methodology framework will guide the conduct of this scoping review. We will search electronic databases (MEDLINE, EMBASE, the Cochrane Library, Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycINFO, Social Work Abstracts, Social Services Abstracts), grey literature sources and the reference lists of key studies to identify studies appropriate for inclusion. 2 reviewers will independently screen all abstracts and full-text studies for inclusion. We will include any study which focuses on quality indicators in the context of PCC. All bibliographic data, study characteristics and indicators will be collected and analysed using a tool developed through an iterative process by the research team. Indicators will be classified according to a predefined conceptual framework and categorised and described using qualitative content analysis. ETHICS AND DISSEMINATION: The scoping review will synthesise patient-centred quality indicators and their characteristics as described in the literature. This review will be the first step to formally identify what quality indicators have been used to evaluate PCC across the healthcare continuum, and will be used to inform a stakeholder consensus process exploring the development of a generic set of patient-centred quality indicators applicable to multiple care settings. The results will be disseminated through a peer-reviewed publication, conference presentations and a one-day stakeholder meeting.

Jones, C., et al. (2015). "A systematic review of the cost of data collection for performance monitoring in hospitals." Syst Rev **4**: 38.

BACKGROUND: Key performance indicators (KPIs) are used to identify where organisational performance is meeting desired standards and where performance requires improvement. Valid and reliable KPIs depend on the availability of high-quality data, specifically the relevant minimum data set ((MDS) the core data identified as the minimum required to measure performance for a KPI) elements. However, the feasibility of collecting the relevant MDS elements is always a limitation of performance monitoring using KPIs. Preferably, data should be integrated into service delivery, and, where additional data are required that are not currently collected as part of routine service delivery, there should be an economic evaluation to determine the cost of data collection. The aim of this systematic review was to synthesise the evidence base concerning the costs of data collection in hospitals for performance monitoring using KPI, and to identify hospital data collection systems that have proven to be cost minimising. METHODS: We searched MEDLINE (1946 to May week 4 2014), Embase (1974 to May week 2 2014), and CINAHL (1937 to date). The database searches were supplemented by searching for grey literature through the OpenGrey database. Data was extracted, tabulated, and summarised as part of a narrative synthesis. RESULTS: The searches yielded a total of 1,135 publications. After assessing each identified study against specific

inclusion exclusion criteria only eight studies were deemed as relevant for this review. The studies attempt to evaluate different types of data collection interventions including the installation of information communication technology (ICT), improvements to current ICT systems, and how different analysis techniques may be used to monitor performance. The evaluation methods used to measure the costs and benefits of data collection interventions are inconsistent across the identified literature. Overall, the results weakly indicate that collection of hospital data and improvements in data recording can be cost-saving. CONCLUSIONS: Given the limitations of this systematic review, it is difficult to conclude whether improvements in data collection systems can save money, increase quality of care, and assist performance monitoring of hospitals. With that said, the results are positive and suggest that data collection improvements may lead to cost savings and aid quality of care. SYSTEMATIC REVIEW REGISTRATION: PROSPERO CRD42014007450 .

Jones, P., et al. (2014). "Review article: what makes a good healthcare quality indicator? A systematic review and validation study." Emerg Med Australas **26**(2): 113-124.

Indicators measuring aspects of performance to assess quality of care are often chosen arbitrarily. The present study aimed to determine what should be considered when selecting healthcare quality indicators, particularly focusing on the application to emergency medicine. Structured searches of electronic databases were supplemented by website searches of quality of care and benchmarking organisations, citation searches and discussions with experts. Candidate attributes of 'good' healthcare indicators were extracted independently by two authors. The validity of each attribute was independently assessed by 16 experts in quality of care and emergency medicine. Valid and reliable attributes were included in a critical appraisal tool for healthcare quality indicators, which was piloted by emergency medicine specialists. Twenty-three attributes were identified, and all were rated moderate to extremely important by an expert panel. The reliability was high: alpha = 0.98. Twelve existing tools explicitly stated a median (range) of 14 (8-17) attributes. A critical appraisal tool incorporating all the attributes was developed. This was piloted by four emergency medicine specialists who were asked to appraise and rank a set of six candidate indicators. Although using the tool took more time than implicit gestalt decision making: median (interquartile range) 190 (43-352) min versus 17.5 (3-34) min, their rankings changed after using the tool. To inform the appraisal of quality improvement indicators for emergency medicine, a comprehensive list of indicator attributes was identified, validated, developed into a tool and piloted. Although expert consensus is still required, this tool provides an explicit basis for discussions around indicator selection.

Joumard, I., et al. (2010). Health Care Systems : Efficiency and Institutions. Economics Department working papers; 769. Paris OCDE**:** 130 , tabl., graph., annexes.
http://www.olis.oecd.org/olis/2010doc.nsf/LinkTo/NT00002BB6/$FILE/JT03283813.PDF

Ce document présente un ensemble d?indicateurs afin d?évaluer la performance des systèmes de santé. Il présente aussi de nouvelles données comparatives sur les politiques et les institutions dans le domaine de la santé pour les différents pays de l?OCDE. Cet ensemble d?indicateurs permet de caractériser empiriquement les systèmes de santé en identifiant des groupes de pays ayant des politiques et institutions comparables. Il permet aussi de mettre en valeur les forces et les faiblesses du système de santé de chaque pays et de déterminer les gains potentiels d?efficacité. L?analyse empirique montre que dans chacun des pays étudiés l?efficacité des dépenses de santé peut être améliorée; qu?il n?existe pas de système qui, pour un coût donné, produit systématiquement des meilleurs résultats - des réformes radicales en faveur d?un système de santé ne sont donc pas nécessaires ; accroitre la cohérence des politiques en matière de santé en adoptant les politiques les plus

performantes à l?intérieur d?un système similaire et en empruntant les éléments les plus appropriés aux autres systèmes s?avérera vraisemblablement plus réaliste et plus efficace pour améliorer l?efficacité de la dépense en matière de santé.

Katz, A., et al. (2006). "Can the quality of care in family practice be measured using administrative data?" Health Serv Res **41**(6): 2238-2254.

OBJECTIVE: To explore the feasibility of using administrative data to develop process indicators for measuring quality in primary care. DATA SOURCES/STUDY SETTING: The Population Health Research Data Repository (Repository) housed at the Manitoba Centre for Health Policy which includes physician claims, hospital discharge abstracts, pharmaceutical use (Drug Program Information Network (DPIN)), and the Manitoba Immunization Monitoring Program (MIMS) for all residents of Manitoba, Canada who used the health care system during the 2001/02 fiscal year. Family physicians were identified from the Physician Resource Database. Indicators were developed based on a literature review and focus group validation. DATA COLLECTION/EXTRACTION METHODS: Data files were extracted from administrative data available in the Repository. We extracted data based on the ICD-9-CM codes and ATC-class drugs prescribed and then linked them to the Physician Resource Database. Physician practices were defined by allocating patients to their most responsible physician. Every family physician in Manitoba that met the inclusion criteria (having either 5 or 10 eligible patients depending on the indicator) was 'scored' on each indicator. Physicians were then grouped according to the proportion of the patients allocated to their practice who received the recommended care for the specific indicator. PRINCIPAL FINDINGS: Using administrative health data we were able to develop and measure eight indicators of quality of care covering both preventive care services and chronic disease management. The number of eligible physicians and patients varied for each indicator as did the percent of patients with recommended care, per physician. For example, the childhood immunization indicator included 544 physicians who, on average, provided immunization for 65 percent of their patients. CONCLUSIONS: Quality of care provided by family physicians can be measured using administrative data. Despite the limitations addressed in this paper, this work establishes a practical methodology to measure quality of care provided by family physicians that can be used for quality improvement initiatives.

Kelley, E. et Hurst, J. (2006). Health care quality indicators project : conceptual framework paper. OECD Health Working Papers ; 23. Paris OCDE**:** 36 , 37 ann., 32 graph., 55 tabl. http://www.oecd.org/dataoecd/1/36/36262363.pdf

Ce document a pour objet de présenter le cadre conceptuel du projet de l'OCDE sur les indicateurs de la qualité des soins de santé (projet HCQI). Deux grandes questions y sont traitées : quels concepts, ou aspects, de la qualité des soins convient-il d'évaluer et comment ceux-ci doivent-ils en théorie être évalués. La nécessité d'élaborer un cadre conceptuel pour le projet a été exprimée par un grand nombre de pays participants. Les pays ont indiqué que ce cadre devait : a) être fondé sur l'expérience des pays et b) pouvoir être utilisé pour éclairer les travaux actuels et futurs de l'OCDE dans le domaine de l'évaluation et du suivi de la qualité des soins de santé. Le projet de l'OCDE sur les indicateurs de la qualité des soins de santé a été lancé en 2001. Son objectif à long terme est d'élaborer un ensemble d'indicateurs qui rendent fidèlement compte de la qualité des soins de santé en se prêtant à des comparaisons fiables entre pays grâce à l'utilisation de données comparables. Le projet HCQI s'appuie sur deux activités internationales préexistantes de coopération, organisées respectivement par le Commonwealth Fund of New York (cinq pays) et le Groupe de travail du Conseil nordique des ministres sur l'évaluation de la qualité (six pays). Vingt trois pays participent à présent au projet. Ce document vise à fournir des orientations pour la

réalisation du projet HCQI en mettant en évidence les éléments techniques sur lesquels faire reposer dans l'immédiat et ultérieurement les travaux qui s'y rapportent. Il définit des priorités pour ces travaux et leur gestion à l'intention de l'OCDE et des pays membres participants pour 2006 et au-delà. Sur la question de savoir quels aspects de la qualité il convient de mesurer, il est proposé de prendre dans toute la mesure du possible comme base conceptuelle pour les indicateurs de la qualité technique des soins de santé, les cadres conceptuels déjà élaborés par plusieurs pays membres. Autrement dit, le cadre doit être multidimensionnel par nature et s'appuyer sur l'expérience pratique acquise par les pays membres à travers l'évaluation des performances des systèmes de santé en général et de la qualité des soins en particulier. Il a été convenu que le cadre tiendra compte du vaste champ couvert par l'évaluation des performances des systèmes de santé, tant dans le présent document que dans les documents cités en référence sur le même sujet, tout en définissant de façon relativement étroite le champ des travaux relatifs au projet. Quant à la question de savoir comment mesurer en théorie la qualité, il est proposé de faire figurer dans l'ensemble d'indicateurs à la fois des indicateurs de processus et des indicateurs de résultats. En outre, le choix des indicateurs devrait être fondé sur trois critères principaux : i) l'importance de ce qui est mesuré ; ii) la pertinence scientifique de l'indicateur ; iii) la faisabilité/le coût de l'obtention des données. Le présent document examine différents types d'indicateurs, le champ qu'il est proposé de couvrir à l'aide de l'ensemble d'indicateurs, les critères de sélection des indicateurs et d'autres questions, comme la couverture géographique (représentativité nationale), le nombre global d'indicateurs à prendre en compte, l'évolution de l'ensemble d'indicateurs au fil du temps et les indicateurs composites. Pour chacune de ces questions sont présentées à la fois des données générales et des informations sur l'approche suivie dans le cadre du projet (tiré du résumé d'auteur).

Kelley, E. et Hurst, J. (2006). Health care quality indicators project : initial indicators report. OECD Health Working Papers ; 22. Paris OCDE**:** 151 , 152 graph., 155 tabl.
http://www.oecd.org/dataoecd/1/34/36262514.pdf

Le projet de l'OCDE sur les indicateurs de la qualité des soins de santé (HCQI) a été lancé en 2001. Son objectif à long terme est d'élaborer un ensemble d'indicateurs qui puissent être utilisés pour déterminer de nouvelles pistes de recherche sur la qualité des soins dans les pays de l'OCDE. Les indicateurs devant finalement être recommandés pour faire partie de cet ensemble d'indicateurs doivent en principe être pertinents du point de vue scientifique et importants sur le plan clinique et stratégique, et leur collecte réalisable dans la pratique au sens où les données y afférentes doivent être disponibles et comparables à l'échelon international. Ces indicateurs ne sont pas non plus censés permettre de porter un jugement sur la performance globale des systèmes de santé dans leur intégralité. Ils devraient essentiellement être utilisés comme point de départ pour comprendre pourquoi des différences existent et par quels moyens les réduire et améliorer les soins de santé dans tous les pays. Le projet est divisé en deux phases. La première, dont le présent rapport présente une synthèse, a été axée sur 17 indicateurs importants et facilement accessibles de l'efficacité des soins. Les indicateurs qui seront pris en compte dans la deuxième phase des travaux porteront sur un éventail plus large d'affections cliniques et d'aspects de la qualité des soins de santé. La première partie du rapport présente l'objet et l'historique du projet, les méthodes utilisées et les résultats obtenus. La deuxième partie fait une synthèse des conclusions des analyses approfondies réalisées par l'OCDE au cours du printemps et de l'été 2005 sur un ensemble de cinq questions posées par les experts nationaux lors de la réunion qu'ils ont tenue en décembre 2004 à Paris. Ces questions concernant les données portent sur des problèmes de comparabilité entre les pays pour des indicateurs particuliers. La troisième et dernière partie du rapport présente des informations détaillées sur la pertinence scientifique et l'importance des indicateurs dont l'inclusion dans l'ensemble initial

d'indicateurs de la qualité des soins de santé de l'OCDE a été recommandée, la disponibilité des données y afférentes et leur comparabilité au niveau international. Le document examine aussi en détail les indicateurs dont l'intégration dans cet ensemble initial n'est actuellement pas recommandée. Ces derniers ne sont pas pour autant définitivement écartés. Plusieurs d'entre-eux sont généralement considérés comme pertinents sur le plan scientifique, mais pour le moment, la disponibilité et la comparabilité des données qui s'y rapportent ne sont pas nécessairement tout-à-fait satisfaisantes. Par conséquent, ces indicateurs ne se prêtent pas actuellement à la comparaison internationale (tiré du résumé d'auteur).

Kelley, E. T., et al. (2006). "Beyond the initial indicators: lessons from the OECD Health Care Quality Indicators Project and the US National Healthcare Quality Report." Int J Qual Health Care **18 Suppl 1**: 45-51.

Interest in comparative quality measurement and evaluation has grown considerably over the past two decades because of factors such as the recognition of widespread variation in clinical practice, the increased availability of evidence about medical effectiveness, and increasing concern about the cost and quality of health care. This article describes and contrasts two current efforts to develop health performance reporting systems: one, an international initiative-the Health Care Quality Indicator (HCQI) Project, sponsored by the Organization for Economic Cooperation and Development (OECD); and the other, a national project-the National Healthcare Quality Report (NHQR), sponsored by the US Agency for Healthcare Quality and Research. There are a number of lessons learned from a comparison of the two efforts that are relevant for the future of each project and for other indicator-based reporting efforts in quality of health care. These lessons are discussed in the article and include: Conceptual frameworks should be established to guide the selection of indicators. Choices should be made early on in the process to focus on a wide range of clinical conditions or to report on a few priority areas. METHODS: should be developed to add and subtract indicators while maintaining a stable set of indicators to track over time. Resources should be allocated to communication strategies and how best to present data results to diverse audiences. Mechanisms should be put in place to maintain project momentum.

Klazinga, N. (2010). Improving Value in Health Care: Measuring Quality, Paris : OCDE http://www.oecd.org/document/42/0,3343,en_2649_33929_46144874_1_1_1_1,00.html - http://books.google.com/books?id=AQ1QmWh4B6oC&printsec=frontcover&hl=fr#v=onepage&q&f=false

This report is about how to improve quality in health care ? a vital objective for health systems everywhere. Quality in health care is multifaceted and has various perspectives. Every patient has a right to receive timely, safe and effective care. Patients also have a right to be informed about the care process and about its risk and benefits. Those who fund and manage health care have a duty to ensure that scarce health care resources are used judiciously and wisely for the greatest public good. The drive to improve quality does not stem simply from the fact that it is the right thing to do. Increased public involvement and awareness have been accompanied by a series of landmark critiques on quality in health care. The larger role of ICTs in health care systems has also meant that information relating to quality is now more abundant. Added to this, cost pressures on health systems have increased dramatically and OECD countries now spend more on health than ever before. Poor-quality health care ruins people?s lives or kills them (Institute of Medicine). It is also wasteful and expensive and results in squandered opportunities to treat those with the greatest need and least capital. As such, quality improvement in health care matters to the

economy and to society. But how is better quality in health care achieved? How do we ensure that the views and experience of those who use health services promote improvements in quality? How do we measure quality and what are the benefits of ensuring that quality improvement policies are adequately linked with other related policy imperatives? Based on the experience of the OECD Health Care Quality Indicator Project, this report provides a template for policy makers and officials who are interested in improving the quality of their health care systems. The report does not advocate a ?one-size-fits-all? approach to quality improvement; rather it points to certain key elements that make up effective quality improvement strategies ? principally, the requirement to align health care quality standards with national and local information systems developments, and to ensure that national strategies and policies aimed at improving quality are linked to robust quality indicators.

Klazinga, N. S. et Fujisawa, R. (2017). Measuring patient experiences (PREMS) : Progress made by the OECD and its member countries between 2006 and 2016. OECD Health Working Paper; 102. Paris OCDE**:** 61 ,fig., tabl.
http://www.oecd-ilibrary.org/social-issues-migration-health/measuring-patient-experiences-prems_893a07d2-en

The OECD has been leading the work on international comparisons of patient-reported experience measures (PREMs) across its member states for over a decade. This paper synthesises national developments in relation to measuring and monitoring PREMs between 2006 and 2016 across countries participating in the OECD Health Care Quality Indicator expert group. This report shows that most OECD countries measure patient experience at a national level. It also highlights that efforts to measure and report patient-reported measures which used to be conducted in an ad hoc manner previously, have been institutionalised and standardised in an increasing number of countries. This national progress has enabled the international reporting of patient experiences with ambulatory care across 17 OECD countries in the recent edition of OECD's flagship publication, Health at a Glance 2017. The scope of these indicators is currently limited, but recent national progress suggests that there is an opportunity to expand PREMs data collection in different domains for international reporting. The OECD plans to continue developing PREMs that would be useful for policy makers, and help drive improvements in health system performance for health care users, building on the PREMs work to date undertaken in consultation with countries.L'OCDE pilote le travail sur les comparaisons internationales des mesures du vécu du point de vue des patients (PREMs) de ses états membres depuis plus d'une décennie. Ce document résume les développements nationaux en matière de mesure et de surveillance des PREMs de 2006 à 2016 des pays participant au groupe d'experts de l'OCDE sur les indicateurs de qualité des soins de santé. Ce rapport montre que la majorité des pays de l'OCDE mesure l'expérience du patient au niveau national. Il souligne le fait que les collectes des mesures du vécu du point de vue des patients, auparavant menées de manière ad hoc, sont standardisées et institutionnalisées dans de plus en plus de pays. Ces progrès au niveau national ont permis un reporting des expériences des patients en soins ambulatoires pour 17 pays de l 'OCDE dans la publication phare de l'OCDE Panorama de la santé 2017. L'étendue du répertoire des indicateurs est actuellement limitée, mais de récents progrès nationaux suggèrent qu'il y aurait une opportunité d'extension de la collecte des données dans différents domaines à un niveau international. L'OCDE compte poursuivre le développement des PREMs qui seraient utiles pour les décideurs politiques et aideraient à améliorer la performance des systèmes de santé pour les usagers, en tirant profit du travail entrepris à ce jour sur les PREMs en consultation avec les pays.

Kossarova, L., et al. (2015). Focus on: international comparisons of healthcare quality - what can the UK learn? QualityWatch. Londres Health Foundation**:** 2 vol. (44; 16), fig., tabl.

> Cette étude compare la qualité des soins de santé britanniques dans quatre secteurs (soins primaires, soins aigus, soins du cancer et santé mentale) à celle de services équivalents dans 12 pays : Australie, Belgique, Canada, France, Allemagne, Irlande, Italie, Pays-Bas, Nouvelle-Zélande, Espagne, Suède et États-Unis. L'analyse révèle que le Royaume-Uni se classe au dernier ou avant-dernier rang sur 16 des 27 indicateurs de qualité utilisés dans l'étude.

Kringos, D. S., et al. (2010). "The European primary care monitor : structure, process and outcome indicators." Bmc Family Practice **11**: 8.
http://www.biomedcentral.com/content/pdf/1471-2296-11-81.pdf

> Scientific research has provided evidence on benefits of well developed primary care systems. The relevance of some of this research for the European situation is limited. There is currently a lack of up to date comprehensive and comparable information on variation in development of primary care, and a lack of knowledge of structures and strategies conducive to strengthening primary care in Europe. The EC funded project Primary Health Care Activity Monitor for Europe (PHAMEU) aims to fill this gap by developing a Primary Care Monitoring System (PC Monitor) for application in 31 European countries. This article describes the development of the indicators of the PC Monitor, which will make it possible to create an alternative model for holistic analyses of primary care.

Kronenberg, C., et al. (2017). "Identifying primary care quality indicators for people with serious mental illness: a systematic review." Br J Gen Pract **67**(661): e519-e530.

> BACKGROUND: Serious mental illness (SMI) - which comprises long-term conditions such as schizophrenia, bipolar disorder, and other psychoses - has enormous costs for patients and society. In many countries, people with SMI are treated solely in primary care, and have particular needs for physical care. AIM: The objective of this study was to systematically review the literature to create a list of quality indicators relevant to patients with SMI that could be captured using routine data, and which could be used to monitor or incentivise better-quality primary care. DESIGN AND SETTING: A systematic literature review, combined with a search of quality indicator databases and guidelines. METHOD: The authors assessed whether indicators could be measured from routine data and the quality of the evidence. RESULTS: Out of 1847 papers and quality indicator databases identified, 27 were included, from which 59 quality indicators were identified, covering six domains. Of the 59 indicators, 52 could be assessed using routine data. The evidence base underpinning these indicators was relatively weak, and was primarily based on expert opinion rather than trial evidence. CONCLUSION: With appropriate adaptation for different contexts, and in line with the relative responsibilities of primary and secondary care, use of the quality indicators has the potential to improve care and to improve the physical and mental health of people with SMI. However, before the indicators can be used to monitor or incentivise primary care quality, more robust links need to be established, with improved patient outcomes.

Laudicella, M., et al. (2012). Hospital readmission rates: signal of failure or success? Londres Imperial college Business school**:** 31 , tabl., fig.
http://spiral.imperial.ac.uk/bitstream/10044/1/9224/1/Laudicella%202012-02.pdf

> Hospital readmission rates are increasingly being used as signals of hospital performance and a basis for hospital reimbursement. However for some interventions their interpretation may be complicated by differential patient survival rates after the initial intervention. If patient

characteristics are not perfectly observable and hospitals differ in their mortality rates, then hospitals with low mortality rates are likely to have a larger share of un-observably sicker patients at risk of a readmission. Their performance on readmissions with respect to other hospitals will then be underestimated. We therefore examine hospitals? performance on readmission rates relaxing the assumption of independence between the data generating process for mortality and readmissions implicitly adopted in the vast majority of empirical applications. We use administrative data on emergency admissions for fractured hip in 290,000 patients aged 65 and over from 2003-2008 in England. We find strong evidence of sample selection bias in the identification of hospitals? performance on 28 days emergency readmissions when the residual correlation between mortality and readmissions is ignored. We use a bivariate sample selection model to allow for the selection process and the dichotomous nature of the outcome variables. Our study suggests that when, as in this example, the residual correlation is different from zero, inference from traditional models of hospital performance on readmissions might be invalid, and we offer a more appropriate method of inferring performance. The results have important implications for performance assessment and financial penalties related to readmissions.

Legida-Quigley, H., et al. (2008). Assuring the quality of health care in the European Union : A case for action, Copenhague : OMS Bureau régional de l'Europe
http://www.euro.who.int/document/e91397.pdf?language=French

Quel que soit le motif du déplacement, l?une des questions que l?on se pose est la suivante : « Si je tombe malade, les soins de santé qui me seront dispensés seront-ils de grande qualité ? ». Jusqu?à présent, on ne pouvait que s?en remettre au destin. Dans cet ouvrage sont examinés, pour la première fois, les systèmes mis en place dans les 27 États membres de l?Union européenne. Le tableau qu?il brosse est nuancé. Certains ont des systèmes bien développés ; ils déterminent des normes en se fondant sur les meilleures bases factuelles disponibles, contrôlent les soins dispensés et prennent des mesures lorsque ces soins ne répondent pas aux attentes. D?autres doivent surmonter des obstacles importants.La capacité de l?Union européenne à prendre des mesures dans le domaine des soins de santé est limitée, mais pour que la libre circulation des citoyens européens devienne une réalité, des systèmes appropriés doivent être mis en place afin d?assurer des soins de haute qualité, même si les stratégies adoptées varient en fonction du contexte local. Cela nécessite un dialogue entre les responsables du financement et dispensateurs de soins de santé en Europe. Cet ouvrage fournit les bases nécessaires pour que ce dialogue puisse être amorcé.

Leichsenring, K., et al. (2014). To Make or to Buy Long-term Care III: Quality Assurance to Avoid Market-failure. Policy brief. Vienne The European Centre for Social Welfare Policy and Research**:** 13.
http://www.euro.centre.org/data/1417084786_81385.pdf

With the implementation of New Public Management (NPM), market-oriented governance, deregulation, competition and strengthened user-choice eventually reached also the area of long-term care provision during the 1990s. In contrast to the classical neo-liberal postulations towards deregulation, however, both theoretical considerations and the emerging practice across Europe have shown the imminent necessity to increase efforts in quality assurance in the context of competitive markets in long-term care. This Policy Brief dwells on experiences in a number of European countries on existing practices of quality assurance in long-term care delivery. It outlines caveats of defining and assessing quality in long-term care and its implications for 'make-or-buy' decisions. Current trends and challenges in quality assurance and quality development are presented to provide policy lessons on the 'make or buy' decision and its impact on outcomes for users and the organisation of care markets. This Policy Brief is the final part of a trilogy dedicated to the reliance on markets for the delivery

of long-term care (see also Part I and Part II). It draws on the Report '"Make or Buy" – Long-term Care Services in Sweden: Lessons for Policy', edited by the European Centre, which is a result of research generously funded under a grant from the Swedish Ministry of Health and Social Affairs.

Lelong, A., et al. (2015). "A quality indicator can be biased by intra-hospital heterogeneity: the case for quality of patient record keeping in France." The European Journal of Public Health **25**(5): 787-791.
http://eurpub.oxfordjournals.org/eurpub/25/5/787.full.pdf

Background: Since 2008, French health institutions providing medical, surgical and obstetrical care are assessed on the basis of a set of quality indicators. The French National Authority for Health developed a survey design in which 80 records are randomly selected from each institution. The main aim was to assess the effects of internal heterogeneity of a hospital that comprises several units. The survey method is based on the hypothesis of intra-institution homogeneity, which overlooks the fact that in wide hospitals homogeneity is related to departments and thus leads to overall intra-hospital heterogeneity. Methods: Simulated databases were created to modelise the heterogeneity of our hospital and computed to assess the reliance of indicator measurement. We used real data from a large teaching hospital having internal heterogeneity related to each department. Results: Variance under heterogeneity was greater than under homogeneity (3- to 18-fold) leading to an increased size of the confidence interval (CI) (at 95%) from 9 (given Haute Autorité de Santé sources) to 22 (for greatest internal heterogeneity). Conclusions: The variations in a quality indicator can be explained by intra-institution heterogeneity and are not related to changes in the quality policy of the hospitals and may lead to errors in terms of pay for performance.

Levitt, C. A., et al. (2014). "Refinement of indicators and criteria in a quality tool for assessing quality in primary care in Canada: a Delphi Panel study." Fam Pract **31**(5): 607-621.
http://fampra.oxfordjournals.org/content/31/5/607.abstract

Purpose. Primary care is the cornerstone of the health care system and increasingly countries are developing indicators for assessing quality in primary care practices. The â€˜Quality Toolâ€™, developed in Ontario, Canada, provides a framework for assessing practices and consists of indicators and criteria. The purpose of this study was to validate the indicators and simplify the Quality Tool.Methods. This study involved a systematic comparison of indicators in the Quality Tool with those in other local and international tools to determine common indicators to include as valid in the Quality Tool. A Delphi process was used to help reach consensus for inclusion of any indicators that were not included in the comparison exercise.Setting. Primary care in Ontario, Canada.Subjects. Key informants were those with known expertise and experience in quality assessment in primary care.Main outcome. Validated set of indicators for inclusion in an updated Quality Tool.Results. Twenty-three stakeholders participated in the Delphi panel. Forty-four indicators were included as valid after the systematic comparison of similar indicators in other assessment tools. Of the 63 indicators brought to the Delphi panel, 37 were included as valid, 15 were excluded and 11 became criteria for other included indicators.Conclusions. The study resulted in a set of 81 validated primary care indicators. The validation of the indicators provided a strong foundation for the next version of the Quality Tool and may be used for quality assessment in primary care

Lin, E., et al. (2015). Medical practice variations in mental health and addictions care. Medical Practice Variations., Berlin : Springer Verlag**:** 1-41.
http://link.springer.com/referencework/10.1007/978-1-4899-7573-7

This chapter provides an overview of the practice variations in care delivery for mental health and addictive disorders and some of the system-level funding and structural factors that contribute to such variation. Practice variations are described for five populations, along with their expected clinical picture and service needs : Children and adolescents, The elderly, Severe mental illness, Mild/moderate illness, Substance use disorders. These variations occur in a system-level climate which has been transformed over the past decades because of a fundamental change in how appropriate care is defined. Specifically,Western countries have been shifting from institutional to more community-based care – a process labeled "deinstitutionalization." National differences in how services are funded and organized in light of deinstitutionalization are described. Pending gold-standard outcome indicators such descriptions allow more in-depth examination of what the potential drivers for system change are and how different funding and structure configurations might be compared and evaluated.

Longo, F., et al. (2017). Do hospitals respond to rivals' quality and efficiency? A spatial econometrics approach. CHE Research Paper Series ;144. York University of York**:** 39 , tabl., annexes. https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP144_hospital_quality_efficiency_spatial_econometrics.pdf

We investigate whether hospitals in the English National Health Service increase their quality (mortality, emergency readmissions, patient reported outcome, and patient satisfaction) or efficiency (bed occupancy rate, cancelled operations, and cost indicators) in response to an increase in quality or efficiency of neighbouring hospitals. We estimate spatial cross-sectional and panel data models, including spatial cross-sectional instrumental variables. Hospitals generally do not respond to neighbours' quality and efficiency. This suggests the absence of spillovers across hospitals in quality and efficiency dimensions and has policy implications, for example, in relation to allowing hospital mergers

Mackenbach, J. P. et McKee, M. (2013). "A comparative analysis of health policy performance in 43 European countries." European Journal of Public Health **23**(2): 195-201. http://eurpub.oxfordjournals.org/content/23/2/195.full.pdf+html?sid=af599ffe-9e91-4ef2-8c43-07daca64e4be

Background: It is unknown whether European countries differ systematically in their pursuit of health policies, and what the determinants of these differences are. In this article, we assess the extent to which European countries vary in the implementation of health policies in 10 different areas, and we exploit these variations to investigate the role of political, economic and social determinants of health policy. Data and Methods: We reviewed policies in the field of tobacco; alcohol; food and nutrition; fertility, pregnancy and childbirth; child health; infectious diseases; hypertension detection and treatment; cancer screening; road safety and air pollution. We developed a set of 27 ?process? and ?outcome? indicators, as well as a summary score indicating a country?s overall success in implementing effective health policies. In exploratory regression analyses, we related these indicators to six background factors: national income, survival/self-expression values, democracy, government effectiveness, left-party participation in government and ethnic fractionalization. Results: We found striking variations between European countries in process and outcome indicators of health policies. On the whole, Sweden, Norway and Iceland perform best, and Ukraine, Russian Federation and Armenia perform worst. Within Western Europe, some countries, such as Denmark and Belgium, perform significantly worse than their neighbours. Survival/self-expression values and ethnic fractionalization were the main predictors of the health policy performance summary score. National income,

survival/self-expression values and government effectiveness were the main predictors of countries? performance in specific areas of health policy. Conclusions: Although many new preventive interventions have been developed, their implementation appears to have varied enormously among European countries. Substantial health gains can be achieved if all countries would follow best practice, but this probably requires the removal of barriers related to both the ?will? and the ?means? to implement health policies.

Mainz, J. (2003). "Defining and classifying clinical indicators for quality improvement." Int J Qual Health Care **15**(6): 523-530.

OBJECTIVE: This paper provides a brief review of definitions, characteristics, and categories of clinical indicators for quality improvement in health care. ANALYSIS: Clinical indicators assess particular health structures, processes, and outcomes. They can be rate- or mean-based, providing a quantitative basis for quality improvement, or sentinel, identifying incidents of care that trigger further investigation. They can assess aspects of the structure, process, or outcome of health care. Furthermore, indicators can be generic measures that are relevant for most patients or disease-specific, expressing the quality of care for patients with specific diagnoses. CONCLUSIONS: Monitoring health care quality is impossible without the use of clinical indicators. They create the basis for quality improvement and prioritization in the health care system. To ensure that reliable and valid clinical indicators are used, they must be designed, defined, and implemented with scientific rigour.

Mainz, J., et al. (2004). "Nationwide continuous quality improvement using clinical indicators: the Danish National Indicator Project." Int J Qual Health Care **16 Suppl 1**: i45-50.

OBJECTIVE: In most countries there is no mandatory national system to track the quality of care delivered to the citizens. This paper describes an example of a national indicator project that aims at documenting and improving the quality of care nationwide. ANALYSIS: The Danish National Indicator Project was established in 2000 as a nationwide multidisciplinary quality improvement project. From 2000 to 2002, disease-specific clinical indicators and standards were developed for six diseases (stroke, hip fracture, schizophrenia, acute gastrointestinal surgery, heart failure, and lung cancer). Indicators and standards have been implemented in all clinical units and departments in Denmark treating patients with the six diseases, and participation is mandatory. All clinical units and departments receive their results every month. National and regional audit processes are organized to explain the results and to prepare implementation of improvements. All results are published in order to inform the public, and to give patients and relatives the opportunity to make informed choices. CONCLUSION: The surveillance of health care quality is greatly aided by the use of relevant quantitative indicators. This paper describes how it is possible to organize nationwide monitoring using clinical indicators.

Mannion, R. et Goddard, M. (2002). "Performance measurement and improvement in health care." Applied Health Economics and Health Policy **1**(1): 13-23, tabl., graph.

Performance measurement is playing an increasingly important role in health care systems around the world, and many countries are designing and implementing measurement systems to achieve a range of objectives. Yet, the production of research evidence to inform practice has not kept pace with this policy development. In this paper we employ a simple model of performance measurement that focuses on issues related to the measurement of performance; the analysis and interpretation of performance information; and the action, which occurs as a consequence. The framework is used to analyse the key elements of the performance measurement process, drawing on experience and evidence from the United

Kingdom. By drawing on the cross-national experience, individual health systems can learn from examples of good practice and avoid implementation errors made elsewhere (Resumé d'auteur).

Marshall, M., et al. (2004). Selecting indicators for the quality of health promotion, prevention and primary care at the Health Systems Level in OECD countries. OECD Health Technical Papers ; n° 16. Paris OCDE**:** 49 , tab.
http://www.oecd.org/dataoecd/27/52/33865865.pdf

Ce rapport présente les recommandations consensuelles d'un groupe d'experts internationaux sur les indicateurs relatifs aux soins primaires et à la prévention. En suivant une méthodologie détaillée, le groupe d'experts a sélectionné 27 indicateurs devant couvrir les trois grands domaines suivants : la promotion de la santé, la prévention, le diagnostic et le traitement dans les soins primaires. La rapport décrit la méthodologie employée et démontre, arguments à l'appui, la viabilité scientifique et l'importance stratégique des 27 indicateurs sélectionnés.

Marshall, M. N., et al. (2003). "Can health care quality indicators be transferred between countries?" Quality and Safety in Health Care **12**(1): 8-12.
http://qualitysafety.bmj.com/content/12/1/8.abstract

Objective: To evaluate the transferability of primary care quality indicators by comparing indicators for common clinical problems developed using the same method in the UK and the USA.Method: Quality indicators developed in the USA for a range of common conditions using the RAND-UCLA appropriateness method were applied to 19 common primary care conditions in the UK. The US indicators for the selected conditions were used as a starting point, but the literature reviews were updated and panels of UK primary care practitioners were convened to develop quality indicators applicable to British general practice.Results: Of 174 indicators covering 18 conditions in the US set for which a direct comparison could be made, 98 (56.3%) had indicators in the UK set which were exactly or nearly equivalent. Some of the differences may have related to differences in the process of developing the indicators, but many appeared to relate to differences in clinical practice or norms of professional behaviour in the two countries. There was a small but non-significant relationship between the strength of evidence for an indicator and the probability of it appearing in both sets of indicators.Conclusion: There are considerable benefits in using work from other settings in developing measures of quality of care. However, indicators cannot simply be transferred directly between countries without an intermediate process to allow for variation in professional culture or clinical practice.

Martin, S., et al. (2010). Do quality improvements in primary care reduce secondary care costs? Primary research into the impact of the Quality and Outcomes Framework on hospital costs and mortality. Londres Health Foundation**:** 46 , fig., tabl.
http://www.health.org.uk/public/cms/75/76/313/2194/Do_quality_improvements_in_primary_care_reduce_secondary_care_costs.pdf?realName=gdrj7N.pdf

The introduction in 2004 of the Quality and Outcomes Framework (QOF) in UK general practice represents one of the most ambitious efforts to measure and incentivise quality improvements in primary care. This report takes advantage of a large database of over 50 million English citizens to determine whether the levels of QOF attainment in general practices have led to improvements in two major outcomes: mortality and the costs of hospital inpatient and outpatient use. The findings are that primary care performance

improvements are associated with some modest but measurable improvements in subsequent outcomes and costs

Minvielle, E. (2012). "La régulation de la qualité des soins hospitaliers : avec ou sans les professionnels de santé ?" Gestions Hospitalieres(514): 152-159, tabl.

[BDSP. Notice produite par EHESP 8npnR0xF. Diffusion soumise à autorisation]. Dans le système de soins français, la régulation de la qualité vise à garantir un niveau de qualité égal quelles que soient les conditions d'accès. Fort de ce principe de solidarité, le régulateur ne doit pas contribuer à différencier par la qualité mais, au contraire, l'améliorer, la rendre homogène et subordonner toute concurrence à un objectif de réduction des inégalités. Cet objectif ambitieux se traduit par d'importantes opérations ces dernières années. A leur lumière, des enseignements apparaissent pour le futur, posant la question centrale du rapport de confiance avec le monde professionnel. (intr.).

Mossialos, E. et al. (2015). International Profiles of Health Care Systems, 2014. New York The Commonwealth Fund**:** 162 , tabl., fig.
http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/jan/1802_mossialos_intl_profiles_2014_v3.pdf

This publication presents overviews of the health care systems of Australia, Canada, Den¬mark, England, France, Germany, Italy, Japan, the Netherlands, New Zealand, Norway, Singapore, Sweden, Switzerland, and the United States. Each overview covers health insurance, public and private financing, health system organization and governance, health care quality and coordination, disparities, efficiency and integration, use of information technology and evidence-based practice, cost containment, and recent reforms and innovations. In addition, summary tables provide data on a number of key health system characteristics and performance indicators, including overall health care spending, hospital spending and utilization, health care access, patient safety, care coordina¬tion, chronic care management, disease prevention, capacity for quality improvement, and public views.

Musallam, E., et al. (2016). "Hospital Disease-Specific Care Certification Programs and Quality of Care: A Narrative Review." Jt Comm J Qual Patient Saf **42**(8): 364-368.

BACKGROUND: Disease-specific care certification (DSCC) programs have been developed to improve the quality and performance of programs or services that may be based within or associated with a hospital or other health care organization. A comprehensive summary of evidence for DSCC programs and their reported effect on the quality of care was prepared in a narrative review, the first of its kind on this topic. METHODS: A systematic search was performed to identify articles that reported about DSCC. Any article that reported DSCC and certifications, published between 2003 and August 2015 (with an update in March 2016), and conducted in the United States was included. Databases searched included PubMed, MEDLINE, and CINAHL. RESULTS: The articles were reviewed in terms of four topics: early development of DSCC, the journey toward DSCC, the relationship between DSCC and organizing process of care, and the relationship between DSCC and outcomes of care. Fifteen articles noted a positive relationship between DSCC programs and quality of care, only 6 of which reported empirical data. Therefore, a systematic review and meta-analysis were not warranted. Only 3 articles involved use of sophisticated statistical modeling with adequate control variables to investigate the effect of DSCC, which makes it difficult to conclude that the change in hospitals' or patients' outcomes were related to the certification. CONCLUSIONS: The majority (13) of the articles focused on Joint Commission DSCC, with the remaining assessing Society of Cardiovascular Patient Care "accreditation" (certification).

Only two studies, each study using a cross-sectional design, that empirically examined the relationship between DSCC and outcomes of care-mortality of care and readmission. More research studies are needed to evaluate the effectiveness of DSCC programs in improving outcomes of care, particularly patient-centered outcome measures, such as patient satisfaction and self-care.

Naylor, C. D., et al. (2002). Etre à la hauteur : mesurer et améliorer la performance des systèmes de santé dans les pays de l'OCDE. Paris OCDE**:** 395 , tabl., graph.
http://www.oecd.org/els/health-systems/measuringup-improvinghealthsystemperformanceinoecdcountries.htm

Comment mesurer la performance des systèmes de santé ? Et comment peut-on l'améliorer de façon constante grâce à ce type de mesures ? Telles sont les grandes questions traitées dans ce volume. Les responsables des politiques de santé cherchent de plus en plus à encourager les systèmes de santé à améliorer leur performance, performance qui se mesure en termes de qualité, d'efficience ou d'équité. De meilleures performances devraient contribuer à réduire la tension entre une demande en augmentation et des ressources limitées. Par ailleurs, on exige de plus en plus des organismes de financement et des prestataires de services de santé qu'ils rendent compte de leurs actes. Cet ouvrage aborde les principaux éléments d'un cadre d'analyse possible de la performance permettant de procéder à des évaluations des systèmes de santé à l'échelon national et d'établir des comparaisons internationales. Il traite aussi de quelques problèmes épineux non résolus : comment pallier l'absence de mesures des résultats en matière de santé ? Comment mieux faire cadrer les incitations et les informations sur les performances avec les objectifs de la politique de santé ? Comment concilier la démarche traditionnelle d'autorégulation professionnelle avec l'exigence d'une plus grande responsabilité de la profession à l'égard du public quant à la qualité des soins de santé dispensés ?

Naylor, C. D., et al. (2002). Measuring up : improving Health System Performance in OECD countries. Paris OCDE**:** 395 , tabl., graph.
http://www.oecd.org/els/health-systems/measuringup-improvinghealthsystemperformanceinoecdcountries.htm

Comment mesurer la performance des systèmes de santé ? Et comment peut-on l'améliorer de façon constante grâce à ce type de mesures ? Telles sont les grandes questions traitées dans ce volume. Les responsables des politiques de santé cherchent de plus en plus à encourager les systèmes de santé à améliorer leur performance, performance qui se mesure en termes de qualité, d'efficience ou d'équité. De meilleures performances devraient contribuer à réduire la tension entre une demande en augmentation et des ressources limitées. Par ailleurs, on exige de plus en plus des organismes de financement et des prestataires de services de santé qu'ils rendent compte de leurs actes. Cet ouvrage aborde les principaux éléments d'un cadre d'analyse possible de la performance permettant de procéder à des évaluations des systèmes de santé à l'échelon national et d'établir des comparaisons internationales. Il traite aussi de quelques problèmes épineux non résolus : comment pallier l'absence de mesures des résultats en matière de santé ? Comment mieux faire cadrer les incitations et les informations sur les performances avec les objectifs de la politique de santé ? Comment concilier la démarche traditionnelle d'autorégulation professionnelle avec l'exigence d'une plus grande responsabilité de la profession à l'égard du public quant à la qualité des soins de santé dispensés ?

Nestrigue, C. et Or, Z. (2012). Estimation du surcoût des évènements indésirables associés aux soins à l'hôpital en France. Document de travail Irdes ; 44. Paris IRDES**:** 24.

http://www.irdes.fr/EspaceRecherche/DocumentsDeTravail/DT44EstimationSurcoutsEvenementsIndesSoinsHopitalFrance.pdf

Les événements indésirables associés aux soins (EIS) représentent non seulement un problème de sécurité et de qualité des soins pour les patients, mais également un problème économique puisque leurs conséquences financières peuvent être importantes. Cependant, jusqu?ici en France, il n'y avait aucune étude de coût à l'échelle nationale regardant l'impact économique des événements indésirables associés aux soins. Notre étude exploite les données hospitalières collectées en routine afin d'établir l'importance et les conséquences économiques de neuf EIS à l'hôpital. Nous avons suivi la méthodologie développée aux Etats-Unis pour construire des indicateurs de sécurité des patients (PSI) et dénombrer les EIS à l'hôpital. Les surcoûts et allongements de durées de séjour liés aux EIS sont mesurés selon deux méthodes : la méthode de stratification et l'analyse de régression.

Ni Riain, A., et al. (2015). "Roadmap for developing a national quality indicator set for general practice." Int J Health Care Qual Assur **28**(4): 382-393.

PURPOSE: The purpose of this paper is to describe a national, comprehensive quality indicator set to support delivering high-quality clinical care in Irish general practice. DESIGN/METHODOLOGY/APPROACH: Potential general practice quality indicators were identified through a literature review. A modified two-stage Delphi process was used to rationalise international indicators into an indicator set, involving both experts from key stakeholder groups (general practitioners (GPs), practice nurses, practice managers, patient and health policy representatives) and predominantly randomly selected GPs. An illustrative evaluation approach was used to road test the indicator set and supporting materials. FINDINGS: In total, 80 panellists completed the two Delphi rounds and staff in 13 volunteer practices participated in the road test. The original 171 indicators was reduced to 147 during the Delphi process and further reduced to 68 indicators during the road test. The indicators were set out in 14 sub-domains across three areas (practice infrastructure, practice processes and procedures, and practice staff). Practice staff planned 77 quality improvement activities after their assessment against the indicators and 31 (40 per cent) were completed with 44 (57 per cent) ongoing and two (3 per cent) not advanced after a six-month road test. A General Practice Indicators of Quality indicator set and support materials were produced at the conclusion. PRACTICAL IMPLICATIONS: It is important and relatively easy to customise existing quality indicators to a particular setting. The development process can be used to raise awareness, build capacity and drive quality improvement activity in general practices. ORIGINALITY/VALUE: The authors describe in detail a method to develop general practice quality indicators for a regional or national population from existing validated indicators using consensus, action research and an illuminative evaluation.

Nolte, E. (2011). International benchmarking of healthcare quality. A review of the literature. Santa Monica Rand corporation**:** 48 , fig., tabl.
http://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR738.pdf

There is growing interest in the systematic assessment and international benchmarking of quality of care provided in different healthcare systems, and major work is under way to support this process through the development and validation of quality indicators that can be used internationally. Recognising that cross-national data comparison remains a challenge, there is now a considerable body of data that allow for comparisons of healthcare quality in selected areas of care. The report includes a description of existing indicators that could be used to compare healthcare quality in different countries, along with a discussion of specific problems in making comparisons at this level of detail. This is illustrated with case

studies of two measures widely used for international comparisons: avoidable mortality and cancer survival. These show both the potential power of cross-national comparisons and some of the difficulties in drawing valid interpretations from the data. The report focuses on the three quality domains identified as important by the NHS Next Stage Review High Quality Care for All, namely effectiveness of care, patient safety and patient experience. It is however important to recognise that access is an important additional component of quality which may be a key determinant of differences in outcome between different countries. Thus comparing quality across countries is only a first step to then assess the causes underlying those differences and determining what actions may be appropriate to take to improve health outcomes.

Nolte, E., et al. (2014). The changing hospital landscape. An exploration of international experiences. Santa Monica Rand corporation**:** 121 , fig., tabl., annexes.
http://www.rand.org/content/dam/rand/pubs/research_reports/RR700/RR728/RAND_RR728.pdf

The nature of hospital activity is changing in many countries, with some experiencing a broad trend towards the creation of hospitals groups or chains and multi-hospital networks. This report seeks to contribute to the understanding of experiences in other countries about the extent to which different hospital 'models' may provide lessons for hospital provision in England by means of a review of four countries: France, Germany, Ireland and the United States, with England included for comparison. We find that here has been a trend towards privatisation and the formation of hospital groups in France, Germany and the United States although it is important to understand the underlying market structure in these countries explaining the drivers for hospital consolidation. Thus, and in contrast to the NHS, in France, Germany and the United States, private hospitals contribute to the delivery of publicly funded healthcare services. There is limited evidence suggesting that different forms of hospital cooperation, such as hospital groups, networks or systems, may have different impacts on hospital performance. Available evidence suggests that hospital consolidation may lead to quality improvements as increased size allows for more costly investments and the spreading of investment risk. There is also evidence that a higher volume of certain services such as surgical procedures is associated with better quality of care. However, the association between size and efficiency is not clear-cut and there is a need to balance 'quality risk' associated with low volumes and 'access risk' associated with the closure of services at the local level.

Nolte, E., et al. (2012). Preventing emergency readmissions to hospital. A scoping review. Santa Monica Rand corporation**:** 51 , tabl., annexes.
http://www.rand.org/content/dam/rand/pubs/technical_reports/2012/RAND_TR1198.pdf

The report reviews the evidence and potential for use of 'emergency readmissions within 28 days of discharge from hospital' as an indicator within the NHS Outcomes Framework. It draws on a rapid review of systematic reviews, complemented by a synopsis of work in four countries designed to better understand current patterns of readmissions and the interpretation of observed patterns. Reviewed studies suggest that between 5 percent and 59 percent of readmissions may be avoidable. Studies are highly heterogeneous, but based on the evidence reviewed, about 15 percent up to 20 percent may be considered reasonable although previous authors have advised against producing a benchmark figure for the percentage of readmissions that can be avoided. The majority of published studies focus on clinical factors associated with readmission. Studies are needed of NHS organisational factors which are associated with readmission or might be altered to prevent readmission. The introduction of new performance indicators always has the potential to produce gaming. Observers from the USA cite experience which suggests hospitals might increase income by

admitting less serious cases, thus simultaneously increasing their income and reducing their rate of readmission. There is also the possibility that there may be some shift in coding of admissions between 'emergency' and 'elective' depending on the incentives. If hospitals are performance managed on the basis of readmission rates, it would be reasonable to expect that some behaviour of this type would occur.

Northcott, H. C. et Harvey, M. D. (2012). "Public perceptions of key performance indicators of healthcare in Alberta, Canada." Int.J Qual.Health Care **24**(3): 214-223.
PM:22461204
http://intqhc.oxfordjournals.org/content/intqhc/24/3/214.full.pdf

OBJECTIVE: /st> To examine the relationship between public perceptions of key performance indicators assessing various aspects of the health-care system. DESIGN: /st> Cross-sequential survey research. Annual telephone surveys of random samples of adult Albertans selected by random digit dialing and stratified according to age, sex and region (n = 4000 for each survey year). The survey questionnaires included single-item measures of key performance indicators to assess public perceptions of availability, accessibility, quality, outcome and satisfaction with healthcare. Cronbach's alpha and factor analysis were used to assess the relationship between key performance indicators focusing on the health-care system overall and on a recent interaction with the health-care system. SETTING: /st> The province of Alberta, Canada during the years 1996-2004. PARTICIPANTS: /st> Four thousand adults randomly selected each survey year. MAIN OUTCOME MEASURE: s) Survey questions measuring public perceptions of healthcare availability, accessibility, quality, outcome and satisfaction with healthcare. RESULTS: /st> Factor analysis identified two principal components with key performance indicators focusing on the health system overall loading most strongly on the first component and key performance indicators focusing on the most recent health-care encounter loading most strongly on the second component. Assessments of the quality of care most recently received, accessibility of that care and perceived outcome of care tended to be higher than the more general assessments of overall health system quality and accessibility. CONCLUSION: /st> Assessments of specific health-care encounters and more general assessments of the overall health-care system, while related, nevertheless comprise separate dimensions for health-care evaluation

OCDE (2005). "Chapitre 5. Améliorer la qualité et l'efficience du système de santé." Etudes économiques de l'OCDE **9**(9): 125-165.
http://www.cairn.info/revue-etudes-economiques-de-l-ocde-2005-9-page-125.htm

Ce chapitre passe en revue les forces et les faiblesses du système de santé suédois ainsi que les défis auxquels il devra faire face dans l'avenir. Il examine les moyens d'améliorer l'accès aux soins de santé primaires, parmi lesquels diverses méthodes de rémunération des médecins généralistes, la question de l'équité du système par comparaison avec d'autres pays et le rôle de la participation des patients aux frais. Sont également abordés la garantie de délai d'attente maximum en chirurgie non urgente et les moyens de remédier aux disparités régionales dans la qualité des services. L'étendue de la décentralisation fait l'objet d'une interrogation quant à ses répercussions possibles sur la qualité des soins et l'utilisation rationnelle des ressources dans certaines secteurs, notamment la psychiatrie et les soins aux personnes âgées. En ce qui concerne les hôpitaux, plusieurs améliorations sont envisagées, en particulier les systèmes de facturation à la pathologie et l'ouverture d'établissements à but lucratif. L'étude se termine par une réflexion sur ce qui pourrait être fait pour assurer au système un financement à la fois plus stable et plus durable.

OCDE (2009). "Chapitre 3. Le NHS : bilan de santé économique." Etudes économiques de l'OCDE **9**(9): 79-108.
http://www.cairn.info/revue-etudes-economiques-de-l-ocde-2009-9-page-79.htm

<titre>Résumé</titre>Le programme de réformes engagé par le gouvernement depuis 2000 dans le secteur de la santé couvre de nombreux aspects de l’organisation des soins et services de santé et il s’est accompagné d’une augmentation notable des dépenses dans ce secteur. Nombre de ces réformes sont de nature à améliorer l’efficience et la réactivité du système et, en fin de compte, les résultats sur le plan de la santé. Ce chapitre donne une vue d’ensemble de l’organisation et du financement du National Health Service ; il en examine les performances, évalue les réformes conduites depuis le début de la décennie, et formule des recommandations en vue de les développer.<np pagenum="080"/>

OCDE (2013). OECD Reviews of Health Care Quality: Sweden 2013: Raising Standards. Paris OCDE**:** 267 , tabl., fig.
http://www.oecd.org/els/health-systems/newoecdseriesonhealthcarequalityreviews.htm

This report reviews the quality of health care in Sweden. It begins by providing an overview of the range of policies and practices aimed at supporting quality of care in Sweden. It then focuses on three key areas particularly relevant to elderly populations: strengthening primary care in Sweden , better assurance for quality in long-term care, and improving care after hip fracture and stroke. In examining these areas, this report seeks to highlight best practices and provides recommendations to improve the quality of care in Sweden.

OCDE (2014). OECD Reviews of Health Care Quality: Czech Republic 2014: Raising Standards. Paris OCDE**:** 158 , tabl., fig.
http://www.oecd-ilibrary.org/social-issues-migration-health/oecd-reviews-of-health-care-quality-czech-republic-2014_9789264208605-en

This book presents a comprehensive review of health care quality in the Czech Republic. It finds that over the past 20 years, the Czech Republic witnessed the unprecedented gains in quality of health care and life expectancy and successfully transferred its Semaschko system into the modern accessible health care system with private-public mix of providers. Nevertheless the health care system in the Czech Republic still has some way to go to achieve the outcomes of the best performing OECD members. While some of the gap might be caused by the one of the lowest levels of health care expenditures among OECD countries (7.2% GDP in 2011) there are possibilities to improve the outcomes without incurring much of the additional costs. The Czech authorities should reach a consensus on the development of quality of care and data infrastructure and aim for sustainable long-term initiatives undisturbed by the political cycles in both of these areas. While the adverse events reporting and voluntary accreditation are the good steps towards the accountability of the providers, the government should do more in this area, undertake the effort to broaden the accreditation process and include outpatient care and link public health authorities to the quality agenda of inpatient care. In the area of data infrastructure more data should be gathered, the process of data gathering should be streamlined and administrative burden for the providers lowered primarily via the merging the data-collecting agencies. Finally, without the active participation of health insurance funds and proper reimbursement mechanisms in place the quality agenda will not be perceived as the priority (résumé de l'éditeur).

OCDE (2014). OECD Reviews of Health Care Quality: Norway 2014: Raising Standards. Paris OCDE**:** 198 , tabl., fig.
http://www.oecd.org/health/health-systems/ReviewofHealthCareQualityNORWAY_ExecutiveSummary.pdf

This report reviews the quality of health care in Norway. It begins by providing an overview of policies and practices aimed at supporting quality of care in Norway (Chapter 1). The report then focuses on three areas that are of particular importance for Norway's health system at present: the role of primary care physicians (Chapter 2), the shifting of care towards primary care settings and away from the hospital sector (Chapter 3), and mental health care (Chapter 4). In examining these areas, this report examines the quality of care currently provided, seeks to highlight best practices, and provides a series of targeted assessments and recommendations for further improvements to quality of care.

OCDE (2015). Evaluating Quality Strategies in Asia-Pacific Countries. Survey Results, Paris : OCDE

The results of the survey provide a useful overview of quality strategies and policies, and show increasing commitment to quality of care in the Asia/Pacific region. The outcome of this study confirms the importance of the WHO-OECD expert network to facilitate communication/dissemination of evidence on quality improvement programmes and policies among countries (résumé de l'éditeur).

OCDE (2015). OECD Reviews of Health Care Quality: Australia 2015: Raising Standards. Paris OCDE**:** 219 , tabl., fig.

Australia's health system functions remarkably well, despite operating under a complex set of institutions that make coordinating patient care difficult. Complications arising from a split in federal and state government funding and responsibilities are central to these challenges. This fragmented health care system can disrupt the continuity of patient care, lead to a duplication of services and leave gaps in care provision. Supervision of these health services by different levels of government can manifest in avoidable impediments such as the poor transfer of health information, and pose difficulties for patients navigating the health system. Adding to the Australian system's complexity is a mix of services delivered through both the public and private sectors. To ease health system fragmentation and promote more integrated services, Australia should adopt a national approach to quality and performance through an enhanced federal government role in steering policy, funding and priority setting. The states, in turn, should take on a strengthened role as health service providers, with responsibility for primary care devolved to the states to better align it with hospital services and community care. A more strategic role for the centre should also leave room for the strategic development of health services at the regional level, encouraging innovation that is responsive to local population need, particularly in rural and remote areas.

OCDE (2015). OECD Reviews of Health Care Quality: Italy 2014: Raising Standards. Paris OCDE**:** 195 , fig.

This report reviews the quality of health care in Italy, seeks to highlight best practices, and provides a series of targeted assessments and recommendations for further improvements to quality of care. Italy's indicators of health system outcomes, quality and efficiency are uniformly impressive. Life expectancy is the fifth highest in the OECD. Avoidable admission rates are amongst the very best in the OECD, and case-fatality after stroke or heart attack are also well below OECD averages. These figures, however, mask profound regional differences. Five times as many children in Sicily are admitted to hospital with an asthma attack than in

Tuscany, for example. Despite this, quality improvement and service redesign have taken a back-seat as the fiscal crisis has hit. Fiscal consolidation has become an over-riding priority, even as health needs rapidly evolve. Italy must urgently prioritise quality of its health care services alongside fiscal sustainability. Regional differences must be lessened, in part by giving central authorities a greater role in supporting regional monitoring of local performance. Proactive, coordinated care for people with complex needs must be delivered by a strengthened primary care sector. Fundamental to each of these steps will be ensuring that the knowledge and skills of the health care workforce are best matched to needs.

OCDE (2015). OECD Reviews of Health Care Quality: Japan 2015: Raising Standards. Paris OCDE**:** 211 , tabl., fig.
http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/oecd-reviews-of-health-care-quality-japan-2015_9789264225817-en#page1

This report reviews the quality of health care in Japan, and seeks to highlight best practices, and provides a series of targeted assessments and recommendations for further improvements to quality of care. One of Japan's foremost policy challenges is to create an economically-active ageing society. Excellent health care will be central to achieving this. A striking feature of the Japanese health system is its openness and flexibility. In general, clinics and hospitals can provide whatever services they consider appropriate, clinicians can credential themselves in any speciality and patients can access any clinician without referral. These arrangements have the advantage of accessibility and responsiveness. Such light-touch governance and abundant flexibility, however, may not best meet the health care needs of a super-ageing society. Japan needs to shift to a more structured health system, separating out more clearly different health care functions (primary care, acute care and long-term care, for example) to ensure that peoples' needs can be met by the most appropriate service, in a coordinated manner if needed. As this differentiation occurs, the infrastructure to monitor and improve the quality of care must simultaneously deepen and become embedded at every level of governance –institutionally, regionally and nationally.

OCDE (2015). OECD Reviews of Health Care Quality: Portugal 2015: Raising Standards. Paris OCDE**:** 185 , tabl., fig.
http://www.oecd-ilibrary.org/social-issues-migration-health/oecd-reviews-of-health-care-quality-portugal-2015_9789264225985-en

This report reviews the quality of health care in Portugal, seeks to highlight best practices, and provides a series of targeted assessments and recommendations for further improvements to quality of care. The Portuguese National Health Service has responded well to financial pressure, successfully balancing the twin priorities of financial consolidation and continuous quality improvement. Even in the post-crisis years when GDP fell and health spending declined, improvements in quality of care continued. The need to reduce health spending has been met through a combination of structural reforms, and a well-designed suite of quality initiatives. Reforms around the purchasing and use of pharmaceuticals and medical devices have helped drive down costs, and Portugal has been innovative in how public funds are used to pay providers, increasingly basing payments on quality and efficiency. Important priorities for further work in the Portuguese health system do remain. Portugal will need to improve clinical processes and pathways, particularly in the acute sector. There is still room to improve efficiency, for instance increasing the share of generic drug consumption, and using the Portuguese health workforce more effectively, especially through expanded roles for nurses. Further structural reform is needed with an emphasis on shifting care out of hospitals into less-expensive community settings, and Portugal will also need to reflect on the strategic direction of the primary care system which, following an

impressive reform, now risks developing into a two-tiered system with increasingly divergent levels of care quality.

OCDE (2016). OECD Reviews of Health Care Quality: United Kingdom 2016: Raising Standards. Paris OCDE**:** 296 , tabl., fig.

Health systems in the United Kingdom have, for many years, made the quality of care a highly visible priority, internationally pioneering many tools and policies to assure and improve the quality of care. A key challenge, however, is to understand why, despite being a global leader in quality monitoring and improvement, the United Kingdom does not consistently demonstrate strong performance on international benchmarks of quality. This report reviews the quality of health care in the England, Scotland, Wales and Northern Ireland, seeking to highlight best practices, and provides a series of targeted assessments and recommendations for further quality gains in health care. To secure continued quality gains, the four health systems will need to balance top-down approaches to quality management and bottom-up approaches to quality improvement; publish more quality and outcomes data disaggregated by country; and, establish a forum where the key officials and clinical leaders from the four health systems responsible for quality of care can meet on a regular basis to learn from each other's innovations.

OCDE (2017). Caring for quality in health : lessons learnt from 15 reviews of Health Care Quality. Paris OCDE**:** 62 , tab., graph., fig.
http://www.oecd.org/els/health-systems/Caring-for-Quality-in-Health-Final-report.pdf

Over the past four years, the OECD has conducted a series of in-depth reviews of the policies and institutions that underpin the measurement and improvement of health care quality in 15 different health systems. Caring for Quality in Health: Lessons learnt from 15 reviews of health care quality seeks to answer the question of what caring for quality means for a modern health care system by identifying what policies and approaches work best in improving quality of care. Despite differences in health care system priorities, and in how quality-improvement tools are designed and applied, a number of common approaches and shared challenges emerged across the 15 OECD Reviews of Health Care Quality analysed. The most important of these concerns transparency. Governments should encourage, and where appropriate require, health systems and health care providers to be open about the effectiveness, safety and patient-centredness of care they provide. More measures of patient outcomes are also needed - especially those reported by patients themselves. These should underpin standards, guidelines, incentives and innovations in service delivery. Greater transparency can lead to optimisation of both quality and efficiency – twin objectives which reinforce, rather than subvert, each other. In practical terms, greater transparency and better performance can be supported by changes in where and how care is delivered; changes in the roles of patients and professionals; and employing tools such as data and incentives more effectively. Key actions in these three areas are set out in the 12 lessons presented in this synthesis report.

OCDE (2017). Panorama de la santé 2017. Indicateurs de l'OCDE. Paris OCDE**:** 221 , ann., graph., tabl.
http://www.oecd-ilibrary.org/social-issues-migration-health/panorama-de-la-sante-2017_health_glance-2017-fr

Cette nouvelle édition du Panorama de la santé présente les données comparables les plus récentes pour les principaux indicateurs relatifs à la santé et à la performance des systèmes de santé dans les pays de l'OCDE. Les pays candidats et les principaux pays partenaires (Afrique du Sud, Brésil, Chine, Colombie, Costa Rica, Fédération de Russie, Inde, Indonésie et

Lituanie) ont également été inclus dans la mesure du possible. Sauf indication contraire, les données présentées dans cette publication sont tirées des statistiques nationales officielles. Cette édition contient des nouveaux indicateurs, particulièrement dans le domaine des facteurs de risque pour la santé. Elle place aussi une plus grande emphase sur l'analyse des tendances temporelles. Parallèlement à l'analyse par indicateur, cette édition propose des instantanés et une série de tableaux de bord qui résument les performances comparatives des pays, ainsi qu'un chapitre spécial sur les principaux facteurs à l'origine des gains d'espérance de vie.

OMS (2000). Rapport sur la santé dans le monde 2000 : pour un système de santé plus performant. Genève OMS**:** 236 , tabl., index.

Ce rapport élaboré par des spécialistes analyse l'influence croissante des systèmes de santé sur la vie quotidienne des gens dans le monde entier. A partir de diverses expériences et en utilisant toute une gamme d'outils analytiques, il retrace l'évolution des systèmes de santé, dégage leurs différentes caractéristiques et définit un ensemble cohérent de fonctions et de buts communs. Fondant son analyse sur ces éléments, il innove en présentant un indice de performance des systèmes de santé qui tient compte de trois buts fondamentaux : améliorer le niveau et la distribution de la santé, faire en sorte que le système réponde mieux aux attentes légitimes de la population et garantir l'équité des contributions financières. Comme il le démontre de manière convaincante, une bonne performance dépend surtout de la prestation de services de grande qualité, mais pas uniquement : les systèmes de santé doivent aussi protéger les citoyens contre les risques financiers de la maladie et répondre à leurs attentes en respectant la dignité. Il explique ensuite que, pour atteindre ces buts, tout système doit être capable d'exercer quatre grandes fonctions : prestations de services, production de ressources, financement et administration générale.

Or, Z. (1997). "Out-performing or under-performing: an analysis of Health Outcomes in France and in other OECD countries." Health and System Science(3-4): 321-344.

Or, Z. (2002). "Improving the performance of health care systems : from measures to action : a review of experiences in four OECD countries." Labour Market and Social Policy Occasional Papers(57): 87 , fig.
http://www.oecd.org/dataoecd/0/58/1847865.pdf

Les pays de l'OCDE sont de plus en plus soucieux d'améliorer les performances de leur système de santé. Le présent document résume les résultats de recherches portant sur des initiatives récentes visant à mieux mesurer et à améliorer les performances des systèmes de santé de quatre pays de l'OCDE : France, Nouvelle-Zélande, Pays-Bas et Suède. Il met en lumière un certain nombre d'études de cas retenues pour illustrer les initiatives qui ont été prises pour améliorer les performances en accordant une plus ou moins grande attention aux questions de mesure. Il tente également de mettre en lumière le rôle du contexte institutionnel, et des « outils » de la gestion et des politiques utilisées pour apporter du changement. Les études de cas et le débat présentés dans ce papier s'appuient sur un rapport plus complet (présenté en annexe), qui décrit en détail ces initiatives et les situe dans le contexte institutionnel plus global du système de santé propre à chaque pays. On peut dégager un certain nombre de conclusions en première analyse : réussite apparente de certaines initiatives comme les registres nationaux de qualité en Suède ; besoin continu d'une autorégulation de la part des professionnels de santé, nécessité de soutenir financièrement l'autorégulation, ainsi que les efforts allant dans le sens d'une plus grande transparence pour en accroître les avantages ; et l'attrait d'une meilleure évaluation des principales réformes des politiques de santé, telles que la mise en place de marchés internes.

Or, Z. (2014). "Implementation of DRG Payment in France: Issues and recent developments." Health Policy **117**(2): 1-5.
http://www.healthpolicyjrnl.com/article/S0168-8510(14)00135-3/pdf

> In France, a DRG-based payment system was introduced in 2004/2005 for funding acute services in all hospitals with the objectives of improving hospital efficiency, transparency and fairness in payments to public and private hospitals. Despite the initial consensus on the necessity of the reform, providers have become increasingly critical of the system because of the problems encountered during the implementation. In 2012 the government announced its intention to modify the payment model to better deal with its adverse effects. The paper reports on the issues raised by the DRG-based payment in the French hospital sector and provides an overview of the main problems with the French DRG payment model. It also summarises the evidence on its impact and presents recent developments for reforming the current model. DRG-based payment addressed some of the chronic problems inherent in the French hospital market and improved accountability and productivity of health-care facilities. However, it has also created new problems for controlling hospital activity and ensuring that care provided is medically appropriate. In order to alter its adverse effects the French DRG model needs to better align greater efficiency with the objectives of better quality and effectiveness of care.

Ovretveit, J. (2001). "Quality evaluation and indicator comparison in health care." Int J Health Plann Manage **16**(3): 229-241.

> By 2005 all healthcare organizations in Europe will be required to take part in a quality evaluation scheme and to collect data about the quality of their service. Hospitals and doctors will need to prove they are safe--quality is no longer assumed. These were the predictions of a recent workshop of Nordic quality experts. The pressures to assess quality are increasing, and there are many assessment, certification, accreditation and measurement schemes in use. Which is best? What evidence is there that any have been effective? How should a hospital or region introduce such a scheme? There are many proponents for different schemes, and an increasing amount of experience to help answer these questions, but little research. This paper provides an overview for non-specialists of the different quality evaluation and indicator schemes for inspection and improvement. It draws on the experiences of quality specialists and leaders in each Nordic country who have applied the schemes in public hospitals and healthcare services. How a scheme is introduced and used may be more important than which particular scheme is chosen. This is one conclusion of the Nordic workshop. Other conclusions are that there is a need for clinicians to be involved, a need to balance simplicity and low cost with scientific validity and credibility with clinicians, and a need for research into different schemes to discover their costs and benefits in healthcare.

Paakkonen, J. et Seppala, T. (2012). Dimensions of health care system quality in Finland. Vatt Working Paper; 31. Helsinki Governement Institute for Economic Research.**:** 31 , tabl.
http://www.vatt.fi/file/vatt_publication_pdf/wp31.pdf

> This paper evaluates the determinants of quality - cost relationship in primary health care. It first summarizes information from various indicators of care by principal component analysis (PCA), effectively producing quality of care indicators: accessibility, coverage and allocative efficiency. It then regresses the costs of care against these indicators to evaluate their relationship. The results suggest that PCA may be used to produce quality of care indicators. Furthermore, the relationship between the costs and quality of care is complex. Better

accessibility is reflected in higher costs, whereas the efficient allocation of resources will bring some cost savings.

Papanicolas, I. é. et Smith, P. C. é. (2013). Health system performance comparison : an agenda for policy, information and research, Berkshire : Open University Press http://www.euro.who.int/__data/assets/pdf_file/0010/162568/e96456.pdf - http://mcgraw-hill.co.uk/html/0335247261.html

International comparison of health system performance has become increasingly popular, made possible by the rapidly expanding availability of health data. It has become one of the most important levers for prompting health system reform. Yet, as the demand for transparency and accountability in healthcare increases, so too does the need to compare data from different health systems both accurately and meaningfully. This timely and authoritative book offers an important summary of the current developments in health system performance comparison. It summarises the current state of efforts to compare systems, and identifies and explores the practical and conceptual challenges that occur. It discusses data and methodological challenges, as well as broader issues such as the interface between evidence and practice. The book draws out the priorities for future work on performance comparison, in the development of data sources and measurement instruments, analytic methodology, and assessment of evidence on performance. It concludes by presenting the key lessons and future priorities, and in doing so offers a rich source of material for policy-makers, their analytic advisors, international agencies, academics and students of health systems (Résumé de l'éditeur).

Paris, V. (2012). "Les performances comparées des systèmes de santé ?" Seve : Les Tribunes De La Sante(35): 43-49.

Evaluer la performance globale des systèmes de santé reste un exercice difficile et souvent empreint de jugements de valeur. Les dimensions de la performance sont multiples, ont évolué au cours du temps. Cet article se concentre sur les aspects de la performance aujourd'hui considérés comme les plus pertinents : l'amélioration de l'état de santé attribuable au système de soins, la qualité des soins, la capacité du système à répondre aux attentes des populations, l'équité dans l'accès aux soins et l'efficience productive. Il tente de situer les positions relatives des pays de l'OCDE sur ces dimensions de la performance (résumé de l'éditeur).

Pelone, F., et al. (2015). "Primary care efficiency measurement using data envelopment analysis: a systematic review." J Med Syst **39**(1): 156.

There is a gap between the demand and supply of efficiency analyses within primary care (PC), despite the threatening financial sustainability of health care systems. This paper provides a systematic literature review on PC efficiency analysis using Data Envelopment Analysis (DEA). We reviewed 39 DEA applications in PC, to understand how methodological frameworks impact results and influence the information provided to decision makers. Studies were combined using qualitative narrative synthesis. This paper reports data for each efficiency analysis on the: 1) evaluation context; 2) model specifications; 3) application of methods to test the robustness of findings; 4) presentation of results. Even though a consistent number of analyses aim to support policymakers and practice managers in improving the efficiency of their PC organizations, the results indicate that DEA--at least when applied to PC--is a methodology still in progress; it needs to be further advanced to meet the complexity that characterizes the production of PC outcomes. Future studies are needed to fill some gaps in this particular domain of research, such as on the standardization

of methodologies and the improvement of outcome research in PC. Most importantly, further studies should include extensive uncertainty analyses and be based on good evidence-based rationales. We suggest a number of considerations to academics and researchers to foster the utility of efficiency measurement for the decision making purposes in PC.

Pelone, F., et al. (2013). "How to achieve optimal organization of primary care service delivery at system level: lessons from Europe." International Journal for Quality in Health Care **25**(4): 1-13.

The objective of the study was to measure the relative efficiency of primary care (PC) in turning their structures into services delivery and turning their services delivery into quality outcomes. It became clear that maximizing the individual functions of PC without taking into account the coherence within the health-care system is not sufficient from a policymaker?s point of view when aiming to achieve efficiency.

Perera, G. A., et al. (2013). "Constructing a framework for quality activity in primary care." Aust Health Rev **37**(1): 98-103.

INTRODUCTION: In 2009, the Royal New Zealand College of General Practitioners commissioned the development of a framework to facilitate quality-improvement activity in primary care settings. This paper outlines the development of the framework, which integrates concepts of quality with the reality of practice-based clinical care, and discusses its value for primary care quality improvement. METHOD: Framework development involved: (1) literature review of theoretical approaches to healthcare quality; (2) field work utilising a mixed methods approach to obtain empirical data; and (3) model design. RESULTS: Primary care practitioners are juggling competing priorities. Models and tools that promote quality-related activity at practice level need to take into account, and incorporate by design, day-to-day clinical and practice functions. CONCLUSIONS: The quality framework identifies the components of primary care practice and locates this model within the concepts and activities necessary for quality improvement. It may be used by primary care organisations and practices to facilitate focussed quality-improvement activity and self-directed process review. The framework was developed for, and within a New Zealand primary care setting, and is applicable internationally and within other healthcare settings.

Petrosyan, Y., et al. (2017). "Quality indicators for care of depression in primary care settings: a systematic review." Syst Rev **6**(1): 126.

BACKGROUND: Despite the growing interest in assessing the quality of care for depression, there is little evidence to support measurement of the quality of primary care for depression. This study identified evidence-based quality indicators for monitoring, evaluating and improving the quality of care for depression in primary care settings. METHODS: Ovid MEDLINE and Ovid PsycINFO databases, and grey literature, including relevant organizational websites, were searched from 2000 to 2015. Two reviewers independently selected studies if (1) the study methodology combined a systematic literature search with assessment of quality indicators by an expert panel and (2) quality indicators were applicable to assessment of care for adults with depression in primary care settings. Included studies were appraised using the Appraisal of Indicators through Research and Evaluation (AIRE) instrument, which contains four domains and 20 items. A narrative synthesis was used to combine the indicators within themes. Quality indicators applicable to care for adults with depression in primary care settings were extracted using a structured form. The extracted quality indicators were categorized according to Donabedian's 'structure-process-outcome' framework. RESULTS: The search revealed 3838 studies. Four additional publications were

identified through grey literature searching. Thirty-nine articles were reviewed in detail and seven met the inclusion criteria. According to the AIRE domains, all studies were clear on purpose and stakeholder involvement, while formal endorsement and usage of indicators in practice were scarcely described. A total of 53 quality indicators were identified from the included studies, many of which overlap conceptually or in content: 15 structure, 33 process and four outcome indicators. This study identified quality indicators for evaluating primary care for depression among adult patients. CONCLUSIONS: The identified set of indicators address multiple dimensions of depression care and provide an excellent starting point for further development and use in primary care settings.

Raleigh, V., et al. (2014). Integrated care and support Pioneers: Indicators for measuring the quality of integrated care. Final report**:** 34 , tabl.
http://www.piru.ac.uk/assets/files/IC%20and%20support%20Pioneers-Indicators.pdf

Improved care coordination and integration of services within the health care sector, and across health, social care and other public services, is a priority for the government. The expectation is that integrated care will lead to more person-centered, coordinated care, improve outcomes for individuals, deliver more effective care and support and provide better value from public spending. This report relates to the identification of indicators for measuring integrated care and it outlines the background to our work, the aims of and audiences for the indicators, how the proposed indicators were selected, some general issues relating to the measurement of integrated care, guidance on using the indicators, and some steers on how to use routine quantitative data to measure trends in integrated care.

Raleigh, V. S. et Foot, C. (2010). Getting the measure of quality. Londres King's Fund Institute**:** 32 , tabl.
http://www.kingsfund.org.uk/sites/files/kf/Getting-the-measure-of-quality-Veena-Raleigh-Catherine-Foot-The-Kings-Fund-January-2010.pdf

Quality has been at the centre of recent NHS policy, and the NHS Next Stage Review highlighted the role of information and measurement in supporting quality improvement, particularly in relation to patient safety, clinical effectiveness and patient experience. It is therefore important to be clear how quality can be measured and by whom ? and how the information can be used to improve services. If quality measurement is going to have greatest impact, all those involved ? policy-makers, commissioners, board members, managers and clinicians ? need to be aware of the opportunities and challenges it presents. This report offers information about how quality is defined and how quality measures can be used ? and misused. It sets out the main debates and choices faced by those involved in measuring and using data on quality and outlines some practical issues to be considered in choosing and using quality measures

Rao, S., et al. (2012). Measuring Success: A Framework for Benchmarking Health Care System Performance. Ottawa The Conference Board of Canada**:** 70 , fig.

This report provides a foundation for the forthcoming provincial and international health care system benchmarking reports. It proposes a framework to guide the upcoming Canadian provincial benchmarking report, including a full description of the performance indicators, the rationale for their inclusion, and the ranking methodology. Nine Canadian and six international health benchmarking reports were examined in defining this methodology. The framework was developed in consultation with a technical advisory group, and a workshop was held with stakeholders from the health community in April 2012 to solicit feedback.

Reeves, D., et al. (2007). "Combining multiple indicators of clinical quality: an evaluation of different analytic approaches." Medical Care **45**(6): 489-496.

> OBJECTIVE : To compare different methods of combining quality indicators scores to produce composite scores that summarize the overall performance of health care providers. METHODS : Five methods for computing a composite quality score were compared: the RESULTS : The results varied considerably depending on the method of aggregation used, resulting in substantial differences in how providers scored. The results also varied considerably for the 2 datasets. There was more agreement between methods for dataset B, but for dataset A 6 of the 16 practices moved between the top and bottom quartiles depending upon the method used. CONCLUSIONS : Different methods of computing composite quality scores can lead to different conclusions being drawn about both relative and absolute quality among health care providers. Different methods are suited to different types of application. The main advantages and disadvantages of each method are described and discussed.

Ricci-Cabello, I., et al. (2017). "Identifying Primary Care Pathways from Quality of Care to Outcomes and Satisfaction Using Structural Equation Modeling." Health Serv Res.

> OBJECTIVE: To study the relationships between the different domains of quality of primary health care for the evaluation of health system performance and for informing policy decision making. DATA SOURCES: A total of 137 quality indicators collected from 7,607 English practices between 2011 and 2012. STUDY DESIGN: Cross-sectional study at the practice level. Indicators were allocated to subdomains of processes of care ("quality assurance," "education and training," "medicine management," "access," "clinical management," and "patient-centered care"), health outcomes ("intermediate outcomes" and "patient-reported health status"), and patient satisfaction. The relationships between the subdomains were hypothesized in a conceptual model and subsequently tested using structural equation modeling. PRINCIPAL FINDINGS: The model supported two independent paths. In the first path, "access" was associated with "patient-centered care" (beta = 0.63), which in turn was strongly associated with "patient satisfaction" (beta = 0.88). In the second path, "education and training" was associated with "clinical management" (beta = 0.32), which in turn was associated with "intermediate outcomes" (beta = 0.69). "Patient-reported health status" was weakly associated with "patient-centered care" (beta = -0.05) and "patient satisfaction" (beta = 0.09), and not associated with "clinical management" or "intermediate outcomes." CONCLUSIONS: This is the first empirical model to simultaneously provide evidence on the independence of intermediate health care outcomes, patient satisfaction, and health status. The explanatory paths via technical quality clinical management and patient centeredness offer specific opportunities for the development of quality improvement initiatives.

Rijken, P. M. et Bekkema, N. (2011). Chronic Disease Management Matrix 2010. Results of a survey in ten European countries. Utrecht NIVEL**:** 118 , tabl.
http://calliope.nivel.nl/pdf/CHR028%20EUR015%20report%20CDM%20Matrix_final%20version.pdf

> In recent years, several European countries have set up Disease Management Programmes (DMPs) to rise to this challenge. In order to continuously improve the models for managing chronic diseases it is important to learn about the essential features of these DMPs and the position of primary healthcare within these programmes. For this purpose a survey was conducted to provide an overview of the actual situation regarding chronic disease management in Europe. Experts from ten European countries provided data about the existence of DMPs in their country, the features and outcomes of these DMPs, the

healthcare providers involved and the role of primary care in these DMPs in particular. In addition, some general characteristics of the country?s healthcare system were provided. Experts were asked to report on programmes to manage chronic illness care that met the following criteria. The programme: manages a defined chronic condition (or risk-factor for developing a defined chronic condition); incorporates a systematic and coherent approach; offers multidisciplinary, collaborative care; focuses on an active role for patients; strives to maximize effectiveness and to continuously improve quality of care.

Robertson, R. (2017). Public satisfaction with the NHS and social care in 2016: Results and trends from the Bristish Social Attitudes Survey**:** 121 , tab., graph., fig. https://www.kingsfund.org.uk/sites/files/kf/media/BSA_final2_Kings_Fund_Mar_2017.pdf

Since 1983, NatCen Social Research's British Social Attitudes (BSA) survey has asked members of the public – rather than only patients – about their views on, and feelings towards, the NHS and health and care issues generally. The latest survey was carried out between July and October 2016 and asked a nationally representative sample of nearly 3,000 people about their satisfaction with the NHS overall, and of nearly 1,000 people about their satisfaction with individul NHS services. This report below summarises the headline results. More detail from the survey will be

Rochester-Eyeguokan, C. D., et al. (2016). "The Current Landscape of Transitions of Care Practice Models: A Scoping Review." Pharmacotherapy **36**(1): 117-133.

Transitions of care (TOC) are a set of actions to ensure patient coordination and continuity of care as patients transfer between different locations or levels. During transitions associated with chronic or acute illness, vulnerable patients may be placed at risk with fragmented systems compromising their health and safety. In addition, poor care transitions also have an enormous impact on health care spending. The primary objective of this scoping review is to summarize the current landscape of practice models that deliver TOC services in the United States. The secondary objective is to use the information to characterize the current state of best practice models. A search of the PubMed, Embase, Cumulative Index to Nursing and Allied Health Literature, Web of Science, International Pharmaceutical Abstracts, National Center for Biotechnology Information at the U.S. National Library of Medicine, and Cochrane Library databases (January 1, 2000-April 13, 2015) for articles pertaining to TOC models, limited to U.S. studies published in the English language with human subjects, gleaned 1362 articles. An additional 26 articles were added from the gray literature. Articles meeting inclusion criteria underwent a second review and were categorized into four groups: background information, original TOC research articles not evaluating practice model interventions, original TOC research articles describing practice models, and systematic or Cochrane reviews. The reviewers met weekly to discuss the challenges and resolve disagreements regarding literature reviews with consensus before progressing. A total of 188 articles describing TOC practice models met the inclusion criteria. Despite the strengths of several quality TOC models, none satisfied all the components recommended by leading experts. Multimodal interventions by multidisciplinary teams appear to represent a best practice model for TOC to improve patient outcomes and reduce readmissions, but one size does not fit all. Best model TOC services must include services along the TOC continuum: pretransition and posttransition, as well as at home and in outpatient health care settings. Studies clearly show that single-modal interventions are rarely successful in reducing readmissions and that successful TOC services must be multimodal and multidisciplinary, and continue throughout the care transition. Utilizing best practice TOC models described in this article as a starting point, practitioners interested in developing their own TOC program

should test these tools in new practice environments and add to the body of literature by publishing their findings.

Rodriguez, H. P., et al. (2016). "The Use of Enhanced Appointment Access Strategies by Medical Practices." Med Care **54**(6): 632-638.

BACKGROUND: Strategies to enhance appointment access are being adopted by medical practices as part of patient-centered medical home (PCMH) implementation, but little is known about the use of these strategies nationally. OBJECTIVES: We examine practice use of open access scheduling and after-hours care. RESEARCH DESIGN: Data were analyzed from the Third National Study of Physician Organizations (NSPO3) to examine which enhanced appointment access strategies are more likely to be used by practices with more robust PCMH capabilities and with greater external incentives. Logistic regression estimated the effect of PCMH capabilities and external incentives on practice use of open access scheduling and after-hours care. SUBJECTS: Physician organizations with >20% primary care physicians (n=1106). MEASURES: PCMH capabilities included team-based care, health information technology capabilities, quality improvement orientation, and patient experience orientation. External incentives included public reporting, pay-for-performance (P4P), and accountable care organization participation. RESULTS: A low percentage of practices (19.8%) used same-day open access scheduling, while after-hours care (56.1%) was more common. In adjusted analyses, system-owned practices and practices with greater use of team-based care, health information technology capabilities, and public reporting were more likely to use open access scheduling. Accountable care organization-affiliated practices and practices with greater use of public reporting and P4P were more likely to provide after-hours care. CONCLUSIONS: Open access scheduling may be most effectively implemented by practices with robust PCMH capabilities. External incentives appear to influence practice adoption of after-hours care. Expanding open access scheduling and after-hours care will require distinct policies and supports.

Roland, M. (2004). "Linking physicians' pay to the quality of care - A major experiment in the United Kingdom." New England Journal of Medicine (the) **351**(351): 1448-1454.

Rosano, A., et al. (2013). "The relationship between avoidable hospitalization and accessibility to primary care: a systematic review." Eur J Public Health **23**(3): 356-360.

BACKGROUND: Avoidable hospitalization (AH) has been widely studied as a possible measure of the performance of primary health care (PHC). However, studies examining the relationship between the efficiency and quality of PHC and AH have found mixed results. Our study aims at highlighting those factors related to the relationship between AH and accessibility to PHC in different countries. METHODS: We conducted a systematic search for peer-reviewed studies published between 1990 and October 2010 in English, German, French, Italian or Spanish and indexed primary electronic databases. RESULTS: The final analysis was conducted on the basis of 51 papers. Of them, 72.5% revealed a significant inverse association between the indicator of PHC accessibility and rates of AH. Indicators of PHC calculated at individual level are more likely to reveal contradictory aspects of the relationship between rates of AH and indicators of quality and PHC accessibility. CONCLUSIONS: Most studies confirmed the expected relationship between indicators of PHC accessibility and hospitalization for ambulatory care sensitive conditions (ACSCs), showing lower hospitalization rates for ACSC in areas with greater access to PHC. The findings support the use of ACSC hospitalization as an indicator of primary care quality, with the precaution of applying appropriate adjustment factors.

Rose, K. D., et al. (2011). "Advanced access scheduling outcomes: a systematic review." Arch Intern Med **171**(13): 1150-1159.

BACKGROUND: Advanced ("open") access scheduling, which promotes patient-driven scheduling in lieu of prearranged appointments, has been proposed as a more patient-centered appointment method and has been widely adopted throughout the United Kingdom, within the US Veterans Health Administration, and among US private practices. OBJECTIVE: To describe patient and physician and/or practice outcomes resulting from implementation of advanced access scheduling in the primary care setting. DATA SOURCES: Comprehensive search of electronic databases (MEDLINE, Scopus, Web of Science) through August, 2010, supplemented by reference lists and gray literature. STUDY SELECTION: Studies were assessed in duplicate, and reviewers were blinded to author, journal, and date of publication. Controlled and uncontrolled English-language studies of advanced access implementation in primary care were eligible if they specified methods and reported outcomes data. DATA EXTRACTION: Two reviewers collaboratively assessed risk for bias by using the Cochrane Effective Practice and Organisation of Care Group Risk of Bias criteria. Data were independently extracted in duplicate. DATA SYNTHESIS: Twenty-eight articles describing 24 studies met eligibility criteria. All studies had at least 1 source of potential bias. All 8 studies evaluating time to third-next-available appointment showed reductions (range of decrease, 1.1-32 days), but only 2 achieved a third-next-available appointment in less than 48 hours (25%). No-show rates improved only in practices with baseline no-show rates higher than 15%. Effects on patient satisfaction were variable. Limited data addressed clinical outcomes and loss to follow-up. CONCLUSIONS: Studies of advanced access support benefits to wait time and no-show rate. However, effects on patient satisfaction were mixed, and data about clinical outcomes and loss to follow-up were lacking.

Rosen, A. K., et al. (2016). "Does Use of a Hospital-wide Readmission Measure Versus Condition-specific Readmission Measures Make a Difference for Hospital Profiling and Payment Penalties?" Med Care **54**(2): 155-161.

BACKGROUND: The Centers for Medicare and Medicaid Services (CMS) use public reporting and payment penalties as incentives for hospitals to reduce readmission rates. In contrast to the current condition-specific readmission measures, CMS recently developed an all-condition, 30-day all-cause hospital-wide readmission measure (HWR) to provide a more comprehensive view of hospital performance. OBJECTIVES: We examined whether assessment of hospital performance and payment penalties depends on the readmission measure used. RESEARCH DESIGN: We used inpatient data to examine readmissions for patients discharged from VA acute-care hospitals from Fiscal Years 2007-2010. We calculated risk-standardized 30-day readmission rates for 3 condition-specific measures (heart failure, acute myocardial infarction, and pneumonia) and the HWR measure, and examined agreement between the HWR measure and each of the condition-specific measures on hospital performance. We also assessed the effect of using different readmission measures on hospitals' payment penalties. RESULTS: We found poor agreement between the condition-specific measures and the HWR measure on those hospitals identified as low or high performers (eg, among those hospitals classified as poor performers by the heart failure readmission measure, only 28.6% were similarly classified by the HWR measure). We also found differences in whether a hospital would experience payment penalties. The HWR measure penalized only 60% of those hospitals that would have received penalties based on at least 1 of the condition-specific measures. CONCLUSIONS: The condition-specific measures and the HWR measure provide a different picture of hospital performance. Future research is needed to determine which measure aligns best with CMS's overall goals to reduce hospital readmissions and improve quality.

Rowe, A. K. (2013). "The effect of performance indicator category on estimates of intervention effectiveness." Int J Qual.Health Care **25**(3): 331-339.
PM:23575873

> BACKGROUND: /st> A challenge for systematic reviews on improving health worker performance is that included studies often use different performance indicators, and the validity of comparing interventions with different indicators is unclear. One potential solution is to adjust comparisons by indicator category, with categories based on steps of the case-management process that can be easily recognized (assessment of symptoms, treatment etc.) and that might require different levels of effort to bring about improvements. However, this approach would only be useful if intervention effect sizes varied by indicator category. To explore this approach, studies were analyzed that evaluated the Integrated Management of Childhood Illness (IMCI) strategy. METHODS: /st> Performance indicators were grouped into four categories: patient assessment, diagnosis, treatment and counseling. An effect size of IMCI was calculated for each indicator. Linear regression modeling was used to test for differences among the mean effect sizes of the indicator categories. RESULTS: /st> Six studies were included, with data from 3136 ill child consultations. Mean effect sizes for 63 assessment indicators, 12 diagnosis indicators, 31 treatment indicators and 34 counseling indicators were 50.9 percentage-points (%-points), 44.7, 36.5 and 46.6%-points, respectively. After adjusting for baseline indicator value, compared with the assessment mean effect size, the diagnosis mean was 7.3%-points lower (P = 0.23), the treatment mean was 15.2%-points lower (P = 0.0004) and the counseling mean was 12.9%-points lower (P = 0.0027). CONCLUSION: /st> Adjusting the results of systematic reviews for indicator category and baseline indicator value might be useful for improving the validity of intervention comparisons

Rubin, H. R., et al. (2001). "The advantages and disadvantages of process-based measures of health care quality." Int J Qual Health Care **13**(6): 469-474.

> As consumers, payers, and regulatory agencies require evidence regarding health care qualities the demand for process of care measures will grow. Although outcome measures of quality represent the desired end results of health care, validated process of care measures provide an important additional element to quality improvement efforts, as they illuminate exactly which provider actions could be changed to improve patient outcomes. In this essay, we discuss the advantages and disadvantages of process measures of quality, and outline some practical strategies and issues in implementing them.

Ryan, A. M., et al. (2017). "Linking Spending and Quality Indicators to Measure Value and Efficiency in Health Care." Med Care Res Rev **74**(4): 452-485.

> Policy makers and stakeholders have reached a consensus that both quality and spending or resource use indicators should be jointly measured and prioritized to meet the objectives of our health system. However, the relative merits of alternative approaches that combine quality and spending indicators are not well understood. We conducted a literature review to identify different approaches that combine indicators of quality and spending measures to profile provider efficiency in the context of specific applications in health care. Our investigation identified seven alternative models that are either in use or have been proposed to evaluate provider efficiency. We then used publicly available data to profile hospitals using these approaches. Profiles of hospital efficiency using alternative models yielded wide variation in performance, underscoring the importance of model selection. By identifying the current efficiency models and evaluating their trade-offs within specific

programmatic contexts, our analysis informs stakeholder and policy maker decisions about how to link quality and spending indicators when measuring efficiency in health care.

Saleh, S., et al. (2015). "Quality of care in primary health care settings in the Eastern Mediterranean region: a systematic review of the literature." Int J Qual Health Care **27**(2): 79-88.

PURPOSE: This systematic review aims at offering a comprehensive synthesis of studies addressing quality of care in the primary healthcare (PHC) sector of the Eastern Mediterranean Region (EMR). DATA SOURCES: A systematic search was conducted using Medline, Embase and Global Health Library (IMEMR) electronic databases to identify studies related to quality in PHC between years 2000 and 2012. STUDY SELECTION/DATA EXTRACTION: One hundred and fifty-nine (159) studies fulfilled the eligibility criteria. Each paper was independently reviewed by two reviewers, and the following information was extracted/calculated: dimension of care investigated (structure, processes and outcomes), focus, disease groups, study design, sample size, unit of analysis, response rate, country, setting (public or private) and level of rigor (LOR) score. RESULTS OF DATA SYNTHESIS: Most of the studies were descriptive/cross-sectional in nature with a relatively modest LOR score. Assessment of quality of care revealed that the process dimension of quality, specifically clinical practice and patient-provider relationship, is an area of major concern. However, interventions targeting enhanced quality in PHC in the EMR countries had favorable and effective outcomes in terms of clinical practice. CONCLUSION: These findings highlight gaps in evidence on quality in PHC in the EMR; such evidence is key for decision-making. Researchers and policy-makers should address these gaps to generate contextualized information and knowledge that ensures relevance and targeted high-impact interventions.

Salois, R. (2010). Rapport d'appréciation de la performance du système de santé et de services sociaux 2010. Adopter une approche intégrée de prévention et de gestion des maladies chroniques : recommandations, enjeux et implications - Volume 4. Québec C.S.B.E.**:** 168 , tabl., graph. http://www.csbe.gouv.qc.ca/fileadmin/www/2010_RapportAppreciation/CSBE_T4-RecommandationMaladiesChroniques-052010.pdf

Le commissaire à la santé et au bien-être, M. Robert Salois, présente son rapport annuel, intitulé Rapport d'appréciation de la performance du système de santé et de services sociaux 2010. En 2010, il a choisi d'apprécier les soins et services offerts aux personnes atteintes de maladies chroniques, dont la prévalence et les problèmes de santé associés représentent un défi majeur pour notre système. L'analyse fait l'objet de quatre volumes. Le premier volume brosse un portrait de la de la performance du système de santé et de services sociaux, en particulier celle des soins et services liés aux maladies chroniques. Le second volume dresse un portrait sommaire des maladies chroniques et du fardeau qu'elles représentent au sein du système de santé et de services sociaux ainsi que des soins et services offerts aux personnes. Le troisième volume présente les résultats de la consultation à l'égard des éléments qui caractérisent un système de santé et de services sociaux performant, des actions reconnues efficaces pour en améliorer la performance ainsi que de leur faisabilité dans le contexte des soins liés aux maladies chroniques. À la lumière des analyses de la performance, de l'état de situation et des consultations, le présent document qui constitue le quatrième volume fait office de conclusion de l'exercice d'appréciation de la performance. Les recommandations du Commissaire, qui découlent de sa démarche d'appréciation, y sont exposées. Enfin, les implications de certaines recommandations sont analysées.

Salois, R. (2010). Rapport d'appréciation de la performance du système de santé et de services sociaux 2010. Etat de situation portant sur les maladies chroniques et la réponse du système de santé et de services sociaux - Volume 2. Québec C.S.B.E.**:** 136 , tabl., graph.

http://www.csbe.gouv.qc.ca/fileadmin/www/2010_RapportAppreciation/CSBE_T2-EtatSituationMaladiesChroniques-052010.pdf

Le commissaire à la santé et au bien-être, M. Robert Salois, présente son rapport annuel, intitulé Rapport d'appréciation de la performance du système de santé et de services sociaux 2010. En 2010, il a choisi d?apprécier les soins et services offerts aux personnes atteintes de maladies chroniques, dont la prévalence et les problèmes de santé associés représentent un défi majeur pour notre système. L'analyse fait l'objet de quatre volumes. Le premier volume brosse un portrait de la de la performance du système de santé et de services sociaux, en particulier celle des soins et services liés aux maladies chroniques. Le présent document constitue le second volume. Il dresse un portrait sommaire des maladies chroniques et du fardeau qu'elles représentent au sein du système de santé et de services sociaux ainsi que des soins et services offerts aux personnes. Ce portrait fait ressortir de grands constats et tendances par rapport à l'organisation des soins et services en ce qui concerne les maladies chroniques et leurs déterminants.

Salois, R. (2010). Rapport d'appréciation de la performance du système de santé et de services sociaux 2010. L'appréciation globale et intégrée de la performance : analyse des indicateurs de monitorage - Volume 1. Québec C.S.B.E.**:** 256 , tabl., graph.
http://www.csbe.gouv.qc.ca/fileadmin/www/2010_RapportAppreciation/CSBE_T1-AnalyaseIndicateursMonitorage-052010.pdf

Le commissaire à la santé et au bien-être, M. Robert Salois, présente son rapport annuel, intitulé Rapport d'appréciation de la performance du système de santé et de services sociaux 2010. En 2010, il a choisi d?apprécier les soins et services offerts aux personnes atteintes de maladies chroniques, dont la prévalence et les problèmes de santé associés représentent un défi majeur pour notre système. L'analyse fait l'objet de quatre volumes. Le premier volume brosse un portrait de la de la performance du système de santé et de services sociaux, en particulier celle des soins et services liés aux maladies chroniques. Il présente une analyse des indicateurs de performance de l?ensemble du système ainsi que des indicateurs relatifs aux soins et services liés aux maladies chroniques, à l'échelle du Québec et de ses régions. Grâce aux constats dressés, il propose des pistes de réflexion sur lesquelles les acteurs du système de santé et de services sociaux sont conviés à se pencher.

Salois, R. (2010). Rapport d'appréciation de la performance du système de santé et de services sociaux 2010. Rapport de la démarche de consultation portant sur les soins et services liés aux maladies chroniques - Volume 3. Québec C.S.B.E.**:** 80 , tabl., graph.
http://www.csbe.gouv.qc.ca/fileadmin/www/2010_RapportAppreciation/CSBE_T3-RapportConsultationMaladiesChroniques-052010.pdf

Le commissaire à la santé et au bien-être, M. Robert Salois, présente son rapport annuel, intitulé Rapport d'appréciation de la performance du système de santé et de services sociaux 2010. En 2010, il a choisi d'apprécier les soins et services offerts aux personnes atteintes de maladies chroniques, dont la prévalence et les problèmes de santé associés représentent un défi majeur pour notre système. L'analyse fait l'objet de quatre volumes. Le premier volume brosse un portrait de la de la performance du système de santé et de services sociaux, en particulier celle des soins et services liés aux maladies chroniques. Le second volume dresse un portrait sommaire des maladies chroniques et du fardeau qu'elles représentent au sein du système de santé et de services sociaux ainsi que des soins et services offerts aux personnes. Le présent document constitue le troisième volume. Il présente les résultats de la consultation à l'égard des éléments qui caractérisent un système de santé et de services

sociaux performant, des actions reconnues efficaces pour en améliorer la performance ainsi que de leur faisabilité dans le contexte des soins liés aux maladies chroniques.

Salois, R. (2014). La performance du système de santé et des services sociaux québécois 2014. Résultats et analyses. Québec C.S.B.E.: 113 , tabl., graph.

This report on canadian health system performance is based on analysis of a wide range of data from multiple sources at provincial, national, and international levels. Quebec performs very well with regard to wait times to see a specialist, obtain specialized testing, as well as for hospital readmissions, but performs less well on continuity and coordination between specialists and family physicians. Quebec comes dead last in the use of information technology by physicians, access to a regular doctor, and follow-up care.

Salzer, M. S., et al. (1997). "Validating Quality Indicators." Evaluation Review **21**(3): 292-309. http://journals.sagepub.com/doi/abs/10.1177/0193841X9702100302

Theory and research have not kept pace with the growing interest in evaluating quality of mental health care, resulting in the use of unvalidated quality indicators. A framework for validating quality indicators is offered by which quality is viewed as the relationship between service structures, processes, and outcomes. Adoption of this framework will facilitate the measurement of quality using valid indicators and should be useful to agencies in their continuous quality improvement efforts. Valid information about the quality of mental health care services will help purchasers and consumers make more informed health care decisions.

Sampurno, F., et al. (2018). "Quality indicators for global benchmarking of localised prostate cancer management." J Urol.

PURPOSE: To develop a core set of clinical indicators that enables international benchmarking of localised prostate cancer management using data available in the TrueNTH Global Registry. MATERIALS AND METHODS: An international expert panel completed an online survey and participated in a face-to-face meeting. Participants included urologists (n=3), radiation oncologists (n=3), psychologists (n=2), medical oncologist (n=1), nurse (n=1) and an epidemiologist (n=1) with prostate cancer expertise from seven countries. Current guidelines on prostate cancer treatment and potential quality indicators were identified from a literature review. These potential indicators were refined and developed through a modified Delphi process, during which each panellist independently and repeatedly rated each indicator based on its importance (satisfying the indicator demonstrates a provision of high-quality care) and feasibility (likelihood that data being used to construct the indicator could be collected at a population level). The main outcome measure was items with panel agreement (disagreement index<1), median importance >/=8.5 and median feasibility >/=9. RESULTS AND CONCLUSION: s: Thirty-three indicators received endorsement from the expert panel. These 33 prostate cancer quality indicators assess care relating to diagnosis (n=7), primary treatment (n=7), salvage treatment (n=1) and health outcomes (n=18). In summary, we have developed a set of quality indicators for measuring prostate cancer care from numerous international evidence-based clinical guidelines. These indicators will be pilot tested in the TrueNTH Global Registry. Reports comparing indicator performance will subsequently be distributed to participating sites, with the purpose of improving the consistency and quality of prostate cancer management on a global basis.

Sarma, S. et Peddigrew, C. (2008). "The relationship between family physician density and health related outcomes : the Canadian evidence." Cahiers De Sociologie Et De Demographie Medicales **48**(1): 61-106.

> [BDSP. Notice produite par OBRESA s9prnR0x. Diffusion soumise à autorisation]. Dans le présent article, nous analysons dans quelle mesure la densité des médecins de famille influe sur les résultats liés à la santé au Canada, le cas échéant. Nous partons du principe que la densité des médecins de famille dans une région donnée sert d'indicateur de l'accès aux services de soins primaires appropriés et de leur disponibilité. Nous utilisons les états de la santé générale et mentale signalés par les clients pour mesurer les résultats de la santé générale. Nous nous servons également de plusieurs indicateurs de la qualité des soins qui montrent si une personne présentant un haut risque a reçu une immunisation contre la grippe, une mammographie, un frottis vaginal et un dépistage colorectal. Selon les résultats empiriques de la présente étude, un médecin de famille supplémentaire par 10 000 habitants a un impact statistiquement significatif de l'ordre de 2 à 4% sur l'état général de la santé signalé par les clients, de même que sur d'autres résultats sur la qualité des soins. Par ailleurs, nous observons que des facteurs socio-économiques et démographiques importants, tels que le revenu, le niveau d'instruction et le statut d'immigrant, influent sur les résultats sur la santé qui ont été pris en considération dans le cadre de l'étude. La compréhension de l'influence des facteurs socio-économiques concernant l'offre et la demande de médecins est une considération importante en matière de politiques et de la planification en matière de santé. (Résumé d'auteur).

Saust, L. T., et al. (2016). "Quality assessment of diagnosis and antibiotic treatment of infectious diseases in primary care: a systematic review of quality indicators." Scand J Prim Health Care **34**(3): 258-266.

> OBJECTIVE: To identify existing quality indicators (QIs) for diagnosis and antibiotic treatment of patients with infectious diseases in primary care. DESIGN: A systematic literature search was performed in PubMed and EMBASE. We included studies with a description of the development of QIs for diagnosis and antibiotic use in patients with infectious diseases in primary care. We extracted information about (1) type of infection; (2) target for quality assessment; (3) methodology used for developing the QIs; and (4) whether the QIs were developed for a national or international application. The QIs were organised into three categories: (1) QIs focusing on the diagnostic process; (2) QIs focusing on the decision to prescribe antibiotics; and (3) QIs concerning the choice of antibiotics. RESULTS: Eleven studies were included in this review and a total of 130 QIs were identified. The majority (72%) of the QIs were focusing on choice of antibiotics, 22% concerned the decision to prescribe antibiotics, and few (6%) concerned the diagnostic process. Most QIs were either related to respiratory tract infections or not related to any type of infection. A consensus method (mainly the Delphi technique), based on either a literature study or national guidelines, was used for the development of QIs in all of the studies. CONCLUSIONS: The small number of existing QIs predominantly focuses on the choice of antibiotics and is often drug-specific. There is a remarkable lack of diagnostic QIs. Future development of new QIs, especially disease-specific QIs concerning the diagnostic process, is needed. KEY POINTS In order to improve the use of antibiotics in primary care, measurable instruments, such as quality indicators, are needed to assess the quality of care being provided. A total of 11 studies were found, including 130 quality indicators for diagnosis and antibiotic treatment of infectious diseases in primary care. The majority of the identified quality indicators were focusing on the choice of antibiotics and only a few concerned the diagnostic process. All quality indicators were developed by means of a consensus method and were often based on literature studies or guidelines.

Schmitt, J., et al. (2014). "[Recommendations for quality indicators in German S3 guidelines: a critical appraisal]." Gesundheitswesen **76**(12): 819-826.

BACKGROUND: Assessment of the quality of medical care plays an increasingly important role in the German healthcare system. Requirements for quality indicators include validity, reliability, responsiveness, interpretability and feasibility. Because of the high impact of guidelines, quality indicators that are recommended in such guidelines are of special relevance. METHODS: We conducted a systematic review of all German S3 guidelines (actual as of November 30(th), 2013) to investigate the proportion of guidelines recommending quality indicators, which categories to classify quality indicators were used, and whether quality indicators in German S3 guidelines were developed following evidence-based methods. RESULTS: In 34 from 87 S3 guidelines (39%) a total of 394 quality indicators were defined. The vast majority of the recommended quality indicators focused on process quality. Outcome indicators were only recommended in 9 S3 guidelines (10%). None of the guidelines analysed reported the properties of the recommended quality indicators. CONCLUSION: Despite the increasing relevance of quality assessment for all stakeholders in the German healthcare system only approximately 40% of the S3 guidelines define indicators to measure the quality of care. Recommendations to assess outcome indicators are only provided in 10% of S3 guidelines. The process of the development and recommendation of quality indicators is heterogeneous and frequently not transparently reported. The current practice for the recommendation and validation of quality indicators in German S3 guidelines does not meet the requirements of evidence-based healthcare.

Schoenbaum, S. C. et Holmgren, A. L. (2006). The National commitee for quality assurance's the state of Health care quality 2006. New York Commonwealth Fund**:** 6 , tabl., fig.
http://www.cmwf.org/usr_doc/969_Schoenbaum_NCQA_state_hlt_care.pdf

The National Committee for Quality Assurance's 2006 report on the performance of U.S. health plans found overall improvement in HEDIS clinical quality measures for those plans that collect and publicly report performance data. Improvements, moreover, were broad-based. There are several lessons for those pursuing high performance of the U.S. health system as a whole. Most importantly, the results show there is hope; performance on some HEDIS measures is now approaching 100 percent. Diffusion of measurement has been slow, but steady. The nation needs more and better measures of performance, mechanisms for setting standards of performance, and tools, such as performance-based contracts, for ensuring that improvement occurs.

Schull, M. J., et al. (2010). Development of a Consensus on Evidence-Based Quality of Care Indicators for Canadian Emergency Departments. Toronto ICES**:** 26 , tabl.
http://www.ices.on.ca/file/Impact_no%20physician_July14-08.pdf

There is good evidence to support quality of care monitoring and reporting as a means of improving accountability and quality in health care delivery. The evaluation of emergency department (ED) care in Canada, however, is hampered by the absence of a common agreement on what constitutes appropriate measures of quality of ED care. This report present the results of a national process to establish a parsimonious set of evidence-based indicators of quality of care in Canadian EDs.

Shekelle, P. G., et al. (2001). "Assessing care of vulnerable elders: methods for developing quality indicators." Annals of Internal Medicine **135**(8/2): 647-652.

We present here an explicit method for developing process quality indicators for vulnerable elders based on systematic literature reviews and several levels of expert opinion. Indicators developed with this method covered a range of domains and interventions in medical care. These indicators, which are an explicit product of evidence and opinion, should prove useful for evaluating

Shield, T., et al. (2003). "Quality indicators for primary care mental health services." Quality and Safety in Health Care **12**(2): 100-106.
http://qualitysafety.bmj.com/content/12/2/100.abstract

Objectives: To identify a generic set of face valid quality indicators for primary care mental health services which reflect a multi-stakeholder perspective and can be used for facilitating quality improvement.Design: Modified two-round postal Delphi questionnaire.Setting: Geographical spread across Great Britain.Participants: One hundred and fifteen panellists representing 11 different stakeholder groups within primary care mental health services (clinical psychologist, health and social care commissioner, community psychiatric nurse, counsellor, general practitioner, practice nurse/district nurse/health visitor, psychiatrist, social worker, carer, patient and voluntary organisations).Main outcome measures: Face validity (median rating of 8 or 9 on a nine point scale with agreement by all panels) for assessing quality of care.Results: A maximum of 334 indicators were rated by panels in the second round; 26% were rated valid by all panels. These indicators were categorised into 21 aspects of care, 11 relating to general practices and 10 relating to health authorities or primary care groups/trusts. There was variation in the total number of indicators rated valid across the different panels. Overall, GPs rated the lowest number of indicators as valid (41%, n=138) and carers rated the highest number valid (91%, n=304).Conclusions: The quality indicators represent consensus among key stakeholder groups in defining quality of care within primary care mental health services. These indicators could provide a guide for primary care organisations embarking on quality improvement initiatives in mental health care when addressing national targets and standards relating to primary care set out in the National Service Framework for Mental Health for England. Although many of the indicators relate to parochial issues in UK service delivery, the methodology used in the development of the indicators could be applied in other settings to produce locally relevant indicators.

Simou, E., et al. (2014). "Developing a national framework of quality indicators for public hospitals." Int J Health Plann Manage **29**(3): e187-206.

BACKGROUND: The current study describes the development of a preliminary set of quality indicators for public Greek National Health System (GNHS) hospitals, which were used in the "Health Monitoring Indicators System: Health Map" (Ygeionomikos Chartis) project, with the purpose that these quality indicators would assess the quality of all the aspects relevant to public hospital healthcare workforce and services provided. METHODS: A literature review was conducted in the MEDLINE database to identify articles referring to international and national hospital quality assessment projects, together with an online search for relevant projects. Studies were included if they were published in English, from 1980 to 2010. A consensus panel took place afterwards with 40 experts in the field and tele-voting procedure. RESULTS: Twenty relevant projects and their 1698 indicators were selected through the literature search, and after the consensus panel process, a list of 67 indicators were selected to be implemented for the assessment of the public hospitals categorized under six distinct dimensions: Quality, Responsiveness, Efficiency, Utilization, Timeliness, and Resources and Capacity. CONCLUSION: Data gathered and analyzed in this manner provided a novel evaluation and monitoring system for Greece, which can assist decision-makers,

healthcare professionals, and patients in Greece to retrieve relevant information, with the long-term goal to improve quality in care in the GNHS hospital sector.

Simou, E., et al. (2015). "Quality Indicators for Primary Health Care: A Systematic Literature Review." J Public Health Manag Pract **21**(5): E8-e16.

Data have indicated that countries with a strong system of Primary Health Care (PHC) are more likely to have efficient health systems and better health outcomes than countries that focus strongly on hospital services. The aim of the article was to systematically review implemented quality projects used for evaluation of quality in PHC services. A systematic literature review was conducted via MEDLINE to identify papers referring to international or national PHC quality assessment projects, published in English from 1990 to 2010. Projects were included if they had been implemented, had a holistic approach, and reported specifications of the quality indicators used. Sixteen publications were considered eligible for further analyses, referring to 10 relevant projects and a total of 556 indicators. Number and content of indicators and their domains varied across projects. Regarding raw data, lack of standardization of collection tools between projects could lead to invalid comparisons. In areas that international projects operate in parallel to national initiatives, there may be problems regarding expenses and burden of data collection, which might create competing interests and low quality of information. Further actions for alignment of quality projects on primary health care are required, for future results to become comparable.

Siriwardena, A. N. (2012). "Research on the UK Quality and Outcomes Framework (QOF) and answering wider questions on the effectiveness of pay-for-performance (P4P) in health care." Qual Prim Care **20**(2): 81-82.
PM:22824560

Slaghuis, S. S., et al. (2013). "A measurement instrument for spread of quality improvement in healthcare." International Journal for Quality in Health Care **25**(2): 125-131.
http://intqhc.oxfordjournals.org/content/25/2/125.abstract

Objective The aim of this study was to develop and test a measurement instrument for spread of quality improvement in healthcare. The instrument distinguishes: (i) spread of work practices and their results and (ii) spread practices and effectiveness. Relations between spread and sustainability of changed work practices were also explored to assess convergent validity.Design We developed and tested a measurement instrument for spread in a follow-up study. The instrument consisted of 18-items with four subscales.Setting and participants The sample consisted of former improvement teams in a quality improvement program for long-term care (nteams = 73, nrespondents = 127). Data were collected in a questionnaire about 1 year post-pilot site improvement implementation.Interventions Quality improvements in long-term care practices.Main outcome measures Four variables were construed: (i) actions for spread of work practices, (ii) actions for spread of results, (iii) effectiveness of spread of work practices and (iv) effectiveness of spread of results.Results Psychometric analysis yielded positive results on the item level. The intended four-factor model yielded satisfactory fit. The internal consistency of each scale was fine (Cronbach's ×ñ 0.70ƒ_"0.93). Bivariate correlations revealed that the spread variables were strongly related but distinct, and positively related to the sustainability variables.Conclusions The psychometric properties are in line with methodological standards. Convergent validity was confirmed with sustainability. The measurement instrument offers a good starting point for the analysis of spread

Slawomirski, L., et al. (2017). The economics of patient safety. Strengthening a value-based approach to reducing patient harm at national level. OECD Health Working Papers ; 96. Paris OCDE**:** 65 , tabl., fig.
http://www.oecd-ilibrary.org/social-issues-migration-health/oecd-health-working-papers_18152015

About one in ten patients are harmed during health care. This paper estimates the health, financial and economic costs of this harm. Results indicate that patient harm exerts a considerable global health burden. The financial cost on health systems is also considerable and if the flow-on economic consequences such as lost productivity and income are included the costs of harm run into trillions of dollars annually. Because many of the incidents that cause harm can be prevented, these failures represent a considerable waste of healthcare resources, and the cost of failure dwarfs the investment required to implement effective prevention. The paper then examines how patient harm can be minimised effectively and efficiently. This is informed by a snapshot survey of a panel of eminent academic and policy experts in patient safety. System- and organisational-level initiatives were seen as vital to provide a foundation for the more local interventions targeting specific types of harm. The overarching requirement was a culture conducive to safety.

Smith, P. C. et Papanicolas, I. (2012). Health system performance comparison: an agenda for policy, information and research. Copenhague OMS Bureau régional de l'Europe**:** 40 , tabl., fig.
http://www.euro.who.int/__data/assets/pdf_file/0010/162568/e96456.pdf

This policy brief seeks to summarize the current state of the art of health system comparison, identifying data and methodological issues and exploring the current interface between evidence and practice. It also draws out the priorities for future work on performance comparison, in the development of measurement instruments, analytic methodology, and assessment of evidence on performance. It will conclude by presenting key lessons and future priorities policy-makers should take into account.

Smith, P. C. , et al. (2009). Performance measurement for health system improvement : experiences, challenges and prospects, Cambridge ; Cambridge University Press

In a world where there is increasing demand for the performance of health providers to be measured, there is a need for a more strategic vision of the role that performance measurement can play in securing health system improvement. This volume meets this need by presenting the opportunities and challenges associated with performance measurement in a framework that is clear and easy to understand. It examines the various levels at which health system performance is undertaken, the technical instruments and tools available, and the implications using these may have for those charged with the governance of the health system. Technical material is presented in an accessible way and is illustrated with examples from all over the world. Performance Measurement for Health System Improvement is an authoritative and practical guide for policy makers, regulators, patient groups and researchers.

SNBHW (2008). Quality and Efficiency in Swedish Health Care. Regional Comparisons 2007. Stockholm Swedish National Board of Health and Welfare**:** 186 , tabl., fig.
http://www.socialstyrelsen.se/NR/rdonlyres/1482B3AF-ED64-4B31-983F-7788AC43D020/10176/20081313.pdf

The series compares healthcare quality and efficiency in the 21 Swedish county councils and healthcare regions by using a set of national performance indicators. The purpose of publishing comparative data about healthcare performance is twofold. First, the comparisons

are a way of informing and stimulating public debate on healthcare quality and efficiency. The public, as both patients and citizens, has a right to know about the results of the healthcare services that are available to it. The second purpose is to stimulate and support local and regional efforts to improve healthcare services in terms of clinical quality and medical outcomes, as well as patient experience and efficient resource use. In county councils and healthcare regions, political representatives, managers and staff of primary care clinics and hospitals can use the comparisons to locate and pinpoint the strengths and weaknesses of their healthcare systems. Comparisons are a powerful way of driving performance improvement.

Sorbe, S. (2013). Belgium: Enhancing the Cost Efficiency and Flexibility of the Health Sector to Adjust to Population Ageing. OECD Economics Department Working Papers ; 1066. Paris OCDE**:** 33 , tabl., fig. http://dx.doi.org/10.1787/5k44ssnfdnr7-en

La Belgique a su se doter de services de santé accessibles, mais le morcellement des responsabilités au sein du système et le poids de la réglementation risquent de rendre l'adaptation au vieillissement de la population difficile. Le système pourrait être organisé plus simplement en donnant aux caisses d'assurance maladie (mutualités) un rôle plus actif dans l'amélioration de l'efficience, en alignant mieux les incitations des différents niveaux d'administration et en mettant l'accent sur la budgétisation à moyen terme. Au niveau des prestataires de santé, une meilleure circulation de l'information et de meilleures structures incitatives pourraient contribuer à atténuer les variations en termes de pratiques et d'efficience, ainsi qu'à lutter contre la demande induite par les prestataires eux-mêmes. Pour ce faire, il s'agit notamment d'achever la transition vers des budgets hospitaliers fondés sur les pathologies, d'augmenter la part de la rémunération forfaitaire des médecins et de mettre en place des mesures visant à diminuer le niveau élevé des dépenses en médicaments. Une fois que des mesures destinées à améliorer l'efficience seront en place, l'adoption d'un système davantage axé sur la demande pourrait être encouragée en supprimant progressivement les règles hospitalières excessivement normatives. En outre, les rémunérations relatives des médecins devraient être révisées régulièrement afin d'obtenir une offre adaptée dans chaque domaine de spécialité. S'agissant des soins de longue durée, la prise en charge à domicile, qui est globalement efficace au regard de son coût, pourrait être encore plus encouragée en laissant les patients organiser plus librement les soins dont ils bénéficient.

Soroka, S. N. et Mahon, A. N. (2012). Better Value:An analysis of the impact of current healthcare system funding and financing models and the value of health and healthcare in Canada. Ottawa Canadian Health Services Research Foundation / Fondation Canadienne de la Recherche sur les Services de Santé.**:** 27 , fig.
http://www.chsrf.ca/Libraries/Commissioned_Research_Reports/Soroka-BetterCare-EN.sflb.ashx

This report examines the interrelationship between measures of government spending on healthcare, health policy indicators and public attitudes on health policy to identify policy approaches capable of achieving better value in the Canadian healthcare system. After describing its context, the report considers some of the many ways in which value can be defined, setting out a working definition that deems ?better value? to mean improvements in healthcare policy indicators and/or Canadians? attitudes toward the healthcare system. Subsequent sections then explore the ways in which spending change has thus far been linked to shifts toward better value in healthcare.

Squires, D. A. (2012). "Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices, and Quality." Issues in International Health Policy: 13 , tabl.

http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/May/1595_Squires_explaining_high_hlt_care_spending_intl_brief.pdf

This analysis uses data from the Organization for Economic Cooperation and Development and other sources to compare health care spending, supply, utilization, prices, and quality in 13 industrialized countries: Australia, Canada, Denmark, France, Germany, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. The U.S. spends far more on health care than any other country. However this high spending cannot be attributed to higher income, an older population, or greater supply or utilization of hospitals and doctors. Instead, the findings suggest the higher spending is more likely due to higher prices and perhaps more readily accessible technology and greater obesity. Health care quality in the U.S. varies and is not notably superior to the

Staat, M. (2003). "The efficiency of treatment strategies of general practitioners." Hepac : Health Economics in Prevention and Care **4**(3): 232-238, 236 tab.

Les pratiques médicales des médecins généralistes ont un impact sur la production de soins ambulatoires. S'ajoutent aux prestation des généralistes les soins de spécialistes, certains soins hospitaliers, le coût des médicaments, etc. Les différents systèmes de rémunération en vigueur dans les pays modulent par ailleurs ces répercutions. A partir de l'offre de soins ambulatoires de l'Autriche, cet article tente une évaluation de l'efficience des stratégies thérapeutiques des médecins généralistes selon l'index Malmquist (mesure de la productivité).

Stausberg, J., et al. (2015). "Measuring Data Quality: A Review of the Literature between 2005 and 2013." Stud Health Technol Inform **210**: 712-716.

A literature review was done within a revision of a guideline concerned with data quality management in registries and cohort studies. The review focused on quality indicators, feedback, and source data verification. Thirty-nine relevant articles were selected in a stepwise selection process. The majority of the papers dealt with indicators. The papers presented concepts or data analyses. The leading indicators were related to case or data completeness, correctness, and accuracy. In the future, data pools as well as research reports from quantitative studies should be obligatory supplemented by information about their data quality, ideally picking up some indicators presented in this review.

Steel, N. et Willems, S. (2010). "Research learning from the UK Quality and Outcomes Framework: a review of existing research." Qual Prim Care **18**(2): 117-125.

BACKGROUND: A new contract between UK primary care practices and government was implemented in April 2004, with substantial financial rewards to general practices for achievement of standards set out in the Quality and Outcomes Framework (QOF). AIM: We aimed to review the evidence about the effects of the QOF on health care, including unintended outcomes, and equity. METHODS: Relevant papers were identified by searching Medline and from the reference lists of published reviews and papers. A separate systematic literature review was conducted to identify papers with information on the impact of the framework on inequalities. RESULTS: All studies were observational, and so it cannot be assumed that any changes were caused by the framework. The results both for individual indicators and from different studies vary substantially. The diverse nature of the research precluded formal synthesis of data from different studies. Achievement of quality standards was high when the contract was introduced, and has risen each year roughly in line with the pre-existing trend. Inequalities in achievement of standards were generally small when the

framework was implemented, and most have reduced further since. There is weak evidence that achievement for conditions outside the framework was lower initially, and has neither worsened nor improved since. Some interventions in the framework may be cost-effective. Professionals feel consultations and continuity have suffered to some extent. There is very little research about patients' views, or about the aspects of general practice not measured, such as caring, context and complexity. CONCLUSION: The evidence base about the impact of the QOF is growing, but remains patchy and inconclusive. More high quality research is needed to inform decisions about how the framework should change to maximise improvements in health and equity.

Steinmann, L., et al. (2004). "Measuring and comparing the (in) efficiency of German and Swiss hospitals." Hepac : Health Economics in Prevention and Care - European Journal of Health Economics **5**(3): 216-226, tab., graph.

A nonparametric data envelopment analysis (DEA) is performed on hospitals in the federal state of Saxony (Germany) and in Switzerland. This study is of interest from three points of view. First, contrary to most existing work, patient days are not treated as an output but as an input. Second, the usual DEA assumption of a homogeneous sample is tested and rejected for a large part of the observations. The proposed solution is to restrict DEA to comparable observations in the two countries. The finding continues to be that hospitals of Saxony have higher efficiency scores than their Swiss counterparts. The finding proves robust with regard to modifications of DEA that are motivated by differences in hospital planning in Germany and Switzerland.

Stelfox, H. T., et al. (2015). "A scoping review of patient discharge from intensive care: opportunities and tools to improve care." Chest **147**(2): 317-327.

BACKGROUND: We conducted a scoping review to systematically review the literature reporting patient discharge from ICUs, identify facilitators and barriers to high-quality care, and describe tools developed to improve care. METHODS: We searched Medline, Embase, CINAHL, and the Cochrane Central Register of Controlled Trials. Data were extracted on the article type, study details for research articles, patient population, phase of care during discharge, and dimensions of health-care quality. RESULTS: From 8,154 unique publications we included 224 articles. Of these, 131 articles (58%) were original research, predominantly case series (23%) and cohort (16%) studies; 12% were narrative reviews; and 11% were guidelines/policies. Common themes included patient and family needs/experiences (29% of articles) and the importance of complete and accurate information (26%). Facilitators of high-quality care included provider-patient communication (30%), provider-provider communication (25%), and the use of guidelines/policies (29%). Patient and family anxiety (21%) and limited availability of ICU and ward resources (26%) were reported barriers to high-quality care. A total of 47 tools to facilitate patient discharge from the ICU were identified and focused on patient evaluation for discharge (29%), discharge planning and teaching (47%), and optimized discharge summaries (23%). CONCLUSIONS: Common themes, facilitators and barriers related to patient and family needs/experiences, communication, and the use of guidelines/policies to standardize patient discharge from ICU transcend the literature. Candidate tools to improve care are available; comparative evaluation is needed prior to broad implementation and could be tested through local quality-improvement programs.

Stukel, T. A., et al. (2016). Variations in Quality Indicators Across Ontario Physician Networks. Toronto ICES**:** 107 , tabl., fig.

This chartbook reports performance levels for a set of quality indicators that reflect health care delivery across settings of primary and specialty care, acute hospital care and long-term care, as well as shared care and transitions from one setting to another. The quality indicators include screening and prevention, evidence-based medications, drug safety, hospital to community transitions, adverse outcomes, imaging and cancer end-of-life care. Costs for publicly insured health care services are also examined. These measures, assessed at the level of physician networks, provide essential information needed to guide health system transformation and foster communication around shared patients.

Sutherland, K. et Coyle, N. (2008). Quality of healthcare in England, Wales, Scotland, Northern Ireland: an intra-UK chartbook. Londres Health Foundation**:** 125 , fig., tabl.
http://www.health.org.uk/publications/research_reports/paying_the_patient.html

This chartbook is an important illustration of how currently available data can be used to create a coherent picture of the various facets of quality of healthcare ? such as access, safety, effectiveness, patient-centred care, equity and capacity for improvement ? in each of the UK countries.

Tavakoli, M. , et al. (2001). Quality in Health Care : strategic issues in health care management, Burlinghton : Ashgate Publishing Company
http://www.ashgate.com

A travers le monde, tous les systèmes de santé sont actuellement confrontés aux mêmes problématiques : maintenir ou améliorer la qualité et l'accès aux soins, tout en contrôlant les coûts. Rassemblant les contributions de différents experts du domaine, cet ouvrage traite plus particulièrement de l'amélioration de la qualité des soins sous ses approches quantitatives et qualitatives. Il tente d'en identifier les défaillances et d'y trouver des remèdes.

Terner, M., et al. (2013). "Assessing Primary Healthcare Using pan-Canadian Indicators of Health and Health System Performance." Healthcare Quarterly **16**(2): 9-12.
http://www.longwoods.com/product/23416

Updated primary healthcare (PHC) indicators are now available for use across Canada. The Canadian Institute for Health Information identified and updated two sets of priority indicators – a policy set to meet the needs of policy makers and a provider set to meet the needs of providers of PHC at the practice and organization levels. A total of 51 indicator definitions were updated to ensure that they are measurable and operational, align with clinical practice guidelines and available data sources and reflect important dimensions of PHC performance in Canada.

Thomson, R., et al. (2004). "UK Quality Indicator Project (UK QIP) and the UK independent health care sector: a new development." Int J Qual Health Care **16 Suppl 1**: i51-56.

PURPOSE: To describe implementation of the UK Quality Indicator Project (UK QIP) in the independent health care sector, drawing upon 10 years experience in the UK and approaching 20 years experience in the USA. We describe the history of the project, with an emphasis on recent developments, reflecting upon the critical features of the project and its value for participants. BACKGROUND: The International Quality Indicator Project is the largest international data set of quality indicators. It provides participants with quarterly feedback of comparative indicator data and support for effective use of these data within the participants' own quality improvement programmes. The UK QIP now includes about two-

thirds of UK private sector acute hospitals. The UK QIP began as a pilot project in the National Health Service (NHS) public sector in 1991. Implementation of the NHS performance assessment framework, and associated indicator programme, led to a reduction in public sector involvement. In contrast, the private sector, led by the Independent Healthcare Association, sought to identify a provider of key performance indicators to support both internal, within-sector drives for quality improvement and external demands produced by governmental review and the introduction of the National Care Standards Commission. The UK QIP was chosen since it provided a validated, epidemiologically sound system with capacity for support, education and flexibility to meet the changing demands of the sector. The future development of the QIP within the sector, including expansion from acute hospitals to mental health, is described. CONCLUSIONS: Reflection on the process of engagement of the UK independent sector with the QIP emphasizes the generic nature of the project and offers insights into the value of the project. Future challenges, including the issue of public accountability, are discussed in light of the project's underlying philosophy and purpose.

UniversityofYork (2008). Quality and Outcomes Framework : Joint Executive Summary : Reports to the Department of Health from the University of East Anglia & the University of York. York University of York**:** 25.
http://www.york.ac.uk/inst/che/pdf/jointexecutivesummaryUEA-York-%20270308final.pdf

In April 2004 the new General Medical Service (GMS) contract was intro-duced into UK primary care. It included a major pay for performance scheme, known as the Quality and Outcomes Framework (QOF), which used a system of financial incentives for the achievement of various qual-ity indicators. Under the QOF, payments to GP practices vary according to the proportion of patients meeting the indicator target, disease preva-lence, practice size and the number of points assigned to each indicator. Focussing on QOF indicators that are likely to have a direct therapeutic impact, our research aimed to assess the extent to which the introduction of payments could be considered a cost-effective use of resources.

Unverzagt, S., et al. (2014). "Meta-regression analyses to explain statistical heterogeneity in a systematic review of strategies for guideline implementation in primary health care." Plos One **9**(10): e110619.

This study is an in-depth-analysis to explain statistical heterogeneity in a systematic review of implementation strategies to improve guideline adherence of primary care physicians in the treatment of patients with cardiovascular diseases. The systematic review included randomized controlled trials from a systematic search in MEDLINE, EMBASE, CENTRAL, conference proceedings and registers of ongoing studies. Implementation strategies were shown to be effective with substantial heterogeneity of treatment effects across all investigated strategies. Primary aim of this study was to explain different effects of eligible trials and to identify methodological and clinical effect modifiers. Random effects meta-regression models were used to simultaneously assess the influence of multimodal implementation strategies and effect modifiers on physician adherence. Effect modifiers included the staff responsible for implementation, level of prevention and definition pf the primary outcome, unit of randomization, duration of follow-up and risk of bias. Six clinical and methodological factors were investigated as potential effect modifiers of the efficacy of different implementation strategies on guideline adherence in primary care practices on the basis of information from 75 eligible trials. Five effect modifiers were able to explain a substantial amount of statistical heterogeneity. Physician adherence was improved by 62% (95% confidence interval (95% CI) 29 to 104%) or 29% (95% CI 5 to 60%) in trials where other

non-medical professionals or nurses were included in the implementation process. Improvement of physician adherence was more successful in primary and secondary prevention of cardiovascular diseases by around 30% (30%; 95% CI -2 to 71% and 31%; 95% CI 9 to 57%, respectively) compared to tertiary prevention. This study aimed to identify effect modifiers of implementation strategies on physician adherence. Especially the cooperation of different health professionals in primary care practices might increase efficacy and guideline implementation seems to be more difficult in tertiary prevention of cardiovascular diseases.

Van D.en Berg, M. J., et al. (2014). "The Dutch health care performance report: seven years of health care performance assessment in the Netherlands." Health Research Policy and Systems **12**(1): 7. http://www.health-policy-systems.com/content/12/1/1/abstract

In 2006, the first edition of a monitoring tool for the performance of the Dutch health care system was released:the Dutch Health Care Performance Report (DHCPR). The Netherlands was among the first countries in the world developing such a comprehensive tool for reporting performance on quality, access, and affordability of health care. The tool contains 125 performance indicators; the choice for specific indicators resulted from a dialogue between researchers and policy makers. In the 'policy cycle', the DHCPR can rationally be placed between evaluation (accountability) and agenda-setting (for strategic decision making). In this paper, we reflect on important lessons learned after seven years of health care system performance assessment. These lessons entail the importance of a good conceptual framework for health system performance assessment, the importance of repeated measurement, the strength of combining multiple perspectives (e.g., patient, professional, objective, subjective) on the same issue, the importance of a central role for the patients' perspective in performance assessment, how to deal with the absence of data in relevant domains, the value of international benchmarking and the continuous exchange between researchers and policy makers.

van den Dungen, C., et al. (2013). "Quality aspects of Dutch general practice-based data: a conceptual approach." Fam Pract **30**(3): 355-361.
PM:23307817

BACKGROUND: General practice-based data, collected within general practice registration networks (GPRNs), are widely used in research. The quality of the data is important but the recording criteria about what type of information is collected and how this information should be recorded differ between GPRNs. OBJECTIVE: We aim to identify aspects that describe the quality of general practice-based data in the Netherlands. METHODS: To investigate the quality aspects, we used the method of concept mapping, a structured conceptualization process for a complex multi-dimensional topic. We explored the ideas of representatives from 10 Dutch GPRNs on the quality of general practice-based data in five steps: preparation, generation of statements, structuring, representation and interpretation. In a brainstorm session, 10 experts generated statements about good data quality from general practice, which we completed with information from the literature. In total, 18 experts participated in the ranking and clustering of the statements. These results were analysed using ARIADNE software, using a combination of principal component analysis and cluster analysis techniques. Finally, the clusters were labelled based on their content. RESULTS: A total of 72 statements were analysed, which resulted in a two-dimensional picture with six clusters, 'complete health record', 'coding of information', 'episode oriented recording', 'diagnostic validity', 'recording agreements' and 'residual category'. CONCLUSIONS: The quality of general practice-based data can be considered on five content-based aspects. These aspects determine the quality of recording

van den Heuvel, H. (2011). "A strategy for the implementation of a quality indicator system in German primary care." Qual Prim Care **19**(3): 183-191.

> BACKGROUND: The Quality and Outcomes Framework (QOF) has had a major impact on the quality of care in British general practice. It is seen as a major innovation amongst quality indicator systems and as a result various countries are looking at whether such initiatives could be used in their primary care. In Germany also the development of similar schemes has started. AIM: To propose a strategy indicating key issues for the implementation of a quality indicator scheme in German primary care. METHODS: Literature review with a focus on the QOF and German quality indicator literature. RESULTS: There are major differences between the German and British healthcare and primary care systems. The development of quality indicator systems for German general practice is in progress and there is a net force for the implementation of such systems. The following ten key factors are suggested for the successful implementation of such a system in German primary care: involvement of general practitioners (GPs) at all levels of the development, a clear implementation process, investment in practice information technology (IT) systems, an accepted quality indicator set, a quality indicator setting institution and data collection organisation, clear financial and non-financial incentives, a 'practice registration' structure, an exception reporting mechanism, delegation of routine clinical data collection tasks to practice assistants, a stepped implementation approach and adequate evaluation processes. CONCLUSION: For the successful implementation of a quality indicator system in German primary care a number of key issues, as presented in this article, need to be taken into account.

Vlayen, J., et al. (2006). Indicateurs de qualité cliniques. Bruxelles KCE**:** 184 , tabl., fig. http://kce.fgov.be/Download.aspx?ID=630

> Le défi de tout système de santé consiste à offrir des soins de qualité de manière efficace, tant en valeur absolue qu'en rapport avec les moyens mis en ?uvre (effective and efficient). Les indicateurs de qualité permettent de suivre et de mesurer cette qualité des soins mais contrairement à de nombreux autres pays, la Belgique n'a que peu d'expérience dans le développement et l'utilisation d'indicateurs de qualité au niveau politique. Le principal objectif de ce rapport est de fournir un cadre conceptuel relatif au développement et à l'utilisation d'indicateurs de qualité cliniques au niveau politique, en se basant sur une revue critique de la littérature. Le rapport se limite à la qualité des soins dans les hôpitaux aigus mais les conclusions peuvent servir de fondement à des initiatives similaires dans d'autres cadres et pour d'autres types d'indicateurs de qualité. Un second objectif de ce rapport est d'évaluer l'utilisation potentielle des bases de données du résumé clinique minimum et du résumé financier minimum (RCM/RFM) pour la mesure en Belgique des indicateurs de qualité cliniques basés sur des données probantes.

Vlayen, J., et al. (2010). Un premier pas vers la mesure de la performance du système de soins de santé belge. KCE report; 128B. Bruxelles KCE**:** 345 , annexes. http://www.kce.fgov.be/index_fr.aspx?SGREF=3460&CREF=16551

> La présente étude a pour objectif d'une part d'étudier les manières possibles de concevoir un système d'évaluation de la performance du système de soins de santé et d'autre part d'examiner leur application possible en Belgique tout en construisant et en mesurant un premier ensemble d'indicateurs.

Voigtlander, S. et Deiters, T. (2015). "[Minimum Standards for the Spatial Accessibility of Primary Care: A Systematic Review]." Gesundheitswesen **77**(12): 949-957.

BACKGROUND: Regional disparities of access to primary care are substantial in Germany, especially in terms of spatial accessibility. However, there is no legally or generally binding minimum standard for the spatial accessibility effort that is still acceptable. Our objective is to analyse existing minimum standards, the methods used as well as their empirical basis. METHODS: A systematic literature review was undertaken of publications regarding minimum standards for the spatial accessibility of primary care based on a title word and keyword search using PubMed, SSCI/Web of Science, EMBASE and Cochrane Library. RESULTS: 8 minimum standards from the USA, Germany and Austria could be identified. All of them specify the acceptable spatial accessibility effort in terms of travel time; almost half include also distance(s). The travel time maximum, which is acceptable, is 30 min and it tends to be lower in urban areas. Primary care is, according to the identified minimum standards, part of the local area (Nahbereich) of so-called central places (Zentrale Orte) providing basic goods and services. The consideration of means of transport, e. g. public transport, is heterogeneous. The standards are based on empirical studies, consultation with service providers, practical experiences, and regional planning/central place theory as well as on legal or political regulations. CONCLUSIONS: The identified minimum standards provide important insights into the effort that is still acceptable regarding spatial accessibility, i. e. travel time, distance and means of transport. It seems reasonable to complement the current planning system for outpatient care, which is based on provider-to-population ratios, by a gravity-model method to identify places as well as populations with insufficient spatial accessibility. Due to a lack of a common minimum standard we propose - subject to further discussion - to begin with a threshold based on the spatial accessibility limit of the local area, i. e. 30 min to the next primary care provider for at least 90% of the regional population. The exceeding of the threshold would necessitate a discussion of a health care deficit and in line with this a potential need for intervention, e. g. in terms of alternative forms of health care provision.

Vrijens, F., et al. (2015). La performance du système de santé belge. Rapport 2015. KCE Report; 259B. Bruxelles KCE**:** 79 , tabl., fig.
https://kce.fgov.be/fr/publication/report/la-performance-du-système-de-santé-belge-rapport-2015

À travers 106 indicateurs, portant sur la période 2008–2013, ce rapport dresse la liste des points forts et des points faibles du système, et indique aux décideurs politiques et aux responsables de notre système de santé où il serait judicieux de placer les priorités pour garder le système performant, voire l'améliorer. Cet exercice est réalisé dans beaucoup de pays européens, ce qui leur permet de se comparer et de se fixer des objectifs à atteindre pour s'aligner sur les meilleurs. De façon générale, les Belges sont satisfaits de leurs soins de santé, et 78 % s'estiment en bonne santé. Sur le plan de la qualité des soins, notre pays se situe dans la moyenne européenne. Toutefois, l'examen de l'ensemble des indicateurs livre un tableau plus nuancé et 34 signaux d'alarme ont été identifiés.

Vuori, H. (1987). "Patient satisfaction--an attribute or indicator of the quality of care?" QRB Qual Rev Bull **13**(3): 106-108.

Systematic measurement of patient satisfaction is seldom included in routine quality assurance (QA) programs. Practical reasons have been given to explain this omission: the mental and physical state of patients, their lack of the necessary scientific and technical knowledge, the rapid pace of events of care, and methodological problems related to measuring patient satisfaction. However, a strong case can be made to include patient satisfaction in QA, including ethical considerations, philosophical changes occurring in the health care field, and a clear definition of the impact of patient satisfaction on quality care.

This article concludes that patient satisfaction is part and parcel of quality health care; that patients are capable of assessing the quality of care; and that patient satisfaction can be measured.

Weinmann, S., et al. (2010). "Development of a set of schizophrenia quality indicators for integrated care." Epidemiologia E Psichiatria Sociale **19**(1): 52-62, tabl., fig.

This study aimed at developing a prioritized set of quality indicators for schizophrenia care to be used for continuous quality monitoring. They should be evidence-based and rely on routine data. A systematic literature search was performed to identify papers on validated quality indicators published between 1990 to April 2008 in MEDLINE, the Cochrane databases, EMBASE and PsycINFO. Databases of relevant national and international organizations were searched. Indicators were described with respect to meaningfulness, feasibility and actionability. A workshop with relevant stakeholders evaluated the measures through a structured consensus process. The study identified 78 indicators through literature search and selected 22 quality indicators. Furthermore, 12 structural and case-mix indicators were choosen. Only five quality indicators were rated "essential indicators" (priority 1), 14 were rated "additional first choice" (priority 2), and three were rated as "additional second choice" (priority 3). Only four indicators assessed outcome quality. In the majority of indicators the evidence base supporting the indicator recommendation was weak. None of the selected indicators was validated in experimental studies. Evidence and validation base played only a subordinate role for indicator prioritisation by stakeholders indicating that there are discrepancies between clinical questions and requirements in schizophrenia care and scientific research.

Westert, G. P. , et al. (2010). Dutch Health Care Performance Report 2010. Bilthoven RIVM**:** 270 , tabl., fig., ann.
http://www.gezondheidszorgbalans.nl/English-editions/

The overall quality-of-care ratings for 2008 were much like those in 2004 and 2006. On many indicators, the Netherlands compared well with other affluent Western nations. Uptake of preventative screenings was high. Rates of avoidable hospital admissions were low, pointing to a strong primary care and outpatient clinical care. In almost two thirds of cases, general practitioners prescribed medicines in conformity with professional guidelines.Dutch Health Care is accessible, deliveres mostly good-quality care and many improvements have been made. In some areas there is still room for improvement, such as poor telephone accessibility of GP practices during office hours.

Winters, B. D., et al. (2016). "Validity of the Agency for Health Care Research and Quality Patient Safety Indicators and the Centers for Medicare and Medicaid Hospital-acquired Conditions: A Systematic Review and Meta-Analysis." Med Care **54**(12): 1105-1111.

BACKGROUND: The Agency for Health Care Research and Quality Patient Safety Indicators (PSIs) and Centers for Medicare and Medicaid Services Hospital-acquired Conditions (HACs) are increasingly being used for pay-for-performance and public reporting despite concerns over their validity. Given the potential for these measures to misinform patients, misclassify hospitals, and misapply financial and reputational harm to hospitals, these need to be rigorously evaluated. We performed a systematic review and meta-analysis to assess PSI and HAC measure validity. METHODS: We searched MEDLINE and the gray literature from January 1, 1990 through January 14, 2015 for studies that addressed the validity of the HAC measures and PSIs. Secondary outcomes included the effects of present on admission (POA) modifiers, and the most common reasons for discrepancies. We developed pooled results for

measures evaluated by >/=3 studies. We propose a threshold of 80% for positive predictive value or sensitivity for pay-for-performance and public reporting suitability. RESULTS: Only 5 measures, Iatrogenic Pneumothorax (PSI 6/HAC 17), Central Line-associated Bloodstream Infections (PSI 7), Postoperative hemorrhage/hematoma (PSI 9), Postoperative deep vein thrombosis/pulmonary embolus (PSI 12), and Accidental Puncture/Laceration (PSI 15), had sufficient data for pooled meta-analysis. Only PSI 15 (Accidental Puncture and Laceration) met our proposed threshold for validity (positive predictive value only) but this result was weakened by considerable heterogeneity. Coding errors were the most common reasons for discrepancies between medical record review and administrative databases. POA modifiers may improve the validity of some measures. CONCLUSION: This systematic review finds that there is limited validity for the PSI and HAC measures when measured against the reference standard of a medical chart review. Their use, as they currently exist, for public reporting and pay-for-performance, should be publicly reevaluated in light of these findings.

Wong, S. T. et Haggerty, J. (2013). Measuring Patient Experiences in Primary Health Care: A review and classification of items and scales used in publicly-available questionnaires. Vancouver Centre for Health Services and Policy Research**:** 31 , tabl.
http://chspr.ubc.ca/sites/default/files/publication_files/Patient%20experiences%20in%20PHC%202013.pdf

Cette étude identifie les éléments et les indicateurs qui pourraient être utilisés dans la conception d?un sondage de base sur l'expérience des patients au Canada. La revue offre un aperçu de 17 instruments disponibles publiquement pour mesurer l'expérience des patients en matière de soins de santé primaires

Xesfingia, S. et Vozikis, A. (2014). What shapes patient's satisfaction in countries' health care systems? Munich MPRA**:** 13 , fig.
http://mpra.ub.uni-muenchen.de/59755/

Patient satisfaction is an important measure of health care quality as it offers information on the provider's success at meeting clients' expectations and is a key determinant of patients' perspective behavioral intention. This paper studies the relationship between patient's satisfaction of healthcare system and a set of socioeconomic and health provision indicators. We first construct an index of patient's satisfaction and then, at a second stage, this index is related to economic and health provision variables. Our empirical analysis relies on 31 countries and for four years. Our findings support a strong positive association between citizens' satisfaction and public health expenditures, number of physicians and nurses, and the age of the patient, while there is a negative evidence for private health spending and number of hospital beds.

Yu, T. H. et Chung, K. P. (2014). "Is the implementation of quality improvement methods in hospitals subject to the neighbourhood effect?" Int J Qual.Health Care **26**(3): 231-239.
PM:24699197

OBJECTIVE: Quality improvement (QI) methods have been fashionable in hospitals for decades. Previous studies have discussed the relationships between the implementation of QI methods and various external and internal factors, but there has been no examination to date of whether the neighbourhood effect influences such implementation. The aim of this study was to use a multilevel model to investigate whether and how the neighbourhood effect influences the implementation of QI methods in the hospital setting in Taiwan. DESIGN: This is a retrospective questionnaire-based survey. SETTING: All medical centres, regional hospitals and district teaching hospitals in Taiwan. PARTICIPANTS: Directors or

persons in charge of implementing QI methods in hospitals. INTERVENTIONS: None. MAIN OUTCOME MEASURES: The breadth and depth of QI method implementation. RESULTS: Seventy-two of the 139 hospitals contacted returned the questionnaire, yielding a 52% response rate. The breadth and depth of QI method implementation increased over the 10-year study period, particularly between 2004 and 2006. The breadth and depth of the QI methods implemented in the participating hospitals were significantly associated with the average breadth and depth of those implemented by their competitors in the same medical area during the previous period. In addition, time was positively associated with the breadth and depth of QI method implementation. CONCLUSIONS: In summary, the findings of this study show that hospitals' QI implementation status is influenced by that of their neighbours. Hence, the neighbourhood effect is an important factor in understanding hospital behaviour

Impact des modes de rémunération sur la qualité des soins

ÉTUDES FRANÇAISES

(2010). "Agir pour l'accès de chacun aux soins de qualité." Revue Prescrire(322): 638.

Les obstacles à l'accès à des soins de qualité pour tous sont nombreux et variés, et les inégalités de santé ont tendance à s'aggraver en France et dans le monde. L'amélioration de la santé passe par une réduction des inégalités socioéconomiques. Accéder aux soins dépend aussi de la démographie des soignants et de leur répartition sur le territoire, ainsi que de l'organisation des soins et des choix collectifs. Mais à quoi bon lever les obstacles à l'accès aux soins, si les soins ne sont pas de bonne qualité ? Avec des autorisations de mise sur le marché trop laxistes et une pharmacovigilance trop passive, le "marché" du médicament n'est pas assez au service des patients et trop soumis aux influences des firmes. Les politiques de santé sont à courte vue, et certaines dépenses de "santé" sont inutiles, voire nuisibles. La pléthore d'informations de santé est d'intérêt très inégal.

(2013). "Rémunération sur résultats : étendue à l'ensemble des médecins libéraux en France." Revue Prescrire **33**(351): 63-67.

Ammi, M. (2011). Analyse économique de la prévention : offre de prévention, incitations et préférence en médecine libérale. Dijon Université de Bourgogne, Université de Bourgogne. Dijon. FRA**:** 545 , tab., graph., fig.
https://halshs.archives-ouvertes.fr/tel-00859358/document

Dans le champ de la santé, l'économie traditionnelle de la prévention s'articule autour d'une logique de la demande. Si elle est riche d'enseignements sur les comportements individuels de prévention et les interventions publiques en la matière, elle est muette quant au rôle de l'offre de prévention. Cette thèse vise à enrichir l'analyse économique de la prévention d'une logique de l'offre et particulièrement celle du médecin de ville, à étudier les incitations à cette offre et les préférences de ce producteur de services médicaux. Une analyse institutionnelle de l'offre de prévention du médecin français souligne ses lacunes, liées à l'environnement institutionnel, et montre la nécessité d'inciter cet acteur, en particulier lorsque le mode dominant de rémunération est le paiement à l'acte. L'analyse des incitations à la prévention précise qu'un paiement complémentaire à la performance est opérant sous conditions, et que les incitations ne se limitent pas au seul levier monétaire, des incitations non financières et organisationnelles étant des instruments pertinents. L'efficacité des

incitations dépend néanmoins des motivations des médecins et de leur perception de ces dispositifs. Ces perceptions sont approchées empiriquement en révélant les préférences des médecins libéraux face à différents dispositifs incitatifs. Une approche novatrice d'évaluation économique, la méthode des choix discrets, fonde une enquête et l'exploitation économétrique des données collectées. Les résultats d'une

Andriantsehenoharinala, L. (2014). Les médecins ayant refusé la rémunération sur objectifs de santé publique (ROSP)/paiement à la performance (P4P): une approche qualitative des raisons exprimées de leur refus. Montpellier Université de Montpellier 1, Université de Montpellier 1. Faculté de Médecine. Montpellier. FRA. **Thèse de médecine:** 208.
http://www.atoute.org/images/2014/these%20refus%20ROSP%20-%20ANDRIAN.pdf

CONTEXTE : La convention nationale entre médecins généralistes et assurance maladie signée le 26 juillet 2011 et entrée en vigueur le 1e janvier 2012 consacre un nouveau dispositif, la « rémunération sur objectifs de santé publique » (ROSP), qui fait partie des paiements à la performance (P4P, pay for performance). Un espace est ménagé pour les généralistes souhaitant rester conventionnés, mais refusant cette rémunération. PROBLEMATIQUE : Pourquoi ces généralistes refusent-ils, alors que la majorité de leurs confrères ont accepté, qu'il s'agit d'augmenter leurs revenus et que le dispositif parle de santé publique et de qualité des soins ? OBJECTIFS : Décrire, analyser, comparer les raisons exprimées du refus. METHODE : Etude qualitative avec un questionnaire à but descriptif, administré à 42 médecins, permettant ensuite de choisir n=13 généralistes. Puis étude qualitative par entretiens téléphoniques semi-dirigés de ces 13 médecins et analyse thématique. RESULTATS : Les médecins réfutent les résultats attendus : il n'y aura ni amélioration des pratiques, ni amélioration de la santé individuelle ou de la santé publique, ni d'économies sur les dépenses de santé. D'une part parce que les indicateurs sont incapables de juger de la qualité des soins, de la santé des populations et surtout sont incapables de manifester du « travail invisible ». Egalement à cause des enjeux éthiques, moraux et déontologiques : le conflit d'intérêt, comme la transformation du contrat moral de moyens en résultats, sont au cœur de leurs griefs et à la source des effets pervers du dispositif. D'autre part, les médecins réfutent la légitimité du dispositif, dénoncent l'illusion de volonté d'améliorer les pratiques par les tutelles, leur politique d'empêchement de la qualité et leurs propres conflits d'intérêt industriels ainsi que leur stratégie de pouvoir.

Bacache-Beauvallet, M. (2011). "Rémunération à la performance. Effets pervers et désordre dans les services publics." Actes de la recherche en sciences sociales **189**(4): 58-71.
http://www.cairn.info/revue-actes-de-la-recherche-en-sciences-sociales-2011-4-page-58.htm

Barlet, M., et al. (2011). "Médecins généralistes : que pensent-ils de leur rémunération ?" Revue Francaise Des Affaires Sociales(2-3): 124-155.

[BDSP. Notice produite par MIN-SANTE R0xA7qtm. Diffusion soumise à autorisation]. Des nouveaux modes de rémunération des médecins généralistes libéraux (forfaits, paiement à la performance...) se développent en France à l'instar de ce qui se passe dans les autres pays de l'OCDE. À partir d'une enquête auprès de 1 900 médecins généralistes libéraux, l'article analyse l'opinion des médecins sur l'introduction de nouveaux modes de rémunération : 61% y sont favorables et 39% défavorables. Ainsi, l'adhésion d'une forte majorité des médecins nécessiterait la mise en place de modes de rémunération mixtes offrant un véritable choix au médecin. Pour environ un cinquième des médecins interrogés, c'est avant tout le niveau de leur rémunération qui est une source forte d'insatisfaction. Une classification des médecins à partir de leurs opinions sur les modes de rémunération et sur leur niveau de vie permet de distinguer sept profils de médecins.

Bonastre, J., et al. (2013). "Activité, productivité et qualité des soins des hôpitaux avant et après la T2A." Questions D'economie De La Sante (Irdes)(186): 8. http://www.irdes.fr/Publications/Qes2013/Qes186.pdf

Introduite en 2004-2005, la tarification à l'activité (T2A) permet de financer l'activité de court séjour des hôpitaux publics et privés afin d'améliorer l'efficience des établissements de santé et du secteur hospitalier. Pour autant, le suivi de l'impact de la T2A sur l'évolution de l'activité, de la productivité hospitalière et de la qualité des soins restait partiel à ce jour. Cette étude fournit de nouvelles données et analyses quantitatives permettant de répondre à différentes questions : la mise en place de la T2A a-t-elle permis d'accroître la productivité ? La structure de la production a-t-elle été modifiée ? Comment la qualité des soins a-t-elle évolué ?

Bourjac, M. (2005). "T2A : prend-elle en compte la qualité des soins ?" Revue Hospitaliere De France(505): 28-32.

[BDSP. Notice produite par ENSP S7OR0xVQ. Diffusion soumise à autorisation]. L'arrivée de la tarification (T2A) dans les établissements de santé français provoque dans le corps médical des réactions variées allant de l'indifférence polie à la franche panique. Les inquiétudes portent souvent sur une possible dégradation de la qualité des soins résultant de cette réforme. La qualité des soins est une variable peu ou pas mesurée, mais au centre des préoccupations du monde de la santé puisque généralement mise en avant dans les critiques du système et les négociations budgétaires : on demande une augmentation de moyens au prétexte qu'elle entraînerait immanquablement une dégradation de la qualité des soins ; on explique ses surcoûts autant par une meilleure qualité du service rendu que par des spécificités du recrutement. La T2A cherche à déterminer l'essentiel des ressources financières des établissements de santé en fonction de leur activité réelle, exprimée en séjours (RSS : résumé de sortie standardisé), voire en journées (réanimation ; RHS : résumé hebdomadaire standardisé). L'allocation de ressources repose sur un tarif par groupe de prise en charge. Le tarif est déterminé par la moyenne des coûts constatés, indépendamment de la qualité des soins prodigués, laquelle n'est pas évaluée. Dans ces conditions, l'amélioration de la qualité des soins fait-elle partie des objectifs de la T2A ? La qualité de la méthode d'expression de l'activité et de détermination des tarifs permet-elle de garantir celle des soins ? Quels sont les effets potentiels, favorables ou défavorables, du passage à la T2A sur la qualité des soins ?

Bras, P. L. (2011). "Le contrat d'amélioration des pratiques individuelles (CAPI) à la lumière de l'expérience anglaise." Journal D'economie Medicale **29**(5): 216-230.

[BDSP. Notice produite par ORSRA mn8kR0xo. Diffusion soumise à autorisation]. Des dispositifs de rémunération selon les performances ont été mis en place en Angleterre (Quality Outcome Framework, QOF) et en France (contrat d'amélioration des pratiques, CAPI) pour les médecins de premier recours. La mise en regard de ces deux démarches fait apparaître des divergences fondamentales. Le système français est plus fruste que le dispositif anglais (moindre investissement, indicateurs limités, introduction d'objectifs d'économies immédiates, quasiment pas d'indicateurs de résultats, absence de modulation selon la composition ou le comportement de la patientèle, gestion des données externes au cabinet). La rusticité du système français s'explique notamment par le contexte politique des relations avec le corps médical. Le système anglais a été négocié avec les représentants de médecins et fait l'objet d'un large consensus au sein du corps médical. Le système français a

été mis en place malgré l'opposition du corps médical. Par ailleurs, l'essentiel des différences tient non pas au dispositif lui-même mais à ses destinataires. Le QOF s'adresse à des cabinets dotés d'outils informatiques développés et organisés en équipe. Ils peuvent de ce fait gérer les incitations qui leur sont adressées. En France, le dispositif s'adresse à des médecins isolés qui disposent de peu de moyens techniques ou humains. Le contexte d'implantation apparaît comme un élément déterminant des effets que l'on peut attendre de cette forme de rémunération.

Bras, P. L. et Duhamel, G. (2008). Rémunérer les médecins selon leurs performances : les enseignements des expériences étrangères. Paris La documentation française**:** 65. http://www.ladocumentationfrancaise.fr/rapports-publics/084000596/index.shtml

Certains pays ont adopté le dispositif de rémunération des médecins en fonction de leurs performances. Ce rapport présente les exemples britannique et américain : contexte, dispositif, paiement, coûts, résultats et perspectives. Il s'interroge sur la nature de la performance : qualité clinique, relations avec les patients, efficience D'autres questions se posent, telles la cohésion entre la gestion de la performance et le dossier médical personnel, la conception des indicateurs cliniques, l'adhésion et la motivation des médecins, la collecte et le contrôle des données... De cette étude, les auteurs tirent des enseignements pour la France, notamment sur l'opportunité d'implanter ce système de paiement.

Bruant-Bisson, A., et al. (2012). Évaluation des effets de la tarification à l'activité sur le management des établissements de santé. Rapport IGAS ; 2012 011. Paris IGAS**:** 97. http://www.igas.gouv.fr/spip.php?article287

[BDSP. Notice produite par MIN-SANTE R0xkBq89. Diffusion soumise à autorisation]. Ce rapport consacré à l'évaluation des effets de la tarification à l'activité (T2A) sur le management des établissements de santé a été inscrit au programme d'activité de l'Inspection générale des affaires sociales. Prévue par la loi de financement de la sécurité sociale pour 2004, la tarification à l'activité se substitue à la dotation globale versée aux établissements de santé publics et privés participant au service public hospitalier depuis 1984, et au paiement à la journée applicable dans les établissements privés a but lucratif, avec un double objectif : rétablir un lien entre le financement et l'activité des établissements de santé ; instaurer l'équité de traitement entre établissements. Il s'agissait de faire disparaître progressivement les disparités de financement constatées entre des établissements ayant des tailles, des volumes et des secteurs d'activité comparables.

Burnel, P. (2017). "L'impact de la T2A sur la gestion des établissements publics de santé." Journal De Gestion Et D'economie Medicales **35**(2): 67-79. https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-2-page-67.htm

Le présent article a pour objet de faire un point, après 12 ans de mise en œuvre, sur les effets induits par la tarification à l'activité (T2A) sur la gestion et l'organisation des établissements publics de santé (EPS). Il met en évidence, en s'appuyant sur la littérature, que les effets attendus en termes d'efficience ne se sont que partiellement réalisés. Les EPS n'ont pas révisé en profondeur leurs processus et leurs organisations se contentant de mesures d'ajustement sur les charges variables. Il s'ensuit une dégradation des conditions de travail et une perte de sens qui affecte les personnels soignants et, parfois médicaux. Pour dépasser ces limites, cet article explore les voies d'un approche réellement médico-économique centrée sur la refonte des processus de prise en charge en se fondant sur ce qui motive l'action des personnels soignants : les dynamiques du progrès médical qui offre des opportunités nouvelles et la recherche de l'amélioration de la qualité des soins.

Cnamts (2010). Contrat d'Amélioration des Pratiques Individuelles (CAPI) : une dynamique au bénéfice des patients, Paris : Cnamts
http://www.ameli.fr/fileadmin/user_upload/documents/Dp_capi_16_09_2010_vdef.pdf

> Depuis juin 2009, l'Assurance Maladie propose aux médecins traitants qui le souhaitent de s'engager dans une action de santé publique à l'échelle de leur patientèle avec le Contrat d'Amélioration des Pratiques Individuelles, le CAPI, dont l'objectif est de valoriser la qualité et l?efficience des soins. Ce dossier fait un bilan des CAPI à sa date d'anniversaire : le 1et juillet 2010.

Cnamts (2013). Rémunération sur objectifs de santé publique. Une mobilisation des médecins et de l'assurance maladie en faveur de la qualité des soins, Paris : Cnamts

> Mise en place depuis le 1er janvier 2012, la Rémunération sur Objectifs de Santé Publique (ROSP), qui figure au rang des axes majeurs de la convention Médecins -Assurance Maladie signée en juillet 2011 pour 5 ans, concerne aujourd'hui tous les médecins libéraux. La ROSP s'inscrit dans la continuité de la maîtrise médicalisée des dépenses de santé et des thèmes sur lesquels l'ensemble des médecins s'est mobilisé avec l'Assurance Maladie. Cette rémunération sur objectifs de santé publique est entrée en vigueur en 2012 et les premières rémunérations afférentes ont été versées aux médecins concernés à partir du 8 avril 2013. Cette première année d'exercice permet donc de dresser un bilan annuel et, à partir de cette photographie de la situation à fin 2012, de hiérarchiser les priorités, construire le plan d'action et mesurer, demain, les mouvements qui continueront de s'opérer (tiré de l'intro.).

Cnamts (2014). La rémunération sur objectifs de santé publique, deux ans après : des progrès significatifs en faveur de la qualité et de la pertinence de soins, Paris : Cnamts
http://www.ameli.fr/fileadmin/user_upload/documents/10042014_DP_Bilan_ROSP_2_ans_2013.pdf

> Dans le cadre de la convention médicale, l'Assurance Maladie et les syndicats de médecins ont mis en place une nouvelle rémunération des médecins fondée sur l'atteinte d'objectifs de santé publique. Cette rémunération comporte pour les médecins traitants, les cardiologues et les gastroentérologues, quatre volets relatifs à la prévention, au suivi des pathologies chroniques, à la prescription de médicaments et à l'organisation du cabinet. Pour les autres médecins, elle comprend un volet unique relatif à l'organisation du cabinet. Deux ans après sa mise en place, le dispositif de Rémunération sur objectifs de santé publique confirme la progression observée en 2012 qui se poursuit en 2013, au service de la qualité et de l'efficience du système de soins. Le taux général d'atteinte des objectifs s'améliore, en effet, significativement : il passe en un an de 51,1% à 59,7% pour l'ensemble des omnipraticiens1, soit 8,6 points de plus. Cette évolution s'inscrit dans un contexte d'opinion de plus en plus favorable : selon une enquête conduite fin 2013, 7 Français sur 10 considèrent désormais que le système de rémunération sur objectifs de santé publique est une bonne chose. Quant aux médecins, s'ils étaient plutôt réservés vis-à-vis de la mise en place de la relation contractuelle individualisée, en 2011, ils sont aujourd'hui 57% (dont 71% pour les médecins ayant signé un CAPI) à considérer que l'Assurance Maladie les aide par cette évolution à atteindre leurs objectifs de santé publique. De surcroît, pour l'ensemble des objectifs fixés par la convention médicale de 2011, plus de 80% des médecins généralistes interrogés déclarent avoir fait évoluer leurs pratiques ou prévoient de le faire dans l'année qui vient. Ces perceptions positives trouvent une traduction concrète dans les indicateurs de suivi de la ROSP.

Cnamts (2015). La rémunération sur objectifs de santé publique : une amélioration continue en faveur de la qualité et de la pertinence de soins. Bilan à 3 ans, Paris : Cnamts

Cnamts (2016). La rémunération sur objectifs de santé publique. Une amélioration continue en faveur de la qualité et de la pertinence de soins. Bilan à 4 ans, Paris : Cnamts
http://www.ameli.fr/fileadmin/user_upload/documents/10042014_DP_Bilan_ROSP_2_ans_2013.pdf

Après 4 ans de mise en oeuvre, le bilan de la Rémunération sur objectifs de santé publique (Rosp) témoigne de l'intérêt du dispositif comme levier d'évolution des pratiques chez les plus de 110 000 médecins libéraux éligibles. Entre 2011 et 2015, celle-ci a encouragé une prise en charge améliorée des malades chroniques et une prescription plus pertinente et efficiente au service de la maitrise des dépenses de santé ; de plus, elle a agi comme levier de modernisation du cabinet médical, pour le bénéfice des patients. Le taux d'atteinte global pour les médecins généralistes et les médecins à expertise particulière1 est passé de 52,9% à 68,3%2 entre 2012 et 2015. Seul bémol, les indicateurs du volet prévention ne progressent pas.

Cnamts (2017). La rémunération sur objectifs de santé publique. Bilan à 5 ans et présentation du nouveau dispositif, Paris : Cnamts
www.ameli.fr/fileadmin/user_upload/documents/DP_bilan_ROSP_2016_du_21_avril_def.pdf

Après 5 années de mise en oeuvre, le bilan de la Rémunération sur objectifs de santé publique (Rosp) est globalement positif et témoigne de son intérêt comme levier d'évolution des pratiques des médecins libéraux. Malgré un ralentissement observé en 2016, la progression des pratiques se poursuit et montre que cette rémunération complémentaire encourage globalement une meilleure prise en charge des malades chroniques et une prescription plus pertinente et efficiente au service de la qualité et de la maîtrise des dépenses. Elle n'aura cependant pas réussi à inverser la tendance à la baisse des pratiques de dépistage et de vaccination, qui connaissent depuis plusieurs années un contexte de défiance et qui impliquent des efforts de tous les acteurs au-delà des médecins. Fort de ces résultats encourageants, le dispositif a été reconduit dans le cadre de la nouvelle convention médicale signée en 2016. Un dispositif renouvelé, recentré sur la seule pratique clinique et intégrant de nouveaux indicateurs s'appliquera à partir de cette année.

Da, Silva., N.. (2014). La qualité des soins est-elle soluble dans la quantification ? Une critique du paiement à la performance médicale. EconomiX Working Papers; 2014-31. Paris Université de Paris 10**:** 20.
http://economix.fr/pdf/dt/2014/WP_EcoX_2014-31.pdf

L'une des réponses de la politique publique au défi de l'amélioration de la qualité des soins est la mise en place de mécanismes de paiement à la performance qui incite le médecin à atteindre des objectifs chiffrées de qualité. L'hypothèse implicite est que la qualité des soins est soluble dans la quantité. Les normes quantifiées sensées traduire la qualité des soins proviennent des résultats de l'Evidence Based Medicine (EBM) et de sa méthode de recherche principale : l'essai clinique randomisé. Nous développons dans cet exposé deux critiques épistémologiques majeures sur cette utilisation de l'EBM. D'une part, l'épistémologie implicite des objets statistiques qui sous-tend cette méthode est problématique : la maladie n'est pas phénomène indépendant du malade et l'essai clinique randomisé n'est pas une méthode neutre et impartiale. D'autre part, il est également douteux de considérer le soin comme un bien de consommation infiniment reproductible : le service de soin n'est pas un produit.

Dormont, B. (2013). "Le paiement à la performance : contraire à l'éthique ou au service de santé publique ?" Seve : Les Tribunes De La Sante(40): 53-61.

> Mis en place en 2012 sous la forme d'une «rémunération sur objectifs de santé publique», le paiement à la performance a conduit en France au versement d'une rémunération moyenne de 4752 euros aux omnipraticiens. À l'origine ce type de paiement avait soulevé l'opposition du Conseil de l'ordre et de nombreuses critiques émanant de médecins et de chercheurs en sciences sociales. Face à ces oppositions de principe, l'état des lieux montre une variabilité considérable des pratiques en médecine ambulatoire et une prise en charge des maladies chroniques insuffisante chez la majorité des médecins. C'est pourquoi il est conforme à l'éthique de chercher à modifier les comportements afin d'encourager les actes préventifs et d'améliorer l'accès de tous à des soins de qualité. Cependant, comme toute incitation financière, le paiement à la performance peut avoir des effets contraires aux objectifs recherchés. Il est donc important qu'il ne constitue qu'une partie limitée de la rémunération du médecin et qu'une évaluation rigoureuse de ses effets soit systématiquement réalisée(résumé de l'éditeur).

Ferrua, M., et al. (2015). "Incitation Financière à l'Amélioration de la Qualité (IFAQ) pour les établissements de santé français : Résultats de l'expérimentation (2012-2014)." Journal De Gestion Et D'economie Medicales **33**(4-5): 277-290, tabl., graph., rés.

> [BDSP. Notice produite par ORSRA o8R0xoCI. Diffusion soumise à autorisation]. Une expérimentation sur l'Incitation financière à la qualité (IFAQ) a été lancée en France en juin 2012 par le Ministère de la Santé et la Haute Autorité de Santé. Un groupe de travail composé des fédérations hospitalières, des administrations chargées de la santé et de l'assurance maladie a été créé. L'équipe du projet COMPAQH (EA7348-Management des Organisations de Santé, EHESP) a été missionnée pour l'élaboration de la méthode et la conduite de l'expérimentation. La construction du modèle s'est notamment appuyée sur le programme référent en termes de paiement à la performance développé aux Etats-Unis : Hospital Value Based Purchasing (VBP). L'objectif d'IFAQ est de construire un modèle approprié au contexte français permettant de classer les établissements de santé et de rémunérer les meilleurs d'entre eux en fonction de leurs résultats, mais également de leur progression. Le modèle est basé sur l'évaluation de la qualité des établissements de santé à partir d'indicateurs de qualité et de sécurité des soins issus des démarches nationales, de la certification HAS et du niveau de développement de l'informatisation. 222 établissements de santé ont été retenus pour participer à l'expérimentation, 93 ont reçu une rémunération. Le montant de la rémunération dépend du classement et de la valorisation financière de son activité d'hospitalisation en MCO (Médecine Chirurgie Obstétrique) versée par l'assurance maladie. L'expérimentation IFAQ s'est inspirée du modèle VBP mais des différences existent notamment en termes de choix des composantes, du choix de l'expression des résultats des indicateurs, de la prise en compte de l'évolution des résultats et du système d'incitation.

Festy, F. (2011). La nouvelle convention médicale récompensera aussi bien les médecins les plus efficients que ceux qui ont la main lourde sur l'ordonnance?http://puppem.com/Actualites.aspx_

> Cette étude démontre que l'Assurance maladie a été un peu vite en besogne pour fixer ses indicateurs d'efficience de la prescription dans le cadre de la nouvelle convention médicale. Après avoir dressé le tableau comparatif des indicateurs d'efficience de la prescription médicamenteuse entre la nouvelle convention médicale et l'ancien CAPI, François Pesty se lance dans une étude, qui a certainement nécessité énormément de calcul, sur le coût des prescriptions de deux médecins généralistes,

dénommés EFFICIUS et PICSOU, qui obtiendront chacun en 2012 la prime maximale d'efficience, malgré des pratiques plutôt divergentes sur l'efficience. Et de conclure que les objectifs d'efficience de la prescription tels qu'ils ont été fixés dans la nouvelle convention ne favorisent que très peu la juste prescription

Hirtzlin, I. (2017). "Le financement des établissements de santé par la Tarification à l'Activité : impasses et pistes de solutions." Journal De Gestion Et D'economie Medicales **35**(2): 81-92. https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-2-page-81.htm

Hirtzlin, I. (2017). "Le financement des établissements de santé par la Tarification à l'Activité : impasses et pistes de solutions." Journal De Gestion Et D'economie Medicales **35**(2): 81-92.

[BDSP. Notice produite par ORSRA qsAnR0xr. Diffusion soumise à autorisation]. La tarification basée sur l'activité médicale reposant sur les diagnostics principaux des patients a d'abord été expérimentée par le dispositif Medicare, puis généralisée aux États Unis, avant de se diffuser à la plupart des pays d'Europe de l'Ouest, y compris la France, où elle a pris le nom de Tarification à l'activité à partir de 2008. L'efficience attendue du dispositif repose sur le principe de la concurrence par comparaison. La T2A connaît aujourd'hui des remises en cause liées aux limites de l'application pratique des principes incitatifs théoriques. Des pistes de solutions sont explorées dans cet article. Leur objectif est de réintroduire une composante économique dans le calcul des coûts et de tarifer en fonction des bonnes pratiques. Par ailleurs, comme la prise en charge du patient s'insère dans un établissement de santé il convient de tenir compte de ses contraintes productives et de son organisation.

Holue, C. (2012). "Le paiement à la performance est-il un jeu de dupes ?" Medecins : Bulletin D'information De L'ordre National Des Medecins(22): 10-12.

Le paiement à la performance a été instauré par la nouvelle convention nationale organisant les rapports entre les médecins libéraux et l'Assurance maladie, signée en juillet 2011 (Journal officiel du 22 septembre). Ce dispositif remplace et amplifie le contrat pour l'amélioration des pratiques individuelles (CAPI), qui s'adressait aux seuls médecins généralistes. Il s'applique à tous les médecins qui ne l'ont pas refusé par lettre recommandée à leur caisse primaire d'assurance maladie avant le 26 décembre 2011, c'est-à-dire à l'immense majorité d'entre eux. Le déploiement du P4P se déroule en deux temps. Il concerne d'abord les médecins traitants avec une rémunération maximale annuelle de 9 100 euros sur la base de 800 patients, mais le volet « organisation du cabinet » (1 750 euros) s'adresse dès maintenant à toutes les spécialités. Il sera ensuite adapté aux cardiologues, aux endocrinologues, aux pédiatres et aux gastro-entérologues, puis progressivement aux autres spécialités.

Jiang, S., et al. (2013). "The rationale for the french experiment with P4P (Ifaq): lessons from abroad." Journal De Gestion Et D'economie Medicales **30**(7-8): 435-453.

A pay-for-performance (P4P) initiative is launched in 2012 for French hospitals. The research group COMPAQ8Hpst has been mandated to develop the methodology of the experiment. Previous P4P programs in other countries have been reviewed, and their strenghts and weaknesses have been analysed....

Jiang, S., et al. (2012). "The rationale for the french hospital experiment with P4P (IFAQ) : lessons from abroad." Journal De Gestion Et D'economie Medicales **30**(7-8): 435-453, rés., tabl., ann.

[BDSP. Notice produite par ORSRA qGR0xClr. Diffusion soumise à autorisation]. Une initiative relative au paiement à la performance (P4P) a été lancée en 2012 pour les hôpitaux français. Le projet COMPAQ-Hpst a été chargé d'élaborer la méthodologie de cette expérimentation. L'analyse des initiatives étrangères, de leurs forces et faiblesses, a permis de proposer un programme, tenant compte des spécificités françaises, qui a fait l'objet d'une concertation avec les représentants du Ministère de la Santé (Direction Générale de l'Offre de Soins-DGOS), de la Haute Autorité de Santé et les quatre fédérations hospitalières. Cet article présente les leçons tirées de l'étranger, et comment elles ont été ou non adoptées dans le design du P4P français. (résumé d'auteur).

Lalloue, B., et al. (2017). Evaluation of the effects of the French Pay-for-Performance program: IFAQ pilot study**:** Document sous embargo.
https://ideas.repec.org/p/hal/journl/hal-01579386.html

Most studies showed no or little effect of pay-for-performance (P4P) programs on different outcomes. In France, the P4P program IFAQ was generalized to all acute care hospitals in 2016. A pilot study was launched in 2012 to design, implement and assess this program. This article aims to assess the immediate impact of the 2012–14 pilot study. Design and setting From nine process quality indicators (QIs), an aggregated score was constructed as the weighted average, taking into account both achievement and improvement. Among 426 eligible volunteer hospitals, 222 were selected to participate. Eligibility depended on documentation of QIs and results of hospital accreditation. Hospitals with scores above the median received a financial reward based on their ranking and budget. Several characteristics known to have an influence on P4P results (patient age, socioeconomic status, hospital activity, casemix and location) were used to adjust the models. Intervention To assess the effect of the program, comparison between the 185 eligible selected hospitals and the 192 eligible not selected volunteers were done using the difference-in-differences method. Results Whereas all hospitals improved from 2012 to 2014, the difference-in-differences effect was positive but not significant both in the crude (2.89, P = 0.29) and adjusted models (4.07, P = 0.12). Conclusion These results could be explained by several reasons: low level of financial incentives, unattainable goals, too short study period. However, the lack of impact for the first year should not undermine the implementation of other P4P programs. Indeed, the pilot study helped to improve the final model used for generalization.

Massin, S., et al. (2014). "Les médecins généralistes face au paiement à la performance et à la coopération avec les infirmiers." Etudes Et Resultats (Drees)(873): 8.
http://www.drees.sante.gouv.fr/les-medecins-generalistes-face-au-paiement-a-la-performance,11266.html

[BDSP. Notice produite par MIN-SANTE I9oR0xq9. Diffusion soumise à autorisation]. Les conditions d'exercice de la médecine générale connaissent d'importantes évolutions. La quasi-totalité des médecins interrogés fin 2012 déclarent avoir adhéré à la Rémunération sur objectifs de santé publique mise en place par l'Assurance maladie en janvier 2012, et 80% d'entre eux pensent pouvoir en remplir les objectifs. En revanche, ils sous-estiment la rémunération que ce dispositif leur permettrait de recevoir. Un tiers d'entre eux se déclare favorable à des coopérations avec un infirmier. Ce résultat est très sensible au mode de financement d'un tel dispositif : la coopération est nettement mieux acceptée dans le cas où l'auxiliaire médical serait entièrement rémunéré par un forfait extérieur. Les tâches relevant des compétences réglementaires du médecin, comme les prescriptions, seraient moins volontiers confiées à un infirmier, contrairement aux actes d'éducation thérapeutique ou de surveillance de la tension artérielle.

Lepage, M., et Ventelou, B. (2016). "The true impact of the French pay-for-performance program on physicians' benzodiazepines prescription behavior." Eur J Health Econ **17**(6).

OBJECTIVES: The French pay-for-performance (P4P) contract CAPI implemented by the national health insurance included a target-goal which aims at reducing benzodiazepines prescriptions. In this investigation, we would like to assess whether: (1) the general practitioners (GPs) having signed P4P contract obtain better results regarding the target-goal than non-signatories; (2) (part of) this progression is due to the CAPI contract itself (tentative measurement of a "causal effect"); (3) (part of) the money spent on this P4P incentive can be self-financed with the amount of pharmaceuticals saved. METHODS: We matched cross-sectional and longitudinal data including 4622 French GPs from June 2011 to December 2012. A treatment effect model using instrumental variables was performed to take into account potential self-selection issue in signing. After having identified the NET impact of the P4P, we calculate the cost of an avoided benzodiazepines treatment. RESULTS: In our study, GPs who have signed the CAPI contract (36 % of the sample) are more numerous in achieving benzodiazepines target goal than non-signatories: 90.7 vs. 85.5 %. After controlling for the self-selection bias, the propensity of GPs to achieve the benzodiazepines target is only 0.31 % higher for signatories than for their non-signing counterparts-estimate for June 2012, which yields a statistically significant gap. Our economic analysis demonstrates that the CAPI contract does not allow savings, but presents in 2012 a NET cost of 93.6<euro> per avoided benzodiazepines treatment (291<euro> in 2011). CONCLUSIONS: The P4P contract has a positive but modest impact on the achievement of GPs regarding benzodiazepines indicator.

Milcent, C. (2017). "Premier bilan de la tarification à l'activité (T2A) sur la variabilité des coûts hospitaliers." Economie & prévision **210**(1): 67.
http://www.cairn.info/revue-economie-et-prevision-2017-1-page-45.htm

Ce papier étudie la variabilité des coûts hospitaliers pour des séjours comparables en pathologies et en procédures (GHM). À l'époque du budget global, une forte variabilité des coûts était observée entre les hôpitaux publics français. Qu'en est-il aujourd'hui ? Théoriquement, la T2A conduit les établissements à minimiser leurs coûts pour gagner la différence entre le forfait et le coût. Nous montrons une certaine homogénéisation des coûts et une réelle prise en compte de l'hétérogénéité des individus. Les forfaits par GHM ne capturent cependant pas toute l'hétérogénéité entre les établissements, ni entre les patients. Ainsi, les effets néfastes de sélection des patients ou de diminution du niveau de qualité ne sont pas évités par les forfaits actuels.

Moisdon, J.-C. (2014). "Payer la qualité des soins à l'hôpital ?. Réflexions à propos d'un dispositif innovant : l'expérimentation IFAQ (Incitation Financière à la Qualité)." Quaderni **85**(3): 29-38.
http://www.cairn.info/revue-quaderni-2014-3-page-29.htm

IFAQ (Incitation Financière à la Qualité) est une expérimentation visant à anticiper les effets d'une rémunération des établissements de santé français en fonction de leur performance évaluée à partir d'indicateurs. L'article commente cette opération sous trois aspects : le processus de construction du dispositif, largement coopératif, la complexité du modèle aboutissant à un score global pour tout établissement, et les mécanismes qui y ont conduit, la question de la compatibilité entre un incitatif national construit à partir d'indicateurs de processus et une gestion locale de la qualité par les équipes de soignants elles-mêmes.

Mougeot, M. et Naegelen, F. (2014). "La tarification à l'activité : une réforme dénaturée du financement des hôpitaux." Revue française d'économie **XXIX**(3): 111-141.

http://www.cairn.info/revue-francaise-d-economie-2014-3-page-111.htm

> Cet article étudie les propriétés et la mise en œuvre de la politique de tarification à l'activité (T2A) introduite en France en 2004 pour le financement des hôpitaux. Une première partie montre que cette tarification forfaitaire destinée à assurer l'efficacité productive se heurte à des limites importantes tenant à la difficulté de la rendre crédible, à l'absence d'une demande élastique au prix, à ses effets en termes de qualité des soins et à l'hétérogénéité des offreurs et des patients. La seconde partie montre que la mise en œuvre concrète a abouti à une procédure extrêmement complexe qui a perdu ses propriétés incitatives et qu'une succession de mesures incohérentes avec l'objectif initial ont transformée en un mécanisme de remboursement du coût, conjugué à une logique manipulable de découpage d'enveloppes budgétaires.

Or, Z. (2009). "Activity based payment in France." Euro Observer - Health Policy Bulletin of the European Observatory on Health Systems and Policies **11**(4): 5-6.
http://www.euro.who.int/__data/assets/pdf_file/0016/80332/EuroObserver_Winter2009.pdf

> The French hospital system is characterized by a wide choice of public and private providers. More than one third of all inpatient care and 56% of all surgery are provided by private for-profit hospitals. Patients can choose freely between public and private hospitals. Activity based payment (ABP) was first introduced in 2004/ 2005 to pay for acute care services (including home hospitalization) with the objectives of improving efficiency; creating a level playing field for payments to public and private hospitals; improving the transparency of hospital activity and management; and improving quality of care.

Or, Z. (2014). "Implementation of DRG Payment in France: Issues and recent developments." Health Policy **117**(2): 1-5.
http://www.healthpolicyjrnl.com/article/S0168-8510(14)00135-3/pdf

> In France, a DRG-based payment system was introduced in 2004/2005 for funding acute services in all hospitals with the objectives of improving hospital efficiency, transparency and fairness in payments to public and private hospitals. Despite the initial consensus on the necessity of the reform, providers have become increasingly critical of the system because of the problems encountered during the implementation. In 2012 the government announced its intention to modify the payment model to better deal with its adverse effects. The paper reports on the issues raised by the DRG-based payment in the French hospital sector and provides an overview of the main problems with the French DRG payment model. It also summarises the evidence on its impact and presents recent developments for reforming the current model. DRG-based payment addressed some of the chronic problems inherent in the French hospital market and improved accountability and productivity of health-care facilities. However, it has also created new problems for controlling hospital activity and ensuring that care provided is medically appropriate. In order to alter its adverse effects the French DRG model needs to better align greater efficiency with the objectives of better quality and effectiveness of care.

Or, Z., et al. (2013). Activité, productivité et qualité des soins des hôpitaux avant et après la T2A. Document de travail Irdes ; 56. Paris Irdes**:** 76.
http://www.irdes.fr/EspaceRecherche/DocumentsDeTravail/DT56SoinsHospitaliersT2A.pdf

> La tarification à l'activité (T2A), introduite en 2004-2005 pour financer l'activité de court séjour des hôpitaux publics et privés, avait pour but d'améliorer l'efficience des établissements de santé et du secteur hospitalier. Or le suivi de l'impact de la T2A sur

l'évolution de l'activité et de la productivité hospitalière reste à ce jour partiel. Cette étude fournit de nouvelles données et analyses quantitatives permettant d'apprécier les effets de la réforme de la T2A sur l'activité, la productivité et la qualité des soins hospitaliers. Au moyen d'une série d'indicateurs estimés annuellement sur la période 2002-2009, nous tentons de répondre aux questions suivantes : produit-on plus ou moins pour chaque euro dépensé pour l'hôpital depuis l'introduction de la T2A ? La structure de la production a-t-elle été modifiée ? Comment la qualité des soins a-t-elle évolué ? (résumé d'auteur).

Petiot, D., et al. (2016). "La T2A peut-elle concilier diminution des durées de séjour et juste rémunération ?" Revue Hospitaliere De France(570): 42-45, tabl.

[BDSP. Notice produite par EHESP 7R0x99G8. Diffusion soumise à autorisation]. La maîtrise et l'optimisation des durées de séjour sont devenues, en MCO, les objectifs pivots des stratégies d'établissement. L'analyse de la durée de séjour et de l'indice de performance de la durée moyenne de séjour (IP-DMS) constitue à cet égard un exercice indispensable. (introd.).

Polton, D. Conséquence des modes de rémunération des professionnels de santé et des structures de soins sur la pertinence des soins, Paris : Cnamts.

Cette communication présentée au congrès sur la sur et sous-médicalisation d'avril 2015 analyse l'impact du mode de rémunération des médecins et de l'organisation des soins sur la pratique médicale au niveau de la pertinence des soins, du choix du traitement). Une étude comparative est menée à travers différents pays de l'Union européenne... avec une évolution sur une dizaine d'années.

Polton, D. et Aubert, J. M. (2010). "Le contrat d'amélioration des pratiques individuelles, aboutissement ou nouveau départ pour la gestion des soins ? (CAPI)." Lettre Du College (La) **21**(3): 5-7.
http://www.ces-asso.org/docs/Let_CES_3-2010.pdf

Depuis plusieurs années, l'assurance maladie mène une politique active pour accroître la qualité et l'efficience de notre système de santé. Cette politique dite «de maîtrise médicalisée » passe notamment par une sensibilisation du corps médical aux objectifs de santé publique et aux objectifs d'économies. Une étape importante a été le développement de l'accompagnement des professionnels à travers les visites des délégués de l'assurance maladie et les entretiens confraternels. Ainsi en 2010, plus de 450 000 entretiens individuels ont eu lieu entre des professionnels de santé et des représentants de l'assurance maladie sur la prévention, la prise en charge des malades ou la bonne utilisation des ressources. Une nouvelle étape de cette stratégie est la mise en place d'une composante de rémunération à la performance pour les médecins généralistes, le contrat d'amélioration des pratiques individuelles. Ce contrat est inspiré d'expériences étrangères. Après les premières initiatives développées aux États-Unis à la fin des années 1990, une expérience européenne à grande échelle a été mise en place en 2004 dans le cadre de la convention entre les médecins généralistes anglais et le National Health Service. La particularité du contrat français est la combinaison d'objectifs de santé publique et de qualité des soins et d'objectifs d'efficience des pratiques. Dans d'autres pays, ce deuxième volet est abordé au travers d'autres outils de responsabilisation, qui n'existent pas en France.

Polton, D., et al. Les modes incitatifs de rémunération des soins. Actes du séminaire.
https://veilleprosp.wordpress.com/2011/12/12/les-modes-incitatifs-de-remuneration-des-soins/

Au cours de ce séminaire a été abordé : Panorama des modes de rémunération, regard international; Considérations théoriques sur la rémunération des acteurs de santé; paiement à la performance dans le monde; la convention médicale; L'expérimentation sur les maisons de santé (DSS).

Pouvourville, G. d. (2013). "Paying for performance." European Journal of Health Economics (the) **14**(1): 1-4.

Sebar, J.. (2015). "L'évaluation de la performance dans le système de soins : que disent les théories ?" Sante Publique(3): 395-403.

Lepage, M., et Ventelou, B. (2016). "The true impact of the French pay-for-performance program on physicians' benzodiazepines prescription behavior." Eur J Health Econ **17**(6).

OBJECTIVES: The French pay-for-performance (P4P) contract CAPI implemented by the national health insurance included a target-goal which aims at reducing benzodiazepines prescriptions. In this investigation, we would like to assess whether: (1) the general practitioners (GPs) having signed P4P contract obtain better results regarding the target-goal than non-signatories; (2) (part of) this progression is due to the CAPI contract itself (tentative measurement of a "causal effect"); (3) (part of) the money spent on this P4P incentive can be self-financed with the amount of pharmaceuticals saved. METHODS: We matched cross-sectional and longitudinal data including 4622 French GPs from June 2011 to December 2012. A treatment effect model using instrumental variables was performed to take into account potential self-selection issue in signing. After having identified the NET impact of the P4P, we calculate the cost of an avoided benzodiazepines treatment. RESULTS: In our study, GPs who have signed the CAPI contract (36 % of the sample) are more numerous in achieving benzodiazepines target goal than non-signatories: 90.7 vs. 85.5 %. After controlling for the self-selection bias, the propensity of GPs to achieve the benzodiazepines target is only 0.31 % higher for signatories than for their non-signing counterparts-estimate for June 2012, which yields a statistically significant gap. Our economic analysis demonstrates that the CAPI contract does not allow savings, but presents in 2012 a NET cost of 93.6<euro> per avoided benzodiazepines treatment (291<euro> in 2011). CONCLUSIONS: The P4P contract has a positive but modest impact on the achievement of GPs regarding benzodiazepines indicator.

Milcent, C. (2017). "Premier bilan de la tarification à l'activité (T2A) sur la variabilité des coûts hospitaliers." Economie & prévision **210**(1): 67.
http://www.cairn.info/revue-economie-et-prevision-2017-1-page-45.htm

Ce papier étudie la variabilité des coûts hospitaliers pour des séjours comparables en pathologies et en procédures (GHM). À l'époque du budget global, une forte variabilité des coûts était observée entre les hôpitaux publics français. Qu'en est-il aujourd'hui ? Théoriquement, la T2A conduit les établissements à minimiser leurs coûts pour gagner la différence entre le forfait et le coût. Nous montrons une certaine homogénéisation des coûts et une réelle prise en compte de l'hétérogénéité des individus. Les forfaits par GHM ne capturent cependant pas toute l'hétérogénéité entre les établissements, ni entre les patients. Ainsi, les effets néfastes de sélection des patients ou de diminution du niveau de qualité ne sont pas évités par les forfaits actuels.

Veran, O. (2016). Mission sur l'évolution du mode de financement des établissements de santé. Rapport d'étape. sl sn**:** 70.
http://www.olivier-veran.fr/rapport-detape-sur-le-mode-de-financement-des-etablissements-de-sante/rapport-detape-t2a/

Ce rapport intermédiaire est le résultat d'une mission sur l'évolution du mode de financement des établissements de santé, établi par un comité des experts. Il dresse un premier bilan de la tarification à l'activité (T2A) près de 10 ans après sa mise en œuvre. Il fait le constat que la T2A, pensé comme un outil de cotation, efficace pour les activités standardisées, peine à rendre compte de l'activité médicale, notamment les maladies chroniques, les urgences, les soins critiques, les soins palliatifs,… mais aussi les activités hospitalières dites de proximité. Par ailleurs, la T2A a pris dans certains cas une place prépondérante dans l'organisation même de l'hôpital alors que ce n'est pas son rôle. La T2A peine enfin à rendre compte de la pertinence et de la qualité des soins. Le comité émet des propositions applicables à court terme visant à faire évoluer le financement hospitalier lorsque le modèle actuel n'est pas le plus adapté. Il ouvre par ailleurs la voie à des réformes structurelles couvrant l'ensemble des enjeux liés à la question générale du financement des établissements de santé, et qui feront l'objet d'un rapport complémentaire.

Veran, O. (2017). Mission sur l'évolution du mode de financement des établissements de santé : une nouvelle échelle de valeur. sl sn**:** 133 , tab., graph., fig.
http://social-sante.gouv.fr/IMG/pdf/rapport__evolution_des_modes_de_financement_des_etablissements_de_sante.pdf

Ce rapport constitue le deuxième volet d'une mission sur l'évolution du mode de financement des établissements de santé, établi par un comité des experts. Le premier volet du rapport, remis en mai 2016, formulait des préconisations dont certaines ont été intégrées à la Loi de financement de la sécurité sociale pour 2017 comme la mise en place progressive d'une part de financement fixe pour les activités de soins critiques (réanimation, soins intensifs, surveillance continue), la création d'une prestation intermédiaire, entre la consultation et l'hospitalisation de jour, pour mieux valoriser le travail pluridisciplinaire, ou encore l'extension du modèle de financement des hôpitaux de proximité aux établissements de soins de suite et de réadaptation. La seconde partie des travaux conforte les évolutions engagées depuis 2012 ou en cours de mise en œuvre (refonte du financement de l'HAD, évolution du financement lié à la qualité et de celui lié à la précarité). Ces travaux préconisent des évolutions structurelles à moyen terme. Concernant les activités de médecine, chirurgie et obstétrique, ce rapport propose d'expérimenter la cohabitation de trois modes de financement : T2A, financement par épisodes de soins et financement dit « au parcours ». Concernant la psychiatrie, la mission ne recommande pas une réforme globale du modèle de financement mais suggère de pondérer le système actuel en fonction des besoins épidémiologiques de la population et des données médico-économiques en vue de réduire les inégalités de financement.

ÉTUDES INTERNATIONALES

AHRQ Toward a research agenda on quality-payment alignment : findings from an invitational colloquium, Rockville : AHRQ.
http://www.ahrq.gov/qual/nhdr07/nhdr07.pdf

On November 9, 2006, the Agency for Healthcare Research and Quality (AHRQ) and the Commonwealth Fund convened a colloquium to develop a national research agenda on aligning quality with provider payment incentives and consumer financial incentives. This document summarizes the colloquium findings and recommendations for research to investigate the effect of these incentives on improving the quality of health care.

Aijkennar, F. (2012). "Pay for performance in health care : international overview of initiatives." Medical Care Research and Review **69**(3).

Allen, T., et al. (2014). "Can payers use prices to improve quality? Evidence from English Hospitals." Health Econ.

> In most activity-based financing systems, payers set prices reactively based on historical averages of hospital reported costs. If hospitals respond to prices, payers might set prices proactively to affect the volume of particular treatments or clinical practice. We evaluate the effects of a unique initiative in England in which the price offered to hospitals for discharging patients on the same day as a particular procedure was increased by 24%, while the price for inpatient treatment remained unchanged. Using national hospital records for 205 784 patients admitted for the incentivised procedure and 838 369 patients admitted for a range of non-incentivised procedures between 1 December 2007 and 31 March 2011, we consider whether this price change had the intended effect and/or produced unintended effects. We find that the price change led to an almost six percentage point increase in the daycase rate and an 11 percentage point increase in the planned daycase rate. Patients benefited from a lower proportion of procedures reverted to open surgery during a planned laparoscopic procedure and from a reduction in long stays. There was no evidence that readmission and death rates were affected. The results suggest that payers can set prices proactively to incentivise hospitals to improve quality. Copyright (c) 2014 John Wiley & Sons, Ltd

Allen, T., et al. (2016). "Can Payers Use Prices to Improve Quality? Evidence from English Hospitals." Health Econ **25**(1): 56-70.
https://www.ncbi.nlm.nih.gov/pubmed/25385086

> In most activity-based financing systems, payers set prices reactively based on historical averages of hospital reported costs. If hospitals respond to prices, payers might set prices proactively to affect the volume of particular treatments or clinical practice. We evaluate the effects of a unique initiative in England in which the price offered to hospitals for discharging patients on the same day as a particular procedure was increased by 24%, while the price for inpatient treatment remained unchanged. Using national hospital records for 205,784 patients admitted for the incentivised procedure and 838,369 patients admitted for a range of non-incentivised procedures between 1 December 2007 and 31 March 2011, we consider whether this price change had the intended effect and/or produced unintended effects. We find that the price change led to an almost six percentage point increase in the daycase rate and an 11 percentage point increase in the planned daycase rate. Patients benefited from a lower proportion of procedures reverted to open surgery during a planned laparoscopic procedure and from a reduction in long stays. There was no evidence that readmission and death rates were affected. The results suggest that payers can set prices proactively to incentivise hospitals to improve quality.

Allen, T., et al. (2014). "Impacts of pay for performance on the quality of primary care." Risk Manag Healthc Policy **7**: 113-120.
https://www.ncbi.nlm.nih.gov/pubmed/25061341

> Increasingly, financial incentives are being used in health care as a result of increasing demand for health care coupled with fiscal pressures. Financial incentive schemes are one approach by which the system may incentivize providers of health care to improve productivity and/or adapt to better quality provision. Pay for performance (P4P) is an example of a financial incentive which seeks to link providers' payments to some measure of

performance. This paper provides a discussion of the theoretical underpinnings of P4P, gives an overview of the health P4P evidence base, and provide a detailed case study of a particularly large scheme from the English National Health Service. Lessons are then drawn from the evidence base. Overall, we find that the evidence for the effectiveness of P4P for improving quality of care in primary care is mixed. This is to some extent due to the fact that the P4P schemes used in primary care are also mixed. There are many different schemes that incentivize different aspects of care in different ways and in different settings, making evaluation problematic. The Quality and Outcomes Framework in the United Kingdom is the largest example of P4P in primary care. Evidence suggests incentivized quality initially improved following the introduction of the Quality and Outcomes Framework, but this was short-lived. If P4P in primary care is to have a long-term future, the question about scheme effectiveness (perhaps incorporating the identification and assessment of potential risk factors) needs to be answered robustly. This would require that new schemes be designed from the onset to support their evaluation: control and treatment groups, coupled with before and after data.

Alshamsan, R., et al. (2010). "Impact of pay for performance on inequalities in health care: systematic review." J Health Serv Res Policy **15**(3): 178-184.

http://hsr.sagepub.com/content/15/3/178.long

OBJECTIVES: To assess the impact of pay for performance programmes on inequalities in the quality of health care in relation to age, sex, ethnicity and socioeconomic status. METHODS: Systematic search and appraisal of experimental or observational studies that assessed quantitatively the impact of a monetary incentive on health care inequalities. We searched published articles in English identified in the MEDLINE, EMBASE, PsycINFO and Cochrane databases. RESULTS: Twenty-two studies were identified, 20 of which were conducted in the United Kingdom and examined the impact of the Quality and Outcomes Framework. Sixteen studies used practice level data rather than patient level data. Socioeconomic status was the most frequently examined inequality; age, sex and ethnic inequalities were less frequently assessed. There was some weak evidence that the use of financial incentives reduced inequalities in chronic disease management between socioeconomic groups. Inequalities in chronic disease management between age, sex and ethnic groups persisted after the use of such incentives. CONCLUSION: Inequalities in chronic disease management have largely persisted after the introduction of the Quality and Outcome Framework. Pay for performance programmes should be designed to reduce inequalities as well as improve the overall quality of care

Alshamsan, R., et al. (2010). "Has pay for performance improved the management of diabetes in the United Kingdom?" Prim Care Diabetes **4**(2): 73-78.
https://www.ncbi.nlm.nih.gov/pubmed/20363200

Over the past decade the UK government has introduced a number of major policy initiatives to improve the quality of health care. One such initiative was the introduction of the Quality and Outcomes Framework (QOF), a pay for performance scheme launched in April 2004, which aims to improve the primary care management of common chronic conditions including diabetes. Some evidence suggest that introduction of QOF has been associated with improvements in the quality indicators for diabetes care included in the framework. However, it is difficult to disentangle the impact of QOF from other quality initiatives as few studies adjusted for underlying trends in quality. There is some evidence that QOF may have reduced inequalities in diabetes care between affluent and deprived areas but women and individuals from ethnic minority groups appear to have benefited least from this initiative.

Less is known about the impact of QOF on aspects of diabetes care not reflected in the framework, including self-management and continuity of care.

Althausen, P. L. et Mead, L. (2016). "Bundled Payments for Care Improvement: Lessons Learned in the First Year." J Orthop Trauma **30 Suppl 5**: S50-s53.

The Bundled Payments for Care Improvement (BPCI) initiative is the latest cost-saving program developed by the Center for Medicare and Medicaid Innovation. This model is intended to create a system for higher quality and more coordinated care at a lower cost to Medicare. It is currently an optional program for physician groups, hospitals and post-acute care providers to benefit financially from improved care models and cost containment measures. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. Under this initiative, there are certain fraud and abuse waivers in place that allow gainsharing among BPCI organizations and approved providers so long as certain requirements are met. Our practice entered this initiative for total joint arthroplasty episodes of care as well as the hip and femur fracture episode of care. The first year experience demonstrated that a significant learning curve is required. Keys for success include appropriate patient selection for elective surgery, implant pricing control, adherence to preoperative and postoperative protocols, diligent postcare care management, and appropriate choice of metrics to maximize gainsharing potential. Ultimately, the BPCI program has been a successful venture, saving our hospitals over $1.6 million in 2015. In the process, this provided an additional revenue stream for our physicians while decreasing

Ammi, M. et Fortier, G. (2017). "The influence of welfare systems on pay-for-performance programs for general practitioners: A critical review." Social Science & Medicine **178**: 157-166. http://www.sciencedirect.com/science/article/pii/S0277953617301089

While pay-for-performance (P4P) programs are increasingly common tools used to foster quality and efficiency in primary care, the evidence concerning their effectiveness is at best mixed. In this article, we explore the influence of welfare systems on four P4P-related dimensions: the level of healthcare funders' commitment to P4Ps (by funding and length of program operation), program design (specifically target-based vs. participation-based program), physicians' acceptance of the program and program effects. Using Esping-Andersen's typology, we examine P4P for general practitioners (GPs) in thirteen European and North American countries and find that welfare systems contribute to explain variations in P4P experiences. Overall, liberal systems exhibited the most enthusiastic adoption of P4P, with significant physician acceptance, generous incentives and positive but modest program effects. Social democratic countries showed minimal interest in P4P for GPs, with the exception of Sweden. Although corporatist systems adopted performance pay, these countries experienced mixed results, with strong physician opposition. In response to this opposition, health care funders tended to favour participation-based over target-based P4P. We demonstrate how the interaction of decommodification and social stratification in each welfare regime influences these countries' experiences with P4P for GPs, directly for funders' commitment, program design and physicians' acceptance, and indirectly for program effects, hence providing a framework for analyzing P4P in other contexts or care settings.

Andrew, M. R. et Yuhua, B. (2013). "Profiling Provider Outcome Quality for Pay-for-Performance in the Presence of Missing Data: A Simulation Approach." Health Serv Res **48**(2): 810-825. http://ejournals.ebsco.com/direct.asp?ArticleID=4DC1B84664DB79684F82

Andrew, R. et Doran, T. (2012). "The Effect of Improving Processes of Care on Patient Outcomes: Evidence From the United Kingdom's Quality and Outcomes Framework." Medical Care **50**(3): 191-199.

Improvement in process performance in English family practices led to improvements in patient outcomes. Although the effect was modest at the practice-level, process improvements seem to have led to substantial improvements in population health.

Anell, A., et al. (2015). Can Pay-for-Performance to Primary Care Providers Stimulate Appropriate Use of Antibiotics. Lund Lund University**:** 33 , tabl.
https://ideas.repec.org/p/hhs/lunewp/2015_036.html

Resistance to antibiotics is a major threat to the effectiveness of modern health care. This study examines if pay-for-performance (P4P) to care providers stimulates the appropriate use of antibiotics; in particular, if P4P can induce a substitution away from broad-spectrum antibiotics, which contribute more to the development of resistance, to less resistance-driving types. In the context of Swedish primary care, we study the introduction of P4P indicators encouraging substitution of narrow-spectrum antibiotics for broad-spectrum antibiotics in the treatment of children with respiratory tract infections (RTI). During 2006-2013, 8 out of 21 county councils introduced such P4P indicators in their reimbursement schemes for primary care providers. We employ municipality-level register data covering all purchases of RTI related antibiotics and exploit the staggered introduction of pay-for-performance in a difference-in-differences analysis. Despite that the monetary incentives were small, we find that P4P significantly increased narrow-spectrum antibiotics' share of RTI antibiotics consumption. We further find larger effects in areas where there were many private providers, where the incentive was formulated as a penalty rather than a reward, and where all providers were close to a P4P target

Anell, A. et Glenngard, A. H. (2014). "The use of outcome and process indicators to incentivize integrated care for frail older people: a case study of primary care services in Sweden." International Journal of Integrated Care **14**: 11 , tabl.

Background: A number of reforms have been implemented in Swedish health care to support integrated care for frail older people and to reduce utilization of hospital care by this group. Outcomes and process indicators have been used in pay-for-performance (P4P) schemes by both national and local governments to support developments. Objective: To analyse limitations in the use of outcome and process indicators to incentivize integrated care for elderly patients with significant health care needs in the context of primary care. Method: Data were collected from the Region Skåne county council. Eight primary care providers and associated community services were compared in a ranking exercise based on information from interviews and registered data. Registered data from 150 primary care providers were analysed in regression models. Results and conclusion: Both the ranking exercise and regression models revealed important problems related to risk-adjustment, attribution, randomness and measurement fixation when using indicators in P4P schemes and for external accountability purposes. Instead of using indicators in incentive schemes targeting individual providers, indicators may be used for diagnostic purposes and to support development of new knowledge, targeting local systems that move beyond organizational boundaries.

Audit Commission (2012). Right data, right payment: annual report on the Payment by Results (PbR) data assurance programme 2011/12. Londres Audit Commission**:** 25.
http://www.audit-commission.gov.uk/SiteCollectionDocuments/Downloads/pbr2012.pdf

This report presents the key findings from the 2011/12 programme, which includes reviews of commissioner arrangements to secure good data quality on the information that underpins PbR, audits of inpatient clinical coding and the key data set that supports payment under PbR at acute NHS trusts and foundation trusts, and following up on recommendations made in previous audits to see how well NHS trusts and foundation trusts have delivered.

Bailit, M., et al. (2012). Shared-Savings Payment Arrangements in Health Care: Six Case Studies. New York The Commonwealth Fund**:** 21 , tabl.
http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Aug/1624_Bailit_shared_savings_payment_arrangements_six_case_studies.pdf

Driven by widespread interest in improving health care quality and reducing costs and by the Affordable Care Act?s accountable care provisions, shared-savings programs are gaining traction as an alternative approach to paying health care providers. Providers receive a share of the savings they achieve by reducing the growth in costs for delivering care to a defined patient population. This report presents six case studies of pilot shared-savings programs across the country. The cases reveal program variation in the patient populations subject to shared-savings approaches, the health care services covered, the determination of cost savings and payouts to providers, the use of performance targets, and performance measurement. Early results from the pilot programs also vary. Exploring differences in shared-savings approaches, and the outcomes they achieve, will be essential to determining whether they work, how to improve them, and whether and how to diffuse them.

Bao, Y., et al. (2017). "Value-based payment in implementing evidence-based care: the Mental Health Integration Program in Washington state." Am J Manag Care **23**(1): 48-53.

OBJECTIVES: To assess the role of value-based payment (VBP) in improving fidelity and patient outcomes in community implementation of an evidence-based mental health intervention, the Collaborative Care Model (CCM). STUDY DESIGN: Retrospective study based on a natural experiment. METHODS: We used the clinical tracking data of 1806 adult patients enrolled in a large implementation of the CCM in community health clinics in Washington state. VBP was initiated in year 2 of the program, creating a natural experiment. We compared implementation fidelity (measured by 3 process-of-care elements of the CCM) between patient-months exposed to VBP and patient-months not exposed to VBP. A series of regressions were estimated to check robustness of findings. We estimated a Cox proportional hazard model to assess the effect of VBP on time to achieving clinically significant improvement in depression (measured based on changes in depression symptom scores over time). RESULTS: Estimated marginal effects of VBP on fidelity ranged from 9% to 30% of the level of fidelity had there been no exposure to VBP (P <.05 for every fidelity measure). Improvement in fidelity in response to VBP was greater among providers with a larger patient panel and among providers with a lower level of fidelity at baseline. Exposure to VBP was associated with an adjusted hazard ratio of 1.45 (95% confidence interval, 1.04-2.03) for achieving clinically significant improvement in depression. CONCLUSIONS: VBP improved fidelity to key elements of the CCM, both directly incentivized and not explicitly incentivized by the VBP, and improved patient depression outcomes.

Barham, V. et Milliken, O. (2015). "Payment Mechanisms and the Composition of Physician Practices: Balancing Cost-Containment, Access, and Quality of Care." Health Economics **24**(7): 895-906.
http://dx.doi.org/10.1002/hec.3069
http://onlinelibrary.wiley.com/doi/10.1002/hec.3069/abstract?systemMessage=Wiley+Online+Library+will+be+disrupted+on+11th+July+2015+at+10%3A00-16%3A00+BST+%2F+05%3A00-

11%3A00+EDT+%2F+17%3A00-23%3A00++SGT++for+essential+maintenance.++Apologies+for+the+inconvenience

We take explicit account of the way in which the supply of physicians and patients in the economy affects the design of physician remuneration schemes, highlighting the three-way trade-off between quality of care, access, and cost. Both physicians and patients are heterogeneous. Physicians choose both the number of patients and the quality of care to provide to their patients. When determining physician payment rates, the principal must ensure access to care for all patients. When physicians can adjust the number of patients seen, there is no incentive to over-treat. In contrast, altruistic physicians always quality stint: they prefer to add an additional patient, rather than to increase the quality of service provided. A mixed payment mechanism does not increase the quality of service provided with respect to capitation. Offering a menu of compensation schemes may constitute a cost-effective strategy for inducing physicians to choose a given overall caseload but may also generate difficulties with access to care for frail patients. Copyright © 2014 John Wiley & Sons, Ltd.

Batifoulier, P., et al. (2009). Disentangling extrinsic and intrinsic motivations: the case of French GPs dealing with prevention. EconomiX Working Papers; 2009-15. Paris Université de Paris 10**:** 16 , tabl., fig.
http://economix.u-paris10.fr/pdf/dt/2009/WP_EcoX_2009-15.pdf

La littérature économique fait désormais une large place à l?analyse des « motivations professionnelles », examinant notamment les possibles effets d?éviction entre motivations extrinsèques et intrinsèques. Le présent article propose de transposer ces questions dans le champ des professions de santé, avec l?enjeu d?un juste dimensionnement du recours aux politiques de paiement à la performance par le décideur public. Nous mobilisons un panel de 528 médecins généralistes libéraux de la région « Provence Alpes Côte d?Azur » en France et proposons une décomposition statistique interindividuelle entre motivations extrinsèques et intrinsèques dans le domaine des actions de prévention. La part des motivations intrinsèques est relativement plus importante chez les médecins pratiquant les tarifs conventionnés. L?effet significatif de l?âge suit une courbe en U qu?on peut interpréter comme le résultat d?un « cycle de vie des motivations médicales » ou comme celui d?un effet génération. Enfin, l?estimation économétrique établit une corrélation entre une faible part de motivation intrinsèque et le sentiment d?injustice concernant les réformes. La nature transversale des données ne permet pas de conclure quant au sens de la causalité, mais la relation mise en évidence semble bien alimenter la thèse selon laquelle la mise en place d?une politique basée sur les incitations monétaires à la performance est jugée comme désobligeante et peut s?accompagner d?une érosion des motivations intrinsèques dans le travail médical.

Baxter, P. E., et al. (2015). "Leaders' experiences and perceptions implementing activity-based funding and pay-for-performance hospital funding models: A systematic review." Health Policy **119**(8): 1096-1110.

INTRODUCTION: Providing cost-effective, accessible, high quality patient care is a challenge to governments and health care delivery systems across the globe. In response to this challenge, two types of hospital funding models have been widely implemented: (1) activity-based funding (ABF) and (2) pay-for-performance (P4P). Although health care leaders play a critical role in the implementation of these funding models, to date their perspectives have not been systematically examined. PURPOSE: The purpose of this systematic review was to gain a better understanding of the experiences of health care leaders implementing hospital funding reforms within Organisation for Economic Cooperation and Development countries.

METHODS: We searched literature from 1982 to 2013 using: Medline, EMBASE, CINAHL, Academic Search Complete, Academic Search Elite, and Business Source Complete. Two independent reviewers screened titles, abstracts and full texts using predefined criteria. We included 2 mixed methods and 12 qualitative studies. Thematic analysis was used in synthesizing results. RESULTS: Five common themes and multiple subthemes emerged. Themes include: pre-requisites for success, perceived benefits, barriers/challenges, unintended consequences, and leader recommendations. CONCLUSIONS: Irrespective of which type of hospital funding reform was implemented, health care leaders described a complex process requiring the following: organizational commitment; adequate infrastructure; human, financial and information technology resources; change champions and a personal commitment to quality care.

Bazzoli, G. J., et al. (2014). "Hospital financial performance in the recent recession and implications for institutions that remain financially weak." Health Aff.(Millwood.) **33**(5): 739-745.

The recent recession had a profound effect on all sectors of the US economy, including health care. We examined how private hospitals fared through the recession and considered how changes in their financial health may affect their ability to respond to future industry challenges. We categorized 2,971 private short-term general medical or surgical hospitals (both nonprofit and for-profit) according to their pre-recession financial health and safety-net status, and we examined their operational status changes and operating and total financial margins during 2006-11. We found that hospitals that were financially weak before the recession remained so during and after the recession. The total margins of nonprofit hospitals (both safety-net and other institutions) declined in 2008 but returned to their pre-recession levels by 2011. The recession did not create additional fiscal pressure on hospitals that were previously financially weak or in safety-net roles. However, both groups continue to have notable financial deficiencies that could limit their abilities to meet the growing demands on the industry

Benzer, J. K., et al. (2014). "Sustainability of quality improvement following removal of pay-for-performance incentives." J Gen Intern Med **29**(1): 127-132.

BACKGROUND: Although pay-for-performance (P4P) has become a central strategy for improving quality in US healthcare, questions persist about the effectiveness of these programs. A key question is whether quality improvement that occurs as a result of P4P programs is sustainable, particularly if incentives are removed. OBJECTIVE: To investigate sustainability of performance levels following removal of performance-based incentives. DESIGN, SETTING, AND PARTICIPANTS: Observational cohort study that capitalized on a P4P program within the Veterans Health Administration (VA) that included adoption and subsequent removal of performance-based incentives for selected inpatient quality measures. The study sample comprised 128 acute care VA hospitals where performance was assessed between 2004 and 2010. INTERVENTION: VA system managers set annual performance goals in consultation with clinical leaders, and report performance scores to medical centers on a quarterly basis. These scores inform performance-based incentives for facilities and their managers. Bonuses are distributed based on the attainment of these performance goals. MEASUREMENTS: Seven quality of care measures for acute coronary syndrome, heart failure, and pneumonia linked to performance-based incentives. RESULTS: Significant improvements in performance were observed for six of seven quality of care measures following adoption of performance-based incentives and were maintained up to the removal of the incentive; subsequently, the observed performance levels were sustained. LIMITATIONS: This is a quasi-experimental study without a comparison group; causal conclusions are limited. CONCLUSION: The maintenance of performance levels after removal

of a performance-based incentive has implications for the implementation of Medicare's value-based purchasing initiative and other P4P programs. Additional research is needed to better understand human and system-level factors that mediate sustainability of performance-based incentives.

Bernstein, D. (2008). "Le paiement à la performance des médecins généralistes anglais a-t-il atteint ses objectifs ? Un premier bilan." Actualite Et Dossier En Sante Publique(65): 49-52. http://www.hcsp.fr/hcspi/docspdf/adsp/adsp-65/ad654952.pdf

[BDSP. Notice produite par EHESP 7DnrjR0x. Diffusion soumise à autorisation]. Le Quality and Outcomes Framework des médecins généralistes anglais constitue la première expérience de paiement à la performance à la grande échelle en Europe. Quelques années après sa mise en place, ses objectifs ont-ils été atteints ?

Bilger, M., et al. (2016). "Study on Incentives for Glaucoma Medication Adherence (SIGMA): study protocol for a randomized controlled trial to increase glaucoma medication adherence using value pricing." Trials **17**(1): 316.

BACKGROUND: Many glaucoma patients do not adhere to their medication regimens because they fail to internalize the (health) costs of non-adherence, which may not occur until years or decades later. Behavioural economic theory suggests that adherence rates can be improved by offering patients a near-term benefit. Our proposed strategy is to offer adherence-contingent rebates on medication and check-up costs. This form of value pricing (VP) ensures that rebates are granted only to those most likely to benefit. Moreover, by leveraging loss aversion, rebates are expected to generate a stronger behavioural response than equivalent financial rewards. METHODS/DESIGN: The main objective of the Study on Incentives for Glaucoma Medication Adherence (SIGMA) is to test the VP approach relative to usual care (UC) in improving medication adherence. SIGMA is a randomized, controlled, open-label, single-centre superiority trial with two parallel arms. A total of 100 non-adherent (Morisky Medication Adherence Scale </=6) glaucoma patients from the Singapore National Eye Centre are block-randomized (blocking factor: single versus multiple medications users) into the VP and UC arms in a 1:1 ratio. The treatment received by VP patients will be strictly identical to that received by UC patients, with the only exception being that VP patients can earn either a 50 % or 25 % rebate on their glaucoma-related healthcare costs conditional on being adherent on at least 90 % or 75 % of days as measured by a medication event monitoring system. Masking the arm allocation will be precluded by the behavioural nature of the intervention but blocking size will not be disclosed to protect concealment. The primary outcome is the mean change from baseline in percentage of adherent days at month 6. A day will be counted as adherent when the patients take all their medication(s) within the appropriate dosing windows. DISCUSSION: This trial will provide evidence on whether adherence-contingent rebates can improve medication adherence among non-adherent glaucoma patients, and more generally whether this approach represents a promising strategy to cost-effectively improve chronic disease management. TRIAL REGISTRATION: NCT02271269 . Registered on 19 October 2014.

Blum-Boisgard, C., et al. (2008). "Nouvelles formes de tarification : quels effets sur la qualité et l'efficience ? : résumé des discussions." Sante Societe Et Solidarite : Revue De L'observatoire Franco-Quebecois(2/2007): 79-82.

Boeckxstaens, P., et al. (2011). "The equity dimension in evaluations of the quality and outcomes framework: a systematic review." BMC Health Serv Res **11**: 209. PM:21880136

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3182892/pdf/1472-6963-11-209.pdf

BACKGROUND: Pay-for-performance systems raise concerns regarding inequity in health care because providers might select patients for whom targets can easily be reached. This paper aims to describe the evolution of pre-existing (in)equity in health care in the period after the introduction of the Quality and Outcomes Framework (QOF) in the UK and to describe (in)equities in exception reporting. In this evaluation, a theory-based framework conceptualising equity in terms of equal access, equal treatment and equal treatment outcomes for people in equal need is used to guide the work. METHODS: A systematic MEDLINE and Econlit search identified 317 studies. Of these, 290 were excluded because they were not related to the evaluation of QOF, they lacked an equity dimension in the evaluation, their qualitative research focused on experiences or on the nature of the consultation, or unsuitable methodology was used to pronounce upon equity after the introduction of QOF. RESULTS: None of the publications (n = 27) assessed equity in access to health care. Concerning equity in treatment and (intermediate) treatment outcomes, overall quality scores generally improved. For the majority of the observed indicators, all citizens benefit from this improvement, yet the extent to which different patient groups benefit tends to vary and to be highly dependent on the type and complexity of the indicator(s) under study, the observed patient group(s) and the characteristics of the study. In general, the introduction of QOF was favourable for the aged and for males. Total QOF scores did not seem to vary according to ethnicity. For deprivation, small but significant residual differences were observed after the introduction of QOF favouring less deprived groups. These differences are mainly due to differences at the practice level. The variance in exception reporting according to gender and socio-economic position is low. CONCLUSIONS: Although QOF seems not to be socially selective at first glance, this does not mean QOF does not contribute to the inverse care law. Introducing different targets for specific patient groups and including appropriate, non-disease specific and patient-centred indicators that grasp the complexity of primary care might refine the equity dimension of the evaluation of QOF. Also, information on the actual uptake of care, information at the patient level and monitoring of individuals' health care utilisation tracks could make large contributions to an in-depth evaluation. Finally, evaluating pay-for-quality initiatives in a broader health systems impact assessment strategy with equity as a full assessment criterion is of utmost importance

Boland, G. W., et al. (2017). "Report of the ACR's Economics Committee on Value-Based Payment Models." J Am Coll Radiol **14**(1): 6-14.

A major outcome of the current health care reform process is the move away from unrestricted fee-for-service payment models toward those that are based on the delivery of better patient value and outcomes. The authors' purpose, therefore, is to critically evaluate and define those components of the overall imaging enterprise that deliver meaningful value to both patients and referrers and to determine how these components might be measured and quantified. These metrics might then be used to lobby providers and payers for sustainable payment solutions for radiologists and radiology services. The authors evaluated radiology operations and services using the framework of the imaging value chain, which divides radiology service into a number of discrete value-added activities, which ultimately deliver the primary product, most often the actionable report for diagnostic imaging or an effective outcome for interventional radiology. These value activities include scheduling and imaging appropriateness and stewardship, patient preparation, protocol design, modality operations, reporting, report communication, and clinical follow-up (eg, mammography reminder letters). Two further categories are hospital or health care organization citizenship and examination outcome. Each is discussed in turn, with specific activities highlighted.

Boyd, C. M., et al. (2005). "Clinical practice guidelines and quality of care for older patients with multiple comorbid diseases: implications for pay for performance." Jama Journal of the American Medical Association **294**(6): 716-724.

CONTEXT: Clinical practice guidelines (CPGs) have been developed to improve the quality of health care for many chronic conditions. Pay-for-performance initiatives assess physician adherence to interventions that may reflect CPG recommendations. OBJECTIVE: To evaluate the applicability of CPGs to the care of older individuals with several comorbid diseases. DATA SOURCES: The National Health Interview Survey and a nationally representative sample of Medicare beneficiaries (to identify the most prevalent chronic diseases in this population); the National Guideline Clearinghouse (for

Bozic, K. J., et al. (2014). "Bundled payments in total joint arthroplasty: targeting opportunities for quality improvement and cost reduction." Clin Orthop Relat Res **472**(1): 188-193.

BACKGROUND: Understanding the type and magnitude of services that patients receive postdischarge and the financial impact of readmissions is crucial to assessing the feasibility of accepting bundled payments. QUESTIONS/PURPOSES: The purposes of this study were to (1) determine the cost and service components of a 30-day total joint arthroplasty (TJA) episode of care; (2) analyze the portion of the total payment that is used for postdischarge services, including home care; and (3) to evaluate the frequency of readmissions and their impact on total episode-of-care payments. METHODS: All payments to Medicare providers (hospitals, postacute care facilities, physicians, and other healthcare providers) for services beginning with the index procedure and extending 30-days postdischarge were analyzed for 250 Medicare beneficiaries undergoing primary or revision TJA from a single institution over a 12 months. Payments and services were aggregated by procedure type and categorized as index procedure, postacute care, and related hospital readmissions. RESULTS: Mean episode-of-care payments ranged from USD 25,568 for primary TJA in patients with no comorbidities to USD 50,648 for revision TJA in patients with major comorbidities or complications, with wide variability within and across procedures. Postdischarge payments accounted for 36% of total payments. A total of 49% of patients were transferred to postacute care facilities, accounting for 70% of postdischarge payments. The overall 30-day unplanned readmission rate was 10%, accounting for 11% of postdischarge payments. CONCLUSIONS: Episode-of-care payments for TJAs vary widely depending on the type of procedure, patient comorbidities and complications, discharge disposition, and readmission rates. Postdischarge care accounted for more than one-third of total episode payments and varied substantially across patients and procedures.

Bras, P. L. et Duhamel, G. (2008). Rémunérer les médecins selon leurs performances : les enseignements des expériences étrangères. Paris La documentation française**:** 65. http://www.ladocumentationfrancaise.fr/rapports-publics/084000596/index.shtml

Certains pays ont adopté le dispositif de rémunération des médecins en fonction de leurs performances. Ce rapport présente les exemples britannique et américain : contexte, dispositif, paiement, coûts, résultats et perspectives. Il s'interroge sur la nature de la performance : qualité clinique, relations avec les patients, efficience D'autres questions se posent, telles la cohésion entre la gestion de la performance et le dossier médical personnel, la conception des indicateurs cliniques, l'adhésion et la motivation des médecins, la collecte et le contrôle des données... De cette étude, les auteurs tirent des enseignements pour la France, notamment sur l'opportunité d'implanter ce système de paiement.

Bras, P. L. et Duhamel, G. (2010). "Le système de soins anglais, un modèle pour la France ?" Seve : Les Tribunes De La Sante(26): 39-59, tabl., fig.

> L'organisation pluridisciplinaire de la médecine de recours, la prise en compte des performances en termes de qualité dans la rémunération des médecins, la culture de l'évaluation et de la transparence, la promotion du choix des patients, la prise en compte du calcul médico-économique dans les décisions sont autant de caractéristiques du système anglais qui peuvent contribuer à la réflexion dur les évolutions du système français. Il sera intéressant, dès lors que l'on aura un peu de recul, d'examiner, si, compte-tenu de la forte augmentation du budget de la NHS, le système anglais les a améliorés significativement au cours de la décennie 2000.

Brosig-Koch, J., et al. (2013). How Effective are Pay-for-Performance Incentives for Physicians? A Laboratory Experiment. Ruhr Economic Papers ; 143. Essen Universität Duisbourg - Essen: 36 , tabl., graph., fig.
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2278863

> Recent reforms in health care have introduced a variety of pay-for-performance programs using financial incentives for physicians to improve the quality of care. Their effectiveness is, however, ambiguous as it is often difficult to disentangle the effect of financial incentives from the ones of various other simultaneous changes in the system. In this study we investigate the effects of introducing financial pay-for-performance incentives with the help of controlled laboratory experiments. In particular, we use fee-for-service and capitation as baseline payment schemes and test how additional pay-for-performance incentives affect the medical treatment of different patient types. Our results reveal that, on average, patients significantly benefit from introducing pay-for performance, independently of whether it is combined with capitation or fee-for-service incentives. The magnitude of this effect is significantly influenced by the patient type, though. These results hold for medical and non-medical students. A cost-benefit analysis further demonstrates that, overall, the increase in patient benefits cannot overcompensate the additional costs associated with pay-for-performance. Moreover, our analysis of individual data reveals different types of responses to pay-for-performance incentives. We find some indication that pay-for performance might crowd out the intrinsic motivation to care for patients. These insights help to understand the effects caused by introducing pay-for-performance schemes.

Brocklehurst, P., et al. (2013). "The effect of different methods of remuneration on the behaviour of primary care dentists." Cochrane Database Syst Rev(11): Cd009853.

> BACKGROUND: Methods of remuneration have been linked with the professional behaviour of primary care physicians. In dentistry, this can be exacerbated as clinicians operate their practices as businesses and take the full financial risk of the provision of services. The main methods for remunerating primary care dentists include fee-for-service, fixed salary and capitation payments. The aim of this review was to determine the impact that these remuneration mechanisms have upon primary care dentists' behaviour. OBJECTIVES: To evaluate the effects of different methods of remuneration on the level and mix of activities provided by primary care dentists and the impact this has on patient outcomes. SEARCH METHODS: We searched the Cochrane Effective Practice and Organisation of Care (EPOC) Group Specialised Register; the Cochrane Central Register of Controlled Trials (CENTRAL, The Cochrane Library, Issue 7, 2013); MEDLINE (Ovid) (1947 to 11 June 2013); EMBASE (Ovid) (1947 to 11 June 2013); EconLit (1969 to 11 June 2013); the NHS Economic Evaluation Database (EED) (11 June 2013); and the Health Economic Evaluations Database (HEED) (11 June 2013). We conducted cited reference searches for the included studies in ISI Web of

Knowledge; searched grey literature sources; handsearched selected journals; and contacted authors of relevant studies. SELECTION CRITERIA: Primary care dentists were defined as clinicians that deliver routine or mainstream dental care in a primary care environment. We included randomised controlled trials (RCTs), non-randomised controlled clinical trials (NRCTs), controlled before-after (CBA) studies and interrupted time series (ITS) studies. The methods of remuneration that we considered were: fee-for-service, fixed salary and capitation payments. Primary outcome measures were: measures of clinical activity; volume of clinical activity undertaken; time taken and clinical session length, or both; clinician type utilised; measures of health service utilisation; access and attendance as a proportion of the population; re-attendance rates; recall frequency; levels of oral health inequalities; non-attendance rates; healthcare costs; measures of patient outcomes; disease reduction; health maintenance; and patient satisfaction. We also considered measures of practice profitability/income and any reported unintended effects of the included methods of remuneration. DATA COLLECTION AND ANALYSIS: Three of the review authors (PRB, JP, AMG) independently reviewed titles and abstracts and resolved disagreements by discussion. The same three review authors undertook data extraction and assessed the quality of the evidence from all the studies that met the selection criteria, according to Cochrane Collaboration procedures. MAIN RESULTS: Two cluster-RCTs, with data from 503 dental practices, representing 821 dentists and 4771 patients, met the selection criteria. We judged the risk of bias to be high for both studies and the overall quality of the evidence was low/very low for all outcomes, as assessed using the GRADE approach.One study used a factorial design to investigate the impact of fee-for-service and an educational intervention on the placement of fissure sealants in permanent molar teeth. The authors reported a statistically significant increase in clinical activity in the arm that was incentivised with a fee-for-service payment. However, the study was conducted in the four most deprived areas of Scotland, so the applicability of the findings to other settings may be limited. The study did not report data on measures of health service utilisation or measures of patient outcomes.The second study used a parallel group design undertaken over a three-year period to compare the impact of capitation payments with fee-for-service payments on primary care dentists' clinical activity. The study reported on measures of clinical activity (mean percentage of children receiving active preventive advice, health service utilisation (mean number of visits), patient outcomes (mean number of filled teeth, mean percentage of children having one or more teeth extracted and the mean number of decayed teeth) and healthcare costs (mean expenditure). Teeth were restored at a later stage in the disease process in the capitation system and the clinicians tended to see their patients less frequently and tended to carry out fewer fillings and extractions, but also tended to give more preventive advice.There was insufficient information regarding the cost-effectiveness of the different remuneration methods. AUTHORS' CONCLUSIONS: Financial incentives within remuneration systems may produce changes to clinical activity undertaken by primary care dentists. However, the number of included studies is limited and the quality of the evidence from the two included studies was low/very low for all outcomes. Further experimental research in this area is highly recommended given the potential impact of financial incentives on clinical activity, and particular attention should be paid to the impact this has on patient outcomes.

Brosig-Koch, J., et al. (2016). Physician Performance Pay: Evidence from a Laboratory Experiment. Ruhr Economic Papers ; 658. Essen Universität Duisbourg - Essen**:** 37 , tabl., graph., fig. http://econpapers.repec.org/paper/zbwrwirep/658.htm

We present causal evidence from a controlled experiment on the effect of pay for performance on physicians' behavior and patients' health benefits. At a within-subject level, we introduce performance pay to complement either fee-for-service or capitation.

Performance pay is granted if a health care quality threshold is reached, and varies with the patients' severity of illness. We find that performance pay significantly reduces overprovision of medical services due to fee-for-service incentives, and underprovision due to capitation; on average, it increases the patients' health benefit. The magnitude of these effects depends, however, on the patients' characteristics. We also find evidence for a crowding-out of patient-regarding behavior due to performance pay. Health policy implications are discussed.

Brun, F., E.. (2015). Quelle rémunération pour les médecins exerçant dans des structures interprofessionnelles ambulatoires, aux Etats-Unis, au Canada, aux Pays Bas et au Royaume Uni ? Revue de la littérature. Paris Université de Paris Dauphine. **Master Evaluation Médico-Economique et accès au marché (ENAM) ; Université Paris Dauphine:** 53.

Le projet de loi de santé de « Modernisation de notre système de santé » prévoit une évolution de la rémunération des médecins généralistes français. Or, « le droit à des honoraires pour tout malade soigné et le paiement direct par le malade » est un des principes de la chartre fondatrice de la médecine libérale de 1927, d'où l'indignation de nombreux médecins généralistes à ce propos. Bien qu'ils perçoivent aujourd'hui une partie de leur rémunération selon d'autres modalités (forfait par patient dont ils sont le médecin traitant, par patient présentant une maladie chronique, Rémunération sur Objectifs de Santé Publique) la plupart craint une évolution de son mode de rémunération, ainsi qu'une perte d'autonomie, chère à la médecine libérale. Or, le système de soins primaires français est aujourd'hui face à la nécessité d'évoluer : le vieillissement de la population et la croissance exponentielle du nombre de malades chroniques le place devant un défi considérable de financement mais avant cela même, d'organisation des soins. En 2008, la Loi de Financement de la Sécurité Sociale a mis en place une Expérimentation de Nouveaux Modes de Rémunération. destinés aux structures interprofessionnelles visant à valoriser les initiatives de coordination et de coopération. Ce système de rémunération a été généralisé en 2015, mais son évolution dépendra des résultats de l'évaluation de ces Nouveaux Modes de Rémunération (NMR) ainsi que d'éléments de comparaison étrangers. Afin de répondre à ce dernier objectif, cette étude propose une revue de la littérature visant à décrire différents modes de rémunération alternatifs au paiement à l'acte, à destination de groupes interprofessionnels aux Etats-Unis, au Canada, au Royaume Uni et aux Pays Bas. Dans une première partie, elle définit des concepts utiles à la compréhension du sujet, puis expose la méthode utilisée pour la recherche bibliographique. Dans une partie consacrée aux résultats, elle présente séparément pour chaque pays, le contexte d'évolution du système de santé, les structures interprofessionnelles en ambulatoire qui s'y sont développées et leur mode de financement. L'impact de ces modes de financement sera analysé de façon globale dans une courte seconde partie.

Brunt, C. S. et Jensen, G. A. (2014). "Pricing distortions in medicare's physician fee schedule and patient satisfaction with care quality and access." Health Econ **23**(7): 761-775.

Medicare adjusts its payments to physicians for geographic differences in the cost of operating a medical practice, but the method it uses is imprecise. We measure the inaccuracy in its geographic adjustment factors and categorize beneficiaries by whether they live where Medicare's formula is favorable or unfavorable to physicians. Then, using the 2001-2003 Medicare Current Beneficiary Survey, we examine whether differences in physician payment generosity, that is, whether favorable or unfavorable, influence the satisfaction ratings Medicare seniors assign to their quality of care and access to services. We find strong evidence that they do. Many beneficiaries live in payment-unfavorable areas and receive a less satisfying quality of care and less satisfying access to services than beneficiaries

who live where payments are favorable to physicians. Copyright (c) 2013 John Wiley & Sons, Ltd

Burrows, M. (2010). "Financement et organisation des soins primaires au Royaume-Uni, l'exemple du Primary Care Trust de Salford." Revue Francaise Des Affaires Sociales(3): 23-33, graph.

Directeur d'un Primary Care Trust (PCT), organisme responsable au niveau local du financement et de l'organisation des soins dans la ville de Salford (Angleterre), Mike Burrows présente le cadre général de délivrance des soins primaires au Royaume-Uni. Il propose une description de l'organisation et du fonctionnement des Primary Care Trusts et des trois contrats actuellement en vigueur entre le National Health Service (NHS) et les médecins généralistes au Royaume-Uni, en illustrant son propos à travers l?exemple du PCT de Salford.

Busse, R., et al. (2013). "Diagnosis-related groups in Europe : moving towards transparency, efficiency, and quality in hospitals ?" British Medical Journal **En ligne**: 1-7.

Calvert, M. et Shankar, A. (2009). "Effect of the quality and outcomes framework on diabetes care in the United Kingdom: retrospective cohort study." British Medical Journal(308): 1-11.

Des incitations financières établies en fonction des performances de santé des professionnels ont tendance à se répandre dans les politiques de santé. En avril 2004, un accord cadre sur la qualité des soins et les paramètres de santé (Program Pay for Performance) a été introduit pour la première fois au Royaume Uni dans le contexte d´un contrat entre les Autorités de Santé et les médecins généralistes. Ce contrat offrait un intéressement financier lorsqu´un certain nombre de paramètres (considérés comme des standards de qualité de prise en charge) étaient mesurés et que des modifications de la prise en charge visant à les améliorer étaient mises en place dans le but ultime d´améliorer la qualité des soins. Un certain nombre de critères, cliniques, organisationnels, satisfaction des patients, servaient de mesures. Le diabète était l´un des domaines intéressés par ce contrat cadre, apportant 93 des 650 points qu?il était possible d´obtenir. Les indicateurs, pour le diabète portaient sur 18 grands domaines tels que la mise en place d´un registre des patients diabétiques, la vérification de mesures de la pression artérielle, du cholestérol, de l´hémoglobine glyquée, etc. Les paiements étaient effectués de manière graduelle en fonction du résultat : il fallait un résultat minimal et le résultat optimal (permettant de toucher le maximum d´argent) était fixé en fonction des paramètres : le plus souvent, il était nécessaire que 90% des patients suivis par le MG les atteignent? Mais pour d´autres paramètres, les Autorités de Santé avaient fixé des objectifs plus modestes, ainsi, par exemple, l´objectif était atteint quand 50% des patients diabétiques avaient une HbA1c < 7,5% ou quand la PA était <145/85 chez 60%? Quand un MG considérait que l´objectif thérapeutique était inatteignable (par exemple patient en stade terminal, ou opposition du patient), un patient pouvait être sorti de l´évaluation. Un système de codage permettait de retrouver les paramètres des patients pour cette évaluation, à condition qu´ils soient correctement codés? L´étude a porté sur 147 cabinets de médecine générale (correspondant à un échantillon d´environ 1 million de personnes) dans tout le Royaume Uni. Les mesures des 3 années précédant et des 3 années ayant suivi la mise en place de l´accord cadre ont été comparées. Des améliorations nettes ont été observées dans la mise en place des mesures de prévention des complications du diabète. Cependant, cette amélioration avait déjà été observée avant l´introduction des incitations financières. Néanmoins, le problème principal est que le système n´apporte pas d´information chez environ 2/3 des diabétiques de type 1 et 1/3 des diabétiques de type 2, qui n´entrent pas dans la définition du cas diagnostique (problème de codage). De plus, après l´introduction du contrat cadre, les tendances observées quant à l´amélioration du contrôle glycémique, de la cholestérolémie et de la pression artérielle se sont atténuées.

L´introduction de ce système n´a pas apporté d´amélioration dans la prise en charge des diabétiques de type 1 ni n´a amené à une réduction du nombre de patients diabétiques de type 2 dont l´hémoglobine glyquée était > 10 %. En revanche, le système semble avoir augmenté le nombre de patients diabétiques de type 2 dont l´hémoglobine glyquée est < 7.5 %. Finalement, la prise en charge des patients diabétiques s´est améliorée à la fin des années 90 mais l´impact de ce type de système basé sur un accord cadre portant sur la mesure des complications du diabète et l´amélioration de la qualité des soins n´est pas évident. Il est probable que d´autres stratégies d´amélioration des soins aient été tout aussi importantes que ce système d´incitation financière? De plus, il est possible que beaucoup des patients dont la prise en charge était insuffisante n´aient pas « bénéficié » de cette évaluation.

Campbell, S., et al. (2008). "The experience of pay for performance in English family practice: a qualitative study." Annals of Family Medicine **6**(3): 228-234.

PURPOSE : We conducted an in-depth exploration of family physicians' and nurses' beliefs and concerns about changes to the family health care service as a result of the new pay-for-performance scheme in the United Kingdom (Quality and Outcomes Framework [QOF]). METHODS : Using a semistructured interview format, we interviewed 21 family doctors and 20 nurses in 22 nationally representative practices across England between February and August 2007. RESULTS : Participants believed the financial incentives had been sufficient to change behavior and to achieve targets. The findings suggest that it is not necessary to align targets to professional priorities and values to obtain behavior change, although doing so enhances enthusiasm and understanding. Participants agreed that the aims of the pay-for-performance scheme had been met in terms of improvements in disease-specific processes of patient care and physician income, as well as improved data capture. It also led to unintended effects, such as the emergence of a dual QOF-patient agenda within consultations, potential deskilling of doctors as a result of the enhanced role for nurses in managing long-term conditions, a decline in personal/relational continuity of care between doctors and patients, resentment by team members not benefiting financially from payments, and concerns about an ongoing culture of performance monitoring in the United Kingdom. CONCLUSIONS : The QOF scheme may have achieved its declared objectives of improving disease-specific processes of patient care through the achievement of clinical and organizational targets and increased physician income, but our findings suggest that it has changed the dynamic between doctors and nurses and the nature of the practitioner-patient consultation.

Campbell, S., et al. (2007). "Quality of primary care in England with the introduction of pay for performance." New England Journal of Medicine (the) **357**(357): 181-190.

Campbell, S. M., et al. (2009). "Effects of Pay for Performance on the Quality of Primary Care in England." New England Journal of Medicine (the) **361**(4): 368-378. http://content.nejm.org/cgi/reprint/361/4/368.pdf

Campbell, S. M., et al. (2009). "Effects of pay for performance on the quality of primary care in England." N Engl J Med **361**(4): 368-378.

BACKGROUND: A pay-for-performance scheme based on meeting targets for the quality of clinical care was introduced to family practice in England in 2004. METHODS: We conducted an interrupted time-series analysis of the quality of care in 42 representative family practices, with data collected at two time points before implementation of the scheme (1998 and 2003) and at two time points after implementation (2005 and 2007). At each time point, data on the care of patients with asthma, diabetes, or coronary heart disease were extracted

from medical records; data on patients' perceptions of access to care, continuity of care, and interpersonal aspects of care were collected from questionnaires. The analysis included aspects of care that were and those that were not associated with incentives. RESULTS: Between 2003 and 2005, the rate of improvement in the quality of care increased for asthma and diabetes (P<0.001) but not for heart disease. By 2007, the rate of improvement had slowed for all three conditions (P<0.001), and the quality of those aspects of care that were not associated with an incentive had declined for patients with asthma or heart disease. As compared with the period before the pay-for-performance scheme was introduced, the improvement rate after 2005 was unchanged for asthma or diabetes and was reduced for heart disease (P=0.02). No significant changes were seen in patients' reports on access to care or on interpersonal aspects of care. The level of the continuity of care, which had been constant, showed a reduction immediately after the introduction of the pay-for-performance scheme (P<0.001) and then continued at that reduced level. CONCLUSIONS: Against a background of increases in the quality of care before the pay-for-performance scheme was introduced, the scheme accelerated improvements in quality for two of three chronic conditions in the short term. However, once targets were reached, the improvement in the quality of care for patients with these conditions slowed, and the quality of care declined for two conditions that had not been linked to incentives. Continuity of care was reduced after the introduction of the scheme.

Carroll, C., et al. (2017). Effects of Episode-Based Payment on Health Care Spending and Utilization: Evidence from Perinatal Care in Arkansas. NBER Working Paper Series ; 23926. Cambridge NBER**:** 45 , tabl., fig.
http://www.nber.org/papers/w23926.pdf

We study how physicians respond to financial incentives imposed by episode-based bundled payment (EBP), which encourages lower spending and improved quality for an entire episode of care. Specifically, we study the impact of the Arkansas Health Care Payment Improvement Initiative, a multi-payer program that requires providers in the state to enter into EBP arrangements for perinatal care. Because of its multi-payer nature and the requirement that providers participate, the program covers the vast majority of births in the state. Unlike fee-for service reimbursement, EBP holds physicians responsible for all care within a discrete clinical episode, rewarding physicians not only for efficient use of their own services but also for efficient management of other health care inputs. In a difference-in-differences analysis of commercial claims, we find that perinatal spending decreased by 3.8% overall in Arkansas after the introduction of EBP, compared to surrounding states. We find that the decrease was driven by reduced spending on non-physician health care inputs, specifically the prices paid for inpatient facility care, and that our results are robust to a number of sensitivity and placebo tests. We additionally find that EBP was associated with a limited improvement in quality of care

Cashin, C. et al. (2014). Paying for Performance in Health Care : implications for health system performance and accountability, Maidenhead : Open University Press
http://www.euro.who.int/en/publications/abstracts/paying-for-performance-in-health-care.-implications-for-health-system-performance-and-accountability

Health spending continues to outstrip the economic growth of most member countries of the Organisation for Economic Co-operation and Development (OECD). Pay for performance (P4P) has been identified as an innovative tool to improve the efficiency of health systems but evidence that it increases value for money, boosts quality or improves health outcomes is limited. Using a set of case studies from 12 OECD countries (including Estonia, France, Germany, Turkey and the United Kingdom), this book explores whether the potential power

of P4P has been over-sold, or whether the disappointing results to date are more likely to be rooted in problems of design and implementation or inadequate monitoring and evaluation. Each case study analyses the design and implementation of decisions, including the role of stakeholders; critically assesses objectives versus results; and examines the "net" impacts, including positive spillover effects and unintended consequences. With experiences from both high and middle-income countries, in primary and acute care settings, and both national and pilot programmes, these studies provide health finance policy-makers in diverse settings with a nuanced assessment of P4P programmes and their potential impact on the performance of health systems (4e de couverture).

Cavalieri, M., et al. (2013). "Reimbursement systems and quality of hospital care: An empirical analysis for Italy." Health Policy (Amsterdam, Netherlands) **111**(3): 273-289.
http://linkinghub.elsevier.com/retrieve/pii/S0168851013001516?showall=true

There is an ongoing debate about the effect of different reimbursement systems on hospital performance and quality of care. The present paper aims at contributing to this literature by analysing the impact of different hospital payment schemes on patientsƒ_T outcomes in Italy. The Italian National Health Service is, indeed, a particularly interesting case since it has been subject to a considerable decentralization process with wider responsibilities devolved to regional governments. Therefore, great variability exists in the way tariffs are used, as Regions have settled them in accordance with the characteristics of health care providers. An empirical analysis of the Italian hospital system is carried out using data from the National Program for Outcome Assessment on mortality and readmissions for Acute Myocardial Infarction (AMI), Congestive Heart Failure (CHF), stroke and Chronic Obstructive Pulmonary Diseases (COPD) in the years 2009ƒ_"2010. The results show that hospitals operating in Regions where prospective payments are used more extensively are generally associated with better quality of care

CFHI (2014). Exploring Accountable Care in Canada: Integrating Financial and Quality Incentives for Physicians and Hospitals. Ottawa Canadian Foundation For Healthcare Improvement**:** 44 , tabl.
http://www.cfhi-fcass.ca/sf-docs/default-source/reports/exploring-accountable-care-brown-en.pdf

Pioneered in the US, accountable care organizations (ACOs) are provider organizations that assume accountability for the costs and quality of care. This paper explores the feasibility of establishing ACOs in Ontario, and concludes that they are powerful vehicles for aligning physician and hospital interests in cost reduction and quality improvement.

Chen, C. C. et Cheng, S. H. (2016). "Does pay-for-performance benefit patients with multiple chronic conditions? Evidence from a universal coverage health care system." Health Policy and Planning **31**(1): 83-90.
http://heapol.oxfordjournals.org/content/31/1/83.abstract

Introduction: Numerous studies have examined the impact of pay-for-performance (P4P) programmes, yet little is known regarding their effects on continuity of care (COC) and the role of multiple chronic conditions (MCCs). This study aimed to examine the effects of a P4P programme for diabetes care on health care provision, COC and health care outcomes in diabetic patients with and without comorbid hypertension.Methods: This study utilized a large-scale natural experiment with a 4-year follow-up period under a compulsory universal health insurance programme in Taiwan. The intervention groups consisted of patients with diabetes who were enrolled in the P4P programme in 2005. The comparison groups were selected via propensity score matching with patients who were seen by the same group of physicians. A difference-in-differences analysis was conducted using generalized estimating

equation models to examine the effects of the P4P programme.Results: Significant impacts were observed after the implementation of the P4P programme for diabetic patients with and without hypertension. The programme increased the number of necessary examinations/tests and improved the COC between patients and their physicians. The programme significantly reduced the likelihood of diabetes-related hospital admissions and emergency department visits [odds ratio (OR): 0.71; 95% confidence interval (CI): 0.63–0.80 for diabetic patients with hypertension; OR: 0.74; 95% CI: 0.64–0.86 for patients without hypertension]. However, the effects of the P4P programme diminished to some extent in the second year after its implementation.Conclusion: This study suggests that a financial incentive programme may improve the provision of necessary health care, COC and health care outcomes for diabetic patients both with and without comorbid hypertension. Health authorities could develop policies to increase participation in P4P programmes and encourage continued improvement in health care outcomes.

Bozic, K. J., et al. (2014). "Bundled payments in total joint arthroplasty: targeting opportunities for quality improvement and cost reduction." Clin Orthop Relat Res **472**(1): 188-193.

BACKGROUND: Understanding the type and magnitude of services that patients receive postdischarge and the financial impact of readmissions is crucial to assessing the feasibility of accepting bundled payments. QUESTIONS/PURPOSES: The purposes of this study were to (1) determine the cost and service components of a 30-day total joint arthroplasty (TJA) episode of care; (2) analyze the portion of the total payment that is used for postdischarge services, including home care; and (3) to evaluate the frequency of readmissions and their impact on total episode-of-care payments. METHODS: All payments to Medicare providers (hospitals, postacute care facilities, physicians, and other healthcare providers) for services beginning with the index procedure and extending 30-days postdischarge were analyzed for 250 Medicare beneficiaries undergoing primary or revision TJA from a single institution over a 12 months. Payments and services were aggregated by procedure type and categorized as index procedure, postacute care, and related hospital readmissions. RESULTS: Mean episode-of-care payments ranged from USD 25,568 for primary TJA in patients with no comorbidities to USD 50,648 for revision TJA in patients with major comorbidities or complications, with wide variability within and across procedures. Postdischarge payments accounted for 36% of total payments. A total of 49% of patients were transferred to postacute care facilities, accounting for 70% of postdischarge payments. The overall 30-day unplanned readmission rate was 10%, accounting for 11% of postdischarge payments. CONCLUSIONS: Episode-of-care payments for TJAs vary widely depending on the type of procedure, patient comorbidities and complications, discharge disposition, and readmission rates. Postdischarge care accounted for more than one-third of total episode payments and varied substantially across patients and procedures.

Chen, T. T., et al. (2011). "The unintended consequence of diabetes mellitus pay-for-performance (P4P) program in Taiwan: are patients with more comorbidities or more severe conditions likely to be excluded from the P4P program?" Health Serv Res **46**(1 Pt 1): 47-60.
https://www.ncbi.nlm.nih.gov/pubmed/20880044

OBJECTIVE: Taiwan has instituted a pay-for-performance (P4P) program for diabetes mellitus (DM) patients that rewards doctors based in part on outcomes for their DM patients. Doctors are permitted to choose which of their DM patients are included in the P4P program. We test whether seriously ill DM patients are disproportionately excluded from the P4P program. DATA SOURCE/STUDY SETTING: This study utilizes data from the National Health Insurance (NHI) database in Taiwan for the period of January 2007 to December 2007. Our sample includes 146,481 DM-P4P patients (16.56 percent of the total) and 737,971 non-DM-P4P

patients. DATA COLLECTION/EXTRACTION METHODS: We use logistic and multilevel models to estimate the effects of patient and hospital characteristics on P4P selection. PRINCIPAL FINDINGS: The results show that older patients and patients with more comorbidities or more severe conditions are prone to be excluded from P4P programs. CONCLUSIONS: We found that DM patients are disproportionately excluded from P4P programs. Our results point to the importance of mandated participation and risk adjustment measures in P4P programs.

Cheng, A. H. et Sutherland, J. M. (2013). "British Columbia's pay-for-performance experiment: Part of the solution to reduce emergency department crowding?" Health Policy (Amsterdam, Netherlands) **113**(1-2): 86-92.

BACKGROUND: Emergency department (ED) overcrowding continues to be a well-publicized problem in a number of countries. In British Columbia, a province in Canada, an ED pay-for-performance (ED P4P) program was initiated in 2007 to create financial incentives for hospitals to reduce patients' ED length of stay (ED LOS). This study's objectives are to determine if the ED P4P program is associated with decreases in ED LOS, and to address the ED P4P program's limitations. METHODS: We analyze monthly hospital-level ED LOS time data since the inception of the financial incentives. Since the ED P4P program was phased in at different hospitals from different health authorities over time, hospitals' data from only two regional health authorities are included in the study. RESULTS: We find association between the implementation of ED P4P and ED LOS time data. However, due to the lack of control data, the findings cannot demonstrate causality. Furthermore, our findings are from hospitals in the greater Vancouver area only. INTERPRETATION: BC's ED P4P was introduced to create incentives for hospitals to reduce ED LOS by providing incremental incentive funding. Available data indicate that the ED P4P program is associated with mixed successes in reducing ED LOS among participating hospitals

Ching-To, A. (1994). "Health care payment systems : cost and quality incentives." Journal of Economics & Management Strategy **3**(1): 93-112.

Chiu, H. C., et al. (2016). "Patient assessment of diabetes care in a pay-for-performance program." International Journal for Quality in Health Care **28**(2): 183-190.
http://intqhc.oxfordjournals.org/content/intqhc/28/2/183.full.pdf
http://intqhc.oxfordjournals.org/content/28/2/183.long

Objective Few studies address quality of care in pay-for-performance (P4P) programs from the perspective of patients' perceptions. This study aimed to examine and compare the patient assessment of diabetes chronic care as perceived by diabetic patients enrolled and not enrolled in a P4P program from the patients' self-reported perspectives.Design A cross-sectional study with case and comparison group design.Setting A large-scale survey was conducted from February to November 2013 in 18 healthcare institutions in Taiwan.Participants A total of 1458 P4P (n = 1037) and non-P4P (n = 421) diabetic patients participated in this large survey. The Chinese version of the Patient Assessment of Chronic Illness Care (PACIC) instrument was used and patients' clinical outcome data (e.g. HbA1c, LDL) were collected.Intervention None.Main Outcome Measures Five subscales from the PACIC were measured, including patient activation, delivery system design/system support, goal setting/tailoring, problem solving/contextual and follow-up/coordination. Patient clinical outcomes were also measured. Multiple linear regression and logistic regression models were used and controlled for patient demographic and health institution characteristics statistically.Results After adjusting for covariates, P4P patients had higher overall scores on the PACIC and five subscales than non-P4P patients. P4P patients also had

better clinical processes of care (e.g. HbA1c test) and intermediate outcomes.Conclusions Patients who participated in the program likely received better patient-centered care given the original Chronic Care Model. Better perceptions of diabetic care assessment also better clinical outcomes. The PACIC instrument can be used for the patient assessment of chronic care in a P4P program.

Christianson, J., et al. (2011). Paying for quality: Understanding and assessing physician pay-for-performance initiatives. Research synthesis report; 13. Princeton Robert Wood Johnson Foundation**:** 44 ,tabl. ann.
http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2007/rwjf19901/subassets/rwjf19901_1

Pay-for-performance (P4P) initiatives have been discussed since the early 1990s, but support for the concept has grown recently, fueled by experience with quality of care measures, endorsements by key players and research that underlines the need for quality improvements and reform to the physician payment system. This synthesis examines the evidence on P4P. Key findings include: About one-third of U.S. physicians already face quality-based incentives under their managed care contracts. These measures most often relate to clinical targets, efficiency, patient satisfaction and use of information technology, but apply to a limited set of specific diseases and preventive care services. While 80 percent of plans pay for meeting benchmarks, 20 percent pay for improvements in performance. Overall, incentive payments are small, averaging at most 5 percent of total payments. While large-scale, "real-life" research consistently shows improvement in quality indicators when P4P is in place, it is hard to disentangle the impact of P4P from that of other simultaneous quality initiatives. Evidence of P4P impact from small controlled studies has not been positive. Doctors are generally supportive of P4P but concerned about how well it can be implemented.

Christianson, J. B., et al. (2008). "Lessons from evaluations of purchaser pay-for-performance programs: a review of the evidence." Medical Care Research and Review **65**(6 suppl): 5S-35S.

There has been a growing interest in the use of financial incentives to encourage improvements in the quality of health care. Several articles have reviewed past studies of the impact of specific incentive arrangements, but these studies addressed smallscale experiments, making their findings arguably of limited relevance to current improvement efforts. In this article, the authors review evaluations of more recent pay for-performance initiatives instituted by health plans or by provider organizations in cooperation with health plans. Findings show improvement in selected quality measures in most of these initiatives, but the contribution of financial incentives to that improvement is not clear; the incentives typically were implemented in conjunction with other quality improvement efforts, or there was not a convincing comparison group. However, the literature relating to purchaser pay-for-performance initiatives does underscore several important issues that deserve attention going forward that relate to the design and implementation of pay-for-performance initiatives.

Conference Boardof Canada (2014). Family Doctor Incentives: Getting Closer to the Sweet Spot. Ottawa The Conference Board of Canada**:** 18 , tabl., fig.
http://www.conferenceboard.ca/e-library/abstract.aspx?did=6224

This paper adresses the question: What is the best way to pay family doctors to achieve the best patient outcomes? Instead of choosing one model, policy-makers should aim for the right "incentive blend" for each context, guided by principles that consider health care goals,

experience elsewhere, and human motivation. These principles include not undermining doctors' intrinsic motivation, aligning pay with quality improvements, ensuring that incentives do not have loopholes, adjusting for different contexts, and not overplaying financial incentives.

Curtin, K., et al. (2006). "Return on investment in pay for performance: a diabetes case study." Journal of Healthcare Management **51**(6): 365-376.

Dale, C. R., et al. (2016). "Counting Better — The Limits and Future of Quality-Based Compensation." New England Journal of Medicine **375**(7): 609-611.
http://www.nejm.org/doi/full/10.1056/NEJMp1604897

Damberg, C. L., et al. (2015). "Pay-for-performance schemes that use patient and provider categories would reduce payment disparities." Health Aff (Millwood) **34**(1): 134-142.

Providers that care for disproportionate numbers of disadvantaged patients tend to perform less well than other providers on quality measures commonly used in pay-for-performance programs. This can lead to the undesired effect of redistributing resources away from providers that most need them to improve care. We present a new pay-for-performance scheme that retains the motivational aspects of standard incentive designs while avoiding undesired effects. We tested an alternative incentive payment approach that started with a standard incentive payment allocation but then "post-adjusted" provider payments using predefined patient or provider characteristics. We evaluated whether such an approach would mitigate the negative effects of redistributions of payments across provider organizations in California with disparate patient populations. The post-adjustment approach nearly doubled payments to disadvantaged provider organizations and greatly reduced payment differentials across provider organizations according to patients' income, race/ethnicity, and region. The post-adjustment of payments could be a useful supplement to paying for improvement, aligning the goals of disparity reduction and quality improvement.

Das, A., et al. (2016). "Adding A Spending Metric To Medicare's Value-Based Purchasing Program Rewarded Low-Quality Hospitals." Health Affairs **35**(5): 898-906.
http://content.healthaffairs.org/content/35/5/898.abstract
http://content.healthaffairs.org/content/35/5/898.long

In fiscal year 2015 the Centers for Medicare and Medicaid Services expanded its Hospital Value-Based Purchasing program by rewarding or penalizing hospitals for their performance on both spending and quality. This represented a sharp departure from the program's original efforts to incentivize hospitals for quality alone. How this change redistributed hospital bonuses and penalties was unknown. Using data from 2,679 US hospitals that participated in the program in fiscal years 2014 and 2015, we found that the new emphasis on spending rewarded not only low-spending hospitals but some low-quality hospitals as well. Thirty-eight percent of low-spending hospitals received bonuses in fiscal year 2014, compared to 100 percent in fiscal year 2015. However, low-quality hospitals also began to receive bonuses (0 percent in fiscal year 2014 compared to 17 percent in 2015). All high-quality hospitals received bonuses in both years. The Centers for Medicare and Medicaid Services should consider incorporating a minimum quality threshold into the Hospital Value-Based Purchasing program to avoid rewarding low-quality, low-spending hospitals.

Datta, B. et Ya, Q. (2007). An Incentive Mechanism for Using Risk Adjuster to Reimburse Health Care Provider. Discussion Papers in Economics ; n° 2007/30. York University of York**:** 32 , fig., ann.

http://www.york.ac.uk/depts/econ/documents/dp/0730.pdf

> Health care providers are almost always universally reimbursed by third party purchasers. As a result, health care purchasers are faced with risk selection challenges. In response, risk adjustment methods are introduced in the reimbursement for services. However, health care providers under this arrangement have incentives to manipulate the risk elements in an attempt to obtain larger payments from the purchasers i.e. the realisation of risk adjuster then becomes sensitive to the providers upcoding behaviour. Whilst there is usually an outside auditor (e.g from the office of inspector general of the department of health and human services in the United States) who randomly monitors providers'behaviour and imposes penalty in the event that dishonesty is detected, monitoring such behaviour is highly costly. In this paper, we propose a reward scheme to combat such moral hazard problems. We analyse two types of incentive schemes where treatment intensity is contractible in one and not in the other. We show that under both incentive schemes, the honest provider receives the same reward and obtains higher expected utility in comparison to the full information case. Further, with contractible treatment intensity, the contract resembles the full information one.

De Brantes, F.., et al. (2009). "Building a Bridge from Fragmentation to Accountability ? The Prometheus Payment Model." New England Journal of Medicine (the) **361**(11): 1033-1036. http://content.nejm.org/cgi/reprint/NEJMp0906121.pdf

De Brantes, F. et Camillus, J. A. (2007). Evidence-informed case rates : a new health care payment model. New York Commonwealth Fund**:** 20 , tabl., fig. http://www.commonwealthfund.org/usr_doc/deBrantes_evidence-informedcaserates_1022.pdf?section=4039

> As a way to address the flaws of traditional payment methods, like fee-for-service and capitation, the authors of this report suggest a new payment model, based on evidence-informed case rates (ECRs). Under this system, providers are paid a single, risk-adjusted payment across inpatient and outpatient settings to care for a patient diagnosed with a specific condition. Working with experts in the health care field, the authors selected 10 conditions for ECR development, examining issues like diagnosis, services covered by the ECR, and criteria for successful completion of care. This new model, say the authors, can improve health care quality, lower administrative burden, enhance transparency, and support a patient-centered, consumer-driven environment. To further promote quality care, the ECR model calls for a portion of the payment to be withheld and re-distributed based on provider performance on measures of clinical process, outcomes of care, and patient experiences.

De Brunins, R., et al. (2011). "Pay-for-performance in disease management: a systematic review of the literature." Bmc Health Services Research **11**(272): 34 , fig. http://www.biomedcentral.com/content/pdf/1472-6963-11-272.pdf

> Pay-for-performance (P4P) is increasingly implemented in the healthcare system to encourage improvements in healthcare quality. P4P is a payment model that rewards healthcare providers for meeting pre-established targets for delivery of healthcare services by financial incentives. Based on their performance, healthcare providers receive either additional or reduced payment. Currently, little is known about P4P schemes intending to improve delivery of chronic care through disease management. The objectives of this paper are therefore to provide an overview of P4P schemes used to stimulate delivery of chronic

care through disease management and to provide insight into their effects on healthcare quality and costs.

De Voorde, C., et al. (2013). A comparative analysis of hospital care payments in five countries. KCE Report ;207. Bruxelles KCE**:** 122 , tabl., fig. https://kce.fgov.be/sites/default/files/page_documents/KCE_207_hospital_financing.pdf

Recently, the hospital payment system, including the remuneration of medical specialists, has been the topic of considerable policy debate in Belgium. The Minister of Social Affairs and Public Health announced 'a roadmap for a prospective hospital payment system, based pathologies, to be presented to the Council of Ministers at the beginning of October 2013'. As part of that roadmap, the Strategic Cell of the Minister asked KCE (May 2013) to make a comparative analysis of the prospective case-based hospital payment systems, including the remuneration of medical specialists, in a selection of countries. The focus of this comparative analysis is on the 'lessons learned' from the introduction and reforms of such systems. Special attention will be given to financial incentives to improve quality and to encourage the implementation of integrated care systems. The report addresses three research questions : How are hospitals and medical specialists paid in a selection of countries with a prospective case ? What are the intended/unintended consequences of a case prospective hospital payment system? 3. How are incentives for improving quality and for stimulating integrated care systems introduced in hospital payment systems? The ultimate goal of the report is to identify the lessons that can be learned from the hospital payment system and remuneration of medical specialists in the selected countries (résumé de l'éditeur).

Doran, T., et al. (2006). "Pay for performance in family practices in the United Kingdom." New England Journal of Medicine (the) **355**(4): 375-384.

Doran, T., et al. (2008). "Effect of financial incentives on inequalities in the delivery of primary clinical care in England: analysis of clinical activity indicators for the quality and outcomes framework." The Lancet **372**(9640): 728-736.

Doran, T., et al. (2008). "Exclusion of patients from pay-for-performance targets by english physicians." New England Journal of Medicine (the) **359**(3): 274-284.

Doran, T., et al. (2011). "Effect of financial incentives on incentivised and non-incentivised clinical activities: longitudinal analysis of data from the UK Quality and Outcomes Framework." Bmj (Clinical Research Ed.) **342**: 1-12.

OBJECTIVE : To investigate whether the incentive scheme for UK general practitioners led them to neglect activities not included in the scheme. DESIGN : Longitudinal analysis of achievement rates for 42 activities (23 included in incentive scheme, 19 not included) selected from 428 identified indicators of quality of care. SETTING : 148 general practices in England (653à 500 patients). MAIN OUTCOME MEASURES : achievement rates projected from trends in the pre-incentive period (2000-1 to 2002-3) and actual rates in the first three years of the scheme (2004-5 to 2006-7). RESULTS : Achievement rates improved for most indicators in the pre-incentive period. There were significant increases in the rate of improvement in the first year of the incentive scheme (2004-5) for 22 of the 23 incentivised indicators. Achievement for these indicators reached a plateau after 2004-5, but quality of care in 2006-7 remained higher than that predicted by pre-incentive trends for 14 incentivised indicators. There was no overall effect on the rate of improvement for non-incentivised indicators in the first year of the scheme, but by 2006-7 achievement rates were significantly below those predicted by pre-incentive trends. CONCLUSIONS : There were

substantial improvements in quality for all indicators between 2001 and 2007. Improvements associated with financial incentives seem to have been achieved at the expense of small detrimental effects on aspects of care that were not incentivised.

Dowd, B., et al. (2013). "Setting pay for performance targets: do poor performers give up?" Health Economics **22**(2): 168-179.

We examine the effect of a health plan's pay for performance incentives on the percentage of outpatient drug prescriptions that are filled with generic rather than brand-name drugs in physicians' practices in an established physician network - the generic prescription rate (GPR)

Dowd, B., et al. (2013). "Setting pay for performance targets: do poor performers give up?" Health Economics **22**(2): 168-179.
http://dx.doi.org/10.1002/hec.2773

We examine the effect of a health plan's pay for performance incentives on the percentage of outpatient drug prescriptions that are filled with generic rather than brand-name drugs in physicians' practices in an established physician network ƒ_" the generic prescription rate (GPR). The financial reward was based on the performance of the entire network, but the network implemented rewards at the practice level. Practice-level rewards were awarded on an all-or-nothing basis if the GPR met or exceeded specialty-specific targets that increased each year. Although that design gave the practices a strong incentive to meet the target, practices performing far below the target might ƒ_~give upƒ_T, costing the network its reward. Using a partial adjustment model, we estimate that in the absence of pay for performance, the average equilibrium value of GPR was 58.3%. We estimate that GPR would be maximized if the target were set at 77%. The GPR-maximizing target would induce an improvement in average GPR from 58.3% to 65.8% or 7.5 percentage points. When the target is set above 80%, practices with equilibrium GPR below 58.3% will ƒ_~give upƒ_T in the sense that they will not improve relative to their equilibrium value. Copyright ¶¸ 2012 John Wiley & Sons, Ltd

Drummond, M. (2015). "When do performance-based risk-sharing arrangements make sense?" Eur J Health Econ **16**(6): 569-571.

Duckett, S., et al. (2008). "Pay for performance in Australia: Queensland's new Clinical Practice Improvement Payment." Journal of Health Services Research & Policy **13**(3): 174-177.

Dyas, S. R., et al. (2015). "Process-Improvement Cost Model for the Emergency Department." J Healthc Manag **60**(6): 442-457.

The objective of this report is to present a simplified, activity-based costing approach for hospital emergency departments (EDs) to use with Lean Six Sigma cost-benefit analyses. The cost model complexity is reduced by removing diagnostic and condition-specific costs, thereby revealing the underlying process activities' cost inefficiencies. Examples are provided for evaluating the cost savings from reducing discharge delays and the cost impact of keeping patients in the ED (boarding) after the decision to admit has been made. The process-improvement cost model provides a needed tool in selecting, prioritizing, and validating Lean process-improvement projects in the ED and other areas of patient care that involve multiple dissimilar diagnoses.

Eijkenaar, F. (2013). "Key issues in the design of pay for performance programs." The European Journal of Health Economics **14**(1): 117-131.

http://ejournals.ebsco.com/direct.asp?ArticleID=48DAAE89614097FACD1F

Pay for performance (P4P) is increasingly being used to stimulate healthcare providers to improve their performance. However, evidence on P4P effectiveness remains inconclusive. Flaws in program design may have contributed to this limited success. Based on a synthesis of relevant theoretical and empirical literature, this paper discusses key issues in P4P-program design. The analysis reveals that designing a fair and effective program is a complex undertaking. The following tentative conclusions are made: (1) performance is ideally defined broadly, provided that the set of measures remains comprehensible, (2) concerns that P4P encourages "selection" and "teaching to the test" should not be dismissed, (3) sophisticated risk adjustment is important, especially in outcome and resource use measures, (4) involving providers in program design is vital, (5) on balance, group incentives are preferred over individual incentives, (6) whether to use rewards or penalties is context-dependent, (7) payouts should be frequent and low-powered, (8) absolute targets are generally preferred over relative targets, (9) multiple targets are preferred over single targets, and (10) P4P should be a permanent component of provider compensation and is ideally "decoupled" form base payments. However, the design of P4P programs should be tailored to the specific setting of implementation, and empirical research is needed to confirm the conclusions.Pay for performance (P4P) is increasingly being used to stimulate healthcare providers to improve their performance. However, evidence on P4P effectiveness remains inconclusive. Flaws in program design may have contributed to this limited success. Based on a synthesis of relevant theoretical and empirical literature, this paper discusses key issues in P4P-program design. The analysis reveals that designing a fair and effective program is a complex undertaking. The following tentative conclusions are made: (1) performance is ideally defined broadly, provided that the set of measures remains comprehensible, (2) concerns that P4P encourages "selection" and "teaching to the test" should not be dismissed, (3) sophisticated risk adjustment is important, especially in outcome and resource use measures, (4) involving providers in program design is vital, (5) on balance, group incentives are preferred over individual incentives, (6) whether to use rewards or penalties is context-dependent, (7) payouts should be frequent and low-powered, (8) absolute targets are generally preferred over relative targets, (9) multiple targets are preferred over single targets, and (10) P4P should be a permanent component of provider compensation and is ideally "decoupled" form base payments. However, the design of P4P programs should be tailored to the specific setting of implementation, and empirical research is needed to confirm the conclusions

Eijkenaar, F., et al. (2013). "Effects of pay for performance in health care: A systematic review of systematic reviews." Health Policy (Amsterdam, Netherlands) **110**(2-3): 115-130.

BACKGROUND: A vast amount of literature on effects of pay-for-performance (P4P) in health care has been published. However, the evidence has become fragmented and it has become challenging to grasp the information included in it. OBJECTIVES: To provide a comprehensive overview of effects of P4P in a broad sense by synthesizing findings from published systematic reviews. METHODS: Systematic literature search in five electronic databases for English, Spanish, and German language literature published between January 2000 and June 2011, supplemented by reference tracking and Internet searches. Two authors independently reviewed all titles, assessed articles' eligibility for inclusion, determined a methodological quality score for each included article, and extracted relevant data. RESULTS: Twenty-two reviews contain evidence on a wide variety of effects. Findings suggest that P4P can potentially be (cost-)effective, but the evidence is not convincing; many studies failed to find an effect and there are still few studies that convincingly disentangled the P4P effect from the effect of other improvement initiatives. Inequalities among socioeconomic groups

have been attenuated, but other inequalities have largely persisted. There is some evidence of unintended consequences, including spillover effects on unincentivized care. Several design features appear important in reaching desired effects. CONCLUSION: Although data is available on a wide variety of effects, strong conclusions cannot be drawn due to a limited number of studies with strong designs. In addition, relevant evidence on particular effects may have been missed because no review has explicitly focused on these effects. More research is necessary on the relative merits of P4P and other types of incentives, as well as on the long-term impact on patient health and costs

Ellegard, L. M., et al. (2017). "Can pay-for-performance to primary care providers stimulate appropriate use of antibiotics?" Health Econ(Ahead of print).

Antibiotic resistance is a major threat to public health worldwide. As the healthcare sector's use of antibiotics is an important contributor to the development of resistance, it is crucial that physicians only prescribe antibiotics when needed and that they choose narrow-spectrum antibiotics, which act on fewer bacteria types, when possible. Inappropriate use of antibiotics is nonetheless widespread, not least for respiratory tract infections (RTI), a common reason for antibiotics prescriptions. We examine if pay-for-performance (P4P) presents a way to influence primary care physicians' choice of antibiotics. During 2006-2013, 8 Swedish healthcare authorities adopted P4P to make physicians select narrow-spectrum antibiotics more often in the treatment of children with RTI. Exploiting register data on all purchases of RTI antibiotics in a difference-in-differences analysis, we find that P4P significantly increased the share of narrow-spectrum antibiotics. There are no signs that physicians gamed the system by issuing more prescriptions overall.

Ellis, R. P., et al. (2015). Provider Payment Methods and Incentives. International Encyclopedia of Public Health**:** 27.
http://d.repec.org/n?u=RePEc:bos:wpaper:wp2015-023&r=hea

Diverse provider payment systems create incentives that affect the quantity and quality of health care services provided. Payments can be based on provider characteristics, which tend to minimize incentives for quality and quantity. Or payments can be based on quantities of services provided and patient characteristics, which provide stronger incentives for quality and quantity. Payments methods using both broader bundles of services and larger numbers of payment categories are growing in prevalence. The recent innovation of performance-based payment attempts to target payments on key patient attributes so as to improve incentives, better manage patients, and control costs.

Emmert, M., et al. (2012). "Economic evaluation of pay-for-performance in health care: a systematic review." Eur J Health Econ **13**(6): 755-767.
http://link.springer.com/article/10.1007%2Fs10198-011-0329-8

BACKGROUND: Pay-for-performance (P4P) intents to stimulate both more effective and more efficient health care delivery. To date, evidence on whether P4P itself is an efficient method has not been systematically analyzed. OBJECTIVE: To identify and analyze the existing literature regarding economic evaluation of P4P. DATA SOURCES: English, German, Spanish, and Turkish language literature were searched in the following databases: Business Source Complete, the Cochrane Library, Econlit, ISI web of knowledge, Medline (via PubMed), and PsycInfo (January 2000-April 2010). STUDY SELECTION: Articles published in peer-reviewed journals and describing economic evaluations of P4P initiatives. Full economic evaluations, considering costs and consequences of the P4P intervention simultaneously, were the prime focus. Additionally, comparative partial evaluations were included if costs were described

and the study allows for an assessment of consequences. Both experimental and observational studies were considered. RESULTS: In total, nine studies could be identified. Three studies could be regarded as full economic evaluations, and six studies were classified as partial economic evaluations. Based on the full economic evaluations, P4P efficiency could not be demonstrated. Partial economic evaluations showed mixed results, but several flaws limit their significance. Ranges of costs and consequences were typically narrow, and programs differed considerably in design. Methodological quality assessment showed scores between 32% and 65%. CONCLUSION: The results show that evidence on the efficiency of P4P is scarce and inconclusive. P4P efficiency could not be demonstrated. The small number and variability of included studies limit the strength of our conclusions. More research addressing P4P efficiency is needed

Emmert, M., et al. (2012). "Economic evaluation of pay-for-performance in health care: a systematic review." European Journal of Health Economics (the) **13**(6): 755-767, tabl., graph.

Pay-for-performance (P4P) intents to stimulate both more effective and more efficient health care delivery. To date, evidence on whether P4P itself is an efficient method has not been systematically analyzed. To identify and analyze the existing literature regarding economic evaluation of P4P. English, German, Spanish, and Turkish language literature were searched in the following databases: Business Source Complete, the Cochrane Library, Econlit, ISI web of knowledge, Medline (via PubMed), and PsycInfo (January 2000-April 2010). Articles published in peer-reviewed journals and describing economic evaluations of P4P initiatives. Full economic evaluations, considering costs and consequences of the P4P intervention simultaneously, were the prime focus. Additionally, comparative partial evaluations were included if costs were described and the study allows for an assessment of consequences. Both experimental and observational studies were considered. In total, nine studies could be identified. Three studies could be regarded as full economic evaluations, and six studies were classified as partial economic evaluations. Based on the full economic evaluations, P4P efficiency could not be demonstrated. Partial economic evaluations showed mixed results, but several flaws limit their significance. Ranges of costs and consequences were typically narrow, and programs differed considerably in design. Methodological quality assessment showed scores between 32% and 65%. CONCLUSION: The results show that evidence on the efficiency of P4P is scarce and inconclusive. P4P efficiency could not be demonstrated. The small number and variability of included studies limit the strength of our conclusions. More research addressing P4P efficiency is needed.

Endrei, D., et al. (2014). "The effect of performance-volume limit on the DRG based acute care hospital financing in Hungary." Health Policy **115**(2-3): 152-156.

OBJECTIVES: The aim of our paper is to analyse the effect of the so-called performance volume limit (PVL) financing method on acute hospital care. DATA AND METHODS: The data were derived from the nationwide administrative dataset of the National Health Insurance Fund Administration (OEP) covering the period 2003-2008. We analysed the trends in the DRG cost-weights, number of cases, case-mix, and average length of stay. We calculated the average annual reimbursement rate per DRG cost-weight with and without the application of PVL degression according to the hospital type and medical professions. RESULTS: Our results showed that although the national case mix (i.e., the sum of all of the DRG cost-weights produced in one year) did not change between 2003-2006, the trend of the annual number of cases increased, and the average length of stay decreased. During 2007-2008, a significant decline was found in each indicator. The introduction of the PVL resulted in a health insurance budget saving of 1.9% in 2004, 2.6% in 2005, 3.4% in 2006, 5.6% in 2007, and 3.2% in 2008. We found the lowest reimbursement rate per DRG cost-weight at the university

medical schools (HUF 138,200 or euro 550) and children's hospitals (HUF 132,547 or euro 528), whereas the highest was at the county hospitals (HUF 143,451 or euro 571) and city hospitals (HUF 142, 082 or euro 565). CONCLUSIONS: The implementation of the PVL reduced the acute care hospital activity and reimbursement. The effect of the PVL was different on the different types of hospitals, and it had a serious disadvantageous effect on the university medical schools and children's hospitals

Ernst&Young (2015). A Model for Australian General Practice: The Australian Person-Centred Medical Home. Sydney Ernst & Young**:** 54 , fig.

This paper proposes a sustainable model of General Practice and primary health care at a time of significant primary health care reform and change. Within the context of the creation of Primary Health Networks (PHNs), the release of the National Review of Mental Health Programmes and Services report1 and the Reform of the Federation, and the establishment of Medicare Benefits Schedule (MBS) Review Taskforce and the Primary Health Care Advisory Group (PHCAG), this model will help ensure optimal future outcomes for patients with chronic conditions and complex care needs. The model aims to embed the concept of a Patient-Centred Medical Home (PCMH) within primary care that also incorporates a multimodal payment system for General Practice which aligns incentives with outcome-focused care. To ensure the model is evidence-based, sustainable and scalable, the paper recommends a pilot programme which will focus, in particular, on testing the efficacy of the design of incentives to achieve the expected benefits. To this end, the paper's strength and novelty lies in analysing and addressing the practicalities of implementation rather than simply identifying the issues which have already been comprehensively assessed in the PHCAG's Discussion Paper,published in August 2015.

Feng, Y., et al. (2011). The Effect of an Increase in the Rate of Payment on General Practitioners? Intrinsic and Extrinsic Motivation. Research Paper; 11/05. Londres OHE**:** 40 , tabl. http://www.ohe.org/publications/article/the-effect-of-payment-on-gps-motivation-96.cfm

This paper investigates how the increased rate of Quality and Outcomes Framework (QOF) payments implemented on 1 April 2005 affects Scottish general practitioners? (GPs) intrinsic, extrinsic and overall motivation. A first difference method is used to model GPs? intrinsic and overall motivation. GPs? extrinsic motivation is modelled using a probit model and Mundlak approach. The main finding is that the increased QOF payment effectively motivated GPs? health care supply, but it also crowded out GPs? intrinsic motivation. The results suggests that using strong financial incentives to further motivate already well-motivated health care professionals may have unintended effects on their performance.

Feng, Y., et al. (2013). "The tougher the better: an economic analysis of increased payment thresholds on the performance of general practices." Health Economics: n/a-n/a. http://dx.doi.org/10.1002/hec.3022

We investigate whether and how a change in performance-related payment motivated General Practitioners (GPs) in Scotland. We evaluate the effect of increases in the performance thresholds required for maximum payment under the Quality and Outcomes Framework in April 2006. A difference-in-differences estimator with fixed effects was employed to examine the number of patients treated under clinical indicators whose payment schedules were revised and to compare these with the figures for those indicators whose schedules remained unchanged. The results suggest that the increase in the maximum performance thresholds increased GPs' performance by 1.77% on average. Low-performing GPs improved significantly more (13.22%) than their high-performing counterparts (0.24%).

Changes to maximum performance thresholds are differentially effective in incentivising GPs and could be used further to raise GPs' performance across all indicators. Copyright -© 2013 John Wiley & Sons, Ltd

Fernandez-Urrusuno, R. (2013). "Compliance with quality prescribing indicators in terms of their relationship to financial incentives." European Journal of Clinical Pharmacology **69**(10): 1845–1853.

OBJECTIVE : To develop quality prescribing indicators for general practitioners (GPs) who are non-monitored and not included in pay-for-performance programs, and to determine compliance with incentivized and non-incentivized indicators. STUDY DESIGN : Descriptive cross sectional study. SETTING : Aljarafe Primary Health Care Area (Andalusian Public Health Care Service, Spain), a rural and suburban area with a population of 323,857 inhabitants. Health assistance in this area is provided by 176 GPs in 37 health centers. Prescribing indicators were developed by a multidisciplinary group using a qualitative technique based on consensus. The members of the consensus group searched for updated recommendations focused on clinical evidence. Prescribing data were obtained from the computerised pharmacy records of reimbursed drugs and clinical data from the electronic clinical databases and hospital admission records. RESULTS : Fourteen indicators based on the selection of drugs of different therapeutic groups or linked to patientÂ´s clinical information were designed. The compliance with indicators based on the selection of drugs linked to financial incentives was higher than that of indicators not linked to financial incentives. The compliance with indicators based on clinical information varied widely. Inappropriate prescribing ranged from 7 %, in the use of long-acting beta-agonists in asthma, to 86 % in the use of drugs for the prevention of osteoporotic fractures in young women. CONCLUSIONS : This study shows better compliance by GPs with indirect and incentivized quality prescribing indicators, included in pay-for-performance programs, compared with not-incentivized indicators based on the relative use of drugs and on the appropriateness prescribing.

Fichera, E., et al. (2012). Specification of financial incentives for quality in health care contracts. Economics Discussion Paper Series EDP-1218. Manchester Centre for Growth and Business Cycle Research**:** 39 , graph., fig.
http://www.socialsciences.manchester.ac.uk/disciplines/economics/research/discussionpapers/pdf/EDP-1218.pdf

This paper considers how purchasers and providers negotiate the quality element of contracts when the purchasers are required to link a fixed proportion of revenue to quality. A simple model predicts that the complexity of the quality element will depend on purchaser and provider characteristics. Using data extracted from 153 of the 169 contracts for acute hospital services in England in 2010/11, it finds that the complexity of the quality element of the contract is determined by the type of provider, whether negotiation was passed to an agency, the regional contractual constraints and whether the provider had teaching status.

Figueroa, J. F., et al. (2016). "Association between the Value-Based Purchasing pay for performance program and patient mortality in US hospitals: observational study." BMJ **353**.
http://www.bmj.com/content/bmj/353/bmj.i2214.full.pdf

Objective To determine the impact of the Hospital Value-Based Purchasing (HVBP) program—the US pay for performance program introduced by Medicare to incentivize higher quality care—on 30 day mortality for three incentivized conditions: acute myocardial infarction, heart failure, and pneumonia.Design Observational study.Setting 4267 acute care hospitals in the United States: 2919 participated in the HVBP program and 1348 were ineligible and used as controls (44 in general hospitals in Maryland and 1304 critical access

hospitals across the United States).Participants 2 430 618 patients admitted to US hospitals from 2008 through 2013.Main outcome measures 30 day risk adjusted mortality for acute myocardial infarction, heart failure, and pneumonia using a patient level linear spline analysis to examine the association between the introduction of the HVBP program and 30 day mortality. Non-incentivized, medical conditions were the comparators. A secondary outcome measure was to determine whether the introduction of the HVBP program was particularly beneficial for a subgroup of hospital—poor performers at baseline—that may benefit the most.Results Mortality rates of incentivized conditions in hospitals participating in the HVBP program declined at −0.13% for each quarter during the preintervention period and −0.03% point difference for each quarter during the post-intervention period. For non-HVBP hospitals, mortality rates declined at −0.14% point difference for each quarter during the preintervention period and −0.01% point difference for each quarter during the post-intervention period. The difference in the mortality trends between the two groups was small and non-significant (difference in difference in trends −0.03% point difference for each quarter, 95% confidence interval −0.08% to 0.13% point difference, P=0.35). In no subgroups of hospitals was HVBP associated with better outcomes, including poor performers at baseline.Conclusions Evidence that HVBP has led to lower mortality rates is lacking. Nations considering similar pay for performance programs may want to consider alternative models to achieve improved patient outcomes.

Fiorentini, G., et al. (2011). "Incentives in primary care and their impact on potentially avoidable hospital admissions." European Journal of Health Economics (the) **12**(4): 297-309, tabl., fig.

Financial incentives in primary care have been introduced with the purpose of improving appropriateness of care and containing demand. We usually observe pay-for-performance programs, but alternatives, such as pay-for-participation in improvement activities and pay for- compliance with clinical guidelines, have also been implemented. Here, we assess the influence of different programs that ensure extra payments to GPs for containing avoidable hospitalisations. Our dataset covers patients and GPs of the Italian region Emilia-Romagna for the year 2005. By separating pay-for-performance from pay-forparticipation and pay-for-compliance programs, we estimatethe impact of different financial incentives on the probability of avoidable hospitalisations. As dependent variable, we consider two different sets of conditions for which timely and effective primary care should be able to limit the need for hospital admission. The first is based on 27 medical diagnostic related groups that Emilia-Romagna identifies as at risk of inappropriateness in primary care, while the second refers to the internationally recognized ambulatory care-sensitive conditions. We show that pay for- performance schemes may have a significant effect over aggregate indicators of appropriateness, while the effectiveness of pay-for-participation schemes is adequately captured only by taking into account subpopulations affected by specific diseases. Moreover, the same scheme produces different effects on the two sets of indicators used, with performance improvements limited to the target explicitly addressed by the Italian policy maker. This evidence is consistent with the idea that a ??tunnel vision??effect may occur when public authorities monitor specific sets of objectives as proxies for more general improvements in the quality of health care delivered.

Fiorentini, G., et al. (2012). GPs and hospital expenditures. Should we keep expenditure containment programs alive? Rochester Social Science electronic publishing**:** 24 , tabl.
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2075314

Pay-for-performance programs offering additional payments to GPs can be used not only to improve the quality of care but also for cost containment purposes. This paper analyses the impact of removing financial incentives in primary care that were aimed at containing

hospital expenditure in the Italian region of Emilia Romagna during the period 2002-04. The analysis draws on regional databanks linking GPs? characteristics to those of their patients (including all sources of public payments made to GPs), together with information on the utilisation of hospital services. It employes a difference-in-difference specification to assess changes in expenditures for avoidable and total hospital admissions. It identifies the treatment group with GPs operating in districts where the program is withdrawn during the observation period (Leavers). Their performance is compared to that of two separate control groups, namely: GP s working in districts that grant incentives for the entire period (Stayers), and those working in districts that never introduced measures for the containment of hospitalisations (Non Participants). The comparison between treatment and control groups shows that removing incentives does not result in a worse performance by Leavers compared to both control groups. This supports the policy of removing incentives, as such entail extra payments to GPs which, however, do not seem capable of significantly influencing their behaviour in the desired ways.The findings complement previous evidence from the same institutional context showing that only those programs that aim to improve disease management for specific conditions - rather than to simply contain expenditure - have proven successful in reducing avoidable admissions for the target population.

Fishbane, S., et al. (2012). "Changes to the end-stage renal disease quality incentive program." Kidney Int **81**(12): 1167-1171.

Monitoring the quality of dialysis care has long been a component of the Medicare ESRD program. As part of the 2008 Medicare Improvements for Patients and Providers Act (MIPPA), Congress mandated the Quality Incentive Program (QIP), which linked measures of care quality to payments. The legislation embraced the idea that this linkage of federal money to performance would encourage the purchase of greater 'value.' The first 2 program years for the QIP use a simple scoring methodology and a limited scope of quality metrics. For payment year 2014 (performance period calendar year 2012), the program changes substantially, with an expanded number of quality measures and a more complex scoring methodology. In this article, we describe the program structure, quality measures, scoring system, and financial impact.

Fleetcroft, R. et Cookson, R. (2005). Do the incentive payments in the new NHS contract for primary care reflect likely population health gains ? CHE Research Paper ; n° 3. York University of York**:** 7 , tabl.
http://www.york.ac.uk/inst/che/pdf/rp3.pdf

The new contract for primary care in the UK offers fee-for-service payments for a wide range of activities in a quality outcomes framework, with payments designed to reflect likely workload. This study aims to explore the link between these financial incentives and the likely population health gains. Methods: The study examines a subset of eight preventive interventions covering 38 of the 81 clinical indicators in the quality framework. The maximum payment for each service was calculated and compared with the likely population health gain in terms of lives saved per 100,000 population based on evidence from McColl et al. (1998). Results: Maximum payments for the eight interventions examined make up 57% of the sumtotal maximum payment for all clinical interventions in the quality outcomes framework. Thereappears to be no relationship between pay and health gain across these eight interventions. Two of the eight interventions (warfarin in atrial fibrillation and statins in primary prevention) receive no incentive. Conclusions: Payments in the new contract do not reflect likely population health gain. There is a danger that clinical activity may be skewed towards high-workload activities that are only marginally effective, to the detriment of more cost effective activities. If improving population health is the primary goal of the NHS, then

fee-for-service incentives should be designed to reflect likely health gain rather than likely workload.

Fleetcroft, R., et al. (2012). "Incentive payments are not related to expected health gain in the pay for performance scheme for UK primary care: cross-sectional analysis." BMC Health Serv Res **12**: 94. https://www.ncbi.nlm.nih.gov/pubmed/22507660

BACKGROUND: The General Medical Services primary care contract for the United Kingdom financially rewards performance in 19 clinical areas, through the Quality and Outcomes Framework. Little is known about how best to determine the size of financial incentives in pay for performance schemes. Our aim was to test the hypothesis that performance indicators with larger population health benefits receive larger financial incentives. METHODS: We performed cross sectional analyses to quantify associations between the size of financial incentives and expected health gain in the 2004 and 2006 versions of the Quality and Outcomes Framework. We used non-parametric two-sided Spearman rank correlation tests. Health gain was measured in expected lives saved in one year and in quality adjusted life years. For each quality indicator in an average sized general practice we tested for associations first, between the marginal increase in payment and the health gain resulting from a one percent point improvement in performance and second, between total payment and the health gain at the performance threshold for maximum payment. RESULTS: Evidence for lives saved or quality adjusted life years gained was found for 28 indicators accounting for 41% of the total incentive payments. No statistically significant associations were found between the expected health gain and incentive gained from a marginal 1% increase in performance in either the 2004 or 2006 version of the Quality and Outcomes Framework. In addition no associations were found between the size of financial payment for achievement of an indicator and the expected health gain at the performance threshold for maximum payment measured in lives saved or quality adjusted life years. CONCLUSIONS: In this subgroup of indicators the financial incentives were not aligned to maximise health gain. This disconnection between incentive and expected health gain risks supporting clinical activities that are only marginally effective, at the expense of more effective activities receiving lower incentives. When designing pay for performance programmes decisions about the size of the financial incentive attached to an indicator should be informed by information on the health gain to be expected from that indicator.

Forsberg, E., et al. (2002). "Performance-based reimbursement in health care." European Journal of Public Health **12**(1): 44-50.

The key question addressed in this study is whether performance-based reimbursement (PBR) is a useful way to create the right incentive for efficiency improvements in health care. In this 4-year prospective cohort study, physicians in one council with PBR and in ten councils without such a system were studied. The results of this study indicate that PBR, compared to an annual budget system, creates a different incentive, an 'inner incentive' which may be stronger than the external incentive of financial pressures. PBR may result in a greater cost awareness and shorter average length of stay, but it may also lead to negative effects on the quality of care. A strong cost awareness was found to be a negative predictor of quality of care indicating that it is a difficult balancing act to maintain cost considerations at a 'good' level in order to retain the benefits of cost awareness without adversely impacting quality of care. There is a need for further studies of the impact of PBR on financial performance and quality of care issues (d'après Medline).

Frandsen, B. et Rebitzer, J. B. (2014). Structuring Incentives Within Organizations: The Case of Accountable Care Organizations. NBER Working Paper Series; 20034. Cambridge NBER**:** 36 ,+annexes, tabl., fig.
http://www.nber.org/papers/w20034

Accountable Care Organizations (ACOs) are new organizations created by the Affordable Care Act to encourage more efficient, integrated care delivery. To promote efficiency, ACOs sign contracts under which they keep a fraction of the savings from keeping costs below target provided they also maintain quality levels. To promote integration and facilitate measurement, ACOs are required to have at least 5,000 enrollees and so must coordinate across many providers. We calibrate a model of optimal ACO incentives using proprietary performance measures from a large insurer. Our key finding is that free-riding is a severe problem and causes optimal incentive payments to exceed cost savings unless ACOs simultaneously achieve extremely large efficiency gains. This implies that successful ACOs will likely rely on motivational strategies that amplify the effects of under-powered incentives. These motivational strategies raise important questions about the limits of ACOs as a policy for promoting more efficient, integrated care.

Friedberg, M. W., et al. (2015). Effects of Health Care Payment Models on Physician Practice in the United States. Santa Monica Rand corporation**:** 119 , fig.
http://www.rand.org/pubs/research_reports/RR869.html

The project reported here, sponsored by the American Medical Association (AMA), aimed to describe the effects that alternative health care payment models (i.e., models other than fee-for-service payment) have on physicians and physician practices in the United States. These payment models included capitation, episode-based and bundled payment, shared savings, pay for performance, and retainer-based practice. Accountable care organizations and medical homes, which are two recently expanding practice and organizational models that frequently participate in one or more of these alternative payment models, were also included. Project findings are intended to help guide efforts by the AMA and other stakeholders to make improvements to current and future alternative payment programs and help physician practices succeed in these new payment models — i.e., to help practices simultaneously improve patient care, preserve or enhance physician professional satisfaction, satisfy multiple external stakeholders, and maintain economic viability as businesses. The report provides both findings and recommendations.

Friedberg, M. W., et al. (2010). "Paying for performance in primary care: potential impact on practices and disparities." Health Aff (Millwood) **29**(5): 926-932.
https://www.ncbi.nlm.nih.gov/pubmed/20439882

Performance-based payments are increasingly common in primary care. With persistent disparities in the quality of care that different populations receive, however, such payments may steer new resources away from the care of racial and ethnic minorities and people of low socioeconomic status. We simulated performance-based payments to Massachusetts practices serving higher and lower shares of patients from these vulnerable communities in Massachusetts. Typical practices serving higher shares of vulnerable populations would receive less per practice compared to others, by estimated amounts of more than $7,000. These findings suggest that pay-for-performance programs should monitor and address the potential impact of performance-based payments on health care disparities.

Flodgren, G., et al. (2011). "An overview of reviews evaluating the effectiveness of financial incentives in changing healthcare professional behaviours and patient outcomes." Cochrane Database Syst Rev(7): Cd009255.

BACKGROUND: There is considerable interest in the effectiveness of financial incentives in the delivery of health care. Incentives may be used in an attempt to increase the use of evidence-based treatments among healthcare professionals or to stimulate health professionals to change their clinical behaviour with respect to preventive, diagnostic and treatment decisions, or both. Financial incentives are an extrinsic source of motivation and exist when an individual can expect a monetary transfer which is made conditional on acting in a particular way. Since there are numerous reviews performed within the healthcare area describing the effects of various types of financial incentives, it is important to summarise the effectiveness of these in an overview to discern which are most effective in changing health professionals' behaviour and patient outcomes. OBJECTIVES: To conduct an overview of systematic reviews that evaluates the impact of financial incentives on healthcare professional behaviour and patient outcomes. METHODS: We searched the Cochrane Database of Systematic Reviews (CDSR) (The Cochrane Library); Database of Abstracts of Reviews of Effectiveness (DARE); TRIP; MEDLINE; EMBASE; Science Citation Index; Social Science Citation Index; NHS EED; HEED; EconLit; and Program in Policy Decision-Making (PPd) (from their inception dates up to January 2010). We searched the reference lists of all included reviews and carried out a citation search of those papers which cited studies included in the review. We included both Cochrane and non-Cochrane reviews of randomised controlled trials (RCTs), controlled clinical trials (CCTs), interrupted time series (ITSs) and controlled before and after studies (CBAs) that evaluated the effects of financial incentives on professional practice and patient outcomes, and that reported numerical results of the included individual studies. Two review authors independently extracted data and assessed the methodological quality of each review according to the AMSTAR criteria. We included systematic reviews of studies evaluating the effectiveness of any type of financial incentive. We grouped financial incentives into five groups: payment for working for a specified time period; payment for each service, episode or visit; payment for providing care for a patient or specific population; payment for providing a pre-specified level or providing a change in activity or quality of care; and mixed or other systems. We summarised data using vote counting. MAIN RESULTS: We identified four reviews reporting on 32 studies. Two reviews scored 7 on the AMSTAR criteria (moderate, score 5 to 7, quality) and two scored 9 (high, score 8 to 11, quality). The reported quality of the included studies was, by a variety of methods, low to moderate. Payment for working for a specified time period was generally ineffective, improving 3/11 outcomes from one study reported in one review. Payment for each service, episode or visit was generally effective, improving 7/10 outcomes from five studies reported in three reviews; payment for providing care for a patient or specific population was generally effective, improving 48/69 outcomes from 13 studies reported in two reviews; payment for providing a pre-specified level or providing a change in activity or quality of care was generally effective, improving 17/20 reported outcomes from 10 studies reported in two reviews; and mixed and other systems were of mixed effectiveness, improving 20/31 reported outcomes from seven studies reported in three reviews. When looking at the effect of financial incentives overall across categories of outcomes, they were of mixed effectiveness on consultation or visit rates (improving 10/17 outcomes from three studies in two reviews); generally effective in improving processes of care (improving 41/57 outcomes from 19 studies in three reviews); generally effective in improving referrals and admissions (improving 11/16 outcomes from 11 studies in four reviews); generally ineffective in improving compliance with guidelines outcomes (improving 5/17 outcomes from five studies in two reviews); and generally effective in improving prescribing costs outcomes (improving 28/34 outcomes from 10 studies in one review).

AUTHORS' CONCLUSIONS: Financial incentives may be effective in changing healthcare professional practice. The evidence has serious methodological limitations and is also very limited in its completeness and generalisability. We found no evidence from reviews that examined the effect of financial incentives on patient outcomes.

GAO (2015). Hospital Value-Based Purchasing: Initial Results Show Modest Effects on Medicare Payments and No Apparent Change in Quality-of-Care Trends. Washington GAO**:** 49 , tab.,fig. http://www.gao.gov/assets/680/672899.pdf

The bonuses and penalties received by most of the approximately 3,000 hospitals eligible for the Hospital Value-based Purchasing (HVBP) program amounted to less than 0.5 percent of applicable Medicare payments each year. GAO found that safety net hospitals, which provide a significant amount of care to the poor, consistently had lower median payment adjustments—that is, smaller bonuses or larger penalties—than hospitals overall in the program's first three years. However, this gap narrowed over time. In contrast, small urban hospitals had higher median payment adjustments each year than hospitals overall, and small rural hospitals' median payment adjustments were similar to hospitals overall in the first two years and higher in the most recent year. GAO's analysis found no apparent shift in existing trends in hospitals' performance on the quality measures included in the HVBP program during the program's initial years. However, shifts in quality trends could emerge in the future as the HVBP program continues to evolve. For example, new quality measures will be added, and the weight placed on clinical process measures—on which hospitals had little room for improvement—will be substantially reduced. For many quality measures not included in the HVBP program, GAO also found that trends in hospitals' performance remained unchanged in the period GAO reviewed, but there were exceptions in the case of three measures that are part of a separate incentive program targeting hospital readmissions. This program focuses exclusively on readmissions and imposes only penalties. The timing of changes in readmission trends provides some indication that the use of financial incentives in quality improvement programs may, under certain circumstances, promote enhanced quality of care. However, understanding the extent of that impact depends on the results of future research.

GAO (2016). Medicare Value-Based Payment Models: Participation Challenges and Available Assistance for Small and Rural Practices. Washington GAO**:** 38 , tab., graph., fig. http://www.gao.gov/assets/690/681541.pdf

Medicare is trying to save money and improve health care quality by using value-based payment models, which encourage doctors to do things like use electronic health records to better track and evaluate patient care. But are small and rural physician practices prepared for such a transition? This study found, for example, that some of these practices have small budgets, making it harder for them to invest in the training and technology they need to participate. It also found that not all of these practices have access to organizations that can help them share staff and IT systems.

Garrison, L. P., et al. (2013). "Performance-Based Risk-Sharing Arrangements-Good Practices for Design, Implementation, and Evaluation: Report of the ISPOR Good Practices for Performance-Based Risk-Sharing Arrangements Task Force." Value in Health: 703-719.

Gavagan, T., et al. (2010). "Effect of financial incentives on improvement in medical quality indicators for primary care." Journal of the American Board of Family Medicine : Jabfm **23**(5): 622-631.

PURPOSE : The efficacy of rewarding physicians financially for preventive services is unproven. The objective of this study was to evaluate the effect of a physician pay-for-performance program similar to the Medicare Physician Quality Reporting Initiative program on quality of preventive care in a network of community health centers. METHODS : A retrospective review of administrative data was done to evaluate a natural quasi-experiment in a network of publicly funded primary care clinics. Physicians in 6 of 11 clinics were given a financial incentive twice the size of the current Centers for Medicare and Medicaid Services' incentive for achieving group targets in preventive care that included cervical cancer screening, mammography, and pediatric immunization. They also received productivity incentives. Six years of performance indicators were compared between incentivized and nonincentivized clinics. We also surveyed the incentivized clinicians about their perception of the incentive program. RESULTS : Although some performance indicators improved for all measures and all clinics, there were no clinically significant differences between clinics that had incentives and those that did not. A linear trend test approached conventional significance levels for Papanicolaou smears (P = .08) but was of very modest magnitude compared with observed nonlinear variations; there was no suggestion of a linear trend for mammography or pediatric immunizations. The survey revealed that most physicians felt the incentives were not very effective in improving quality of care. CONCLUSION : We found no evidence for a clinically significant effect of financial incentives on performance of preventive care in these community health centers. Based on our findings and others, we believe there is great need for more research with strong research designs to determine the effects, both positive and negative, of financial incentives on clinical quality indicators in primary care.

Gemmill, M. (2007). "Pay-for-performance in the US : what lessons for Europe ?" Eurohealth **13**(4): 21-23.

Pay-for-performance (P4P), a model of provider reimbursement linked to quality achievement or improvements, has been gaining traction in the United States. This paper examines the rationale behind P4P programmes and discusses some recent examples of pay-for-performance initiatives within the private insurance, Medicare, and Medicaid programmes in the US. While the evidence on P4P is still relatively scant, we are able to derive some preliminary conclusions on the design and effectiveness of P4P activities from the existing evidence. These considerations are then discussed in light of European health policy, and we provide some insight for European policy makers on the adoption of P4P programmes.

Gibbs, M. (2012). Design and Implementation of Pay for Performance. IZA Working Paper; 6322. Bonn IZA**:** 35 , fig.
http://ftp.iza.org/dp6322.pdf

A large, mature and robust economic literature on pay for performance now exists, which provides a useful framework for thinking about pay for performance systems. This study uses the lessons of the literature to discuss how to design and implement pay for performance in practice.

Gillam, S., et al. (2012). "Pay-for-performance in the United Kingdom : impact of the quality and outcomes framework : a systematic review." Annals of Family Medicine **10**(5): 461-468.

PURPOSE : Primary care practices in the United Kingdom have received substantial financial rewards for achieving standards set out in the Quality and Outcomes Framework since April 2004. This article reviews the growing evidence for the impact of the framework on the quality of primary medical care. METHODS : Five hundred seventy-five articles were

identified by searching the MEDLINE, EMBASE, and PsycINFO databases, and from the reference lists of published reviews and articles. One hundred twenty-four relevant articles were assessed using a modified Downs and Black rating scale for 110 observational studies and a Critical Appraisal Skills Programme rating scale for 14 qualitative studies. Ninety-four studies were included in the review. RESULTS : Quality of care for incentivized conditions during the first year of the framework improved at a faster rate than the preintervention trend and subsequently returned to prior rates of improvement. There were modest cost-effective reductions in mortality and hospital admissions in some domains. Differences in performance narrowed in deprived areas compared with nondeprived areas. Achievement for conditions outside the framework was lower initially and has worsened in relative terms since inception. Some doctors reported improved data recording and teamwork, and nurses enhanced specialist skills. Both groups believed that the person-centeredness of consultations and continuity were negatively affected. Patients' satisfaction with continuity declined, with little change in other domains of patient experience. CONCLUSIONS : Observed improvements in quality of care for chronic diseases in the framework were modest, and the impact on costs, professional behavior, and patient experience remains uncertain. Further research is needed into how to improve quality across different domains, while minimizing costs and any unintended adverse effects of payment for performance schemes. Health care organizations should remain cautious about the benefits of similar schemes.

Gillam, S. et Siriwardena, A. N. é. (2011). The Quality and Outcomes Framework (QOF) : tranforming general practice, Oxon : Radcliffe Publishing
http://www.amazon.co.uk/Quality-Outcomes-Framework-Transforming-Practice/dp/1846194563

The Quality and Outcomes Framework has deeply divided UK general practitioners. I commend this book and applaud its determination to scrutinise every aspect of the Quality and Outcomes Framework - good and bad and in-between. - From the Foreword by Iona Heath General practice in the UK faces transformation following the introduction of the Quality & Outcomes Framework (QOF), a pay-for-performance scheme unprecedented in the NHS, and the most comprehensive scheme of its kind in the world. Champions claim the QOF advances the quality of primary care; detractors fear the end of general practice as we know it. The introduction of the QOF provides a unique opportunity for research, analysis and reflection. This book is the first comprehensive analysis of the impact of the QOF, examining the claims and counter-claims in depth through the experience of those delivering QOF, comparisons with other countries, and analysis of the wealth of research evidence emerging. Assessments of the true impact of QOF will influence the development of health services in the UK and beyond. This book is essential reading for anyone with an interest in the future of general practice and primary care, including health professionals, trainers, students, MRCGP candidates and researchers, managers, and policy-makers and shapers (4e de couverture).

Gillam, S. J., et al. (2012). "Pay-for-Performance in the United Kingdom: Impact of the Quality and Outcomes Framework. A Systematic Review." Annals of Family Medicine **10**(5): 461-468, fig.
http://www.annfammed.org/content/10/5/461.full.pdf

Primary care practices in the United Kingdom have received substantial financial rewards for achieving standards set out in the Quality and Outcomes Framework since April 2004. This article reviews the growing evidence for the impact of the framework on the quality of primary medical care.

Gillam, S. J., et al. (2012). "Pay-for-Performance in the United Kingdom: Impact of the Quality and Outcomes Framework. A Systematic Review." Annals of Family Medicine **10**(5): 461-468.

http://www.annfammed.org/content/10/5/461.full.pdf
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3438214/pdf/0100461.pdf

> Primary care practices in the United Kingdom have received substantial financial rewards for achieving standards set out in the Quality and Outcomes Framework since April 2004. This article reviews the growing evidence for the impact of the framework on the quality of primary medical care

Girault, A., et al. (2017). "Implementing hospital pay-for-performance: Lessons learned from the French pilot program." Health Policy **121**(4): 407-417.

> Despite a wide implementation of pay-for-performance (P4P) programs, evidence on their impact in hospitals is still limited. Our objective was to assess the implementation of the French P4P pilot program (IFAQ1) across 222 hospitals. The study consisted of a questionnaire among four leaders in each enrolled hospital, combined with a qualitative analysis based on 33 semi-structured interviews conducted with staff in four participating hospitals. For the questionnaire results, descriptive statistics were performed and responses were analyzed by job title. For the interviews, transcripts were analysed using coding techniques. Survey results showed that leaders were mostly positive about the program and reported a good level of awareness, in contrast to the frontline staff, who remained mostly unaware of the program's existence. The main barriers were attributed to lack of clarity in program rules, and to time constraints. Different strategies were then suggested by leaders. The qualitative results added further explanations for low program adoption among hospital staff, so far. Ultimately, although paying for quality is still an intuitive approach; gaps in program awareness within enrolled hospitals may pose an important challenge to P4P efficacy. Implementation evaluations are therefore necessary for policymakers to better understand P4P adoption processes among hospitals.

Glasziou, P. P. et Buchan, H. (2012). "When financial incentives do more good than harm: a checklist." British Medical Journal(345): e5047-5051.

> Des chercheurs australiens ont étudié les effets du paiement à la performance (« P4P ») des médecins dans des pays ayant plusieurs années de recul en la matière. Leur conclusion est nuancée : le P4P n?améliore pas nécessairement la qualité des soins. Pire, il peut s?avérer contre productif.

Glasziou, P. P. et Buchan, H. (2012). "When financial incentives do more good than harm: a checklist." British Medical Journal(345): e5047-e5051.

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Godager, G., et al. (2013). Does performance disclosure influence physicians' medical decisions? An experimental analysis. Working paper 2013/01. Oslo HERO**:** 28 , tabl.
http://www.med.uio.no/helsam/forskning/nettverk/hero/publikasjoner/skriftserie/2013/hero2013-1.pdf

> Pay-for-performance schemes targeting quality improvements and cost reductions in markets for medical care have become increasingly popular among health policy- makers during the last decade. Typically, such schemes attach financial incentives to a set of

indicators which consist of some processed information that is believed to constitute an adequate description of the provider. Due to the asymmetric information inherent in medical markets, changes in the information structure are likely to cause substantial change to the environment in which health care providers operate. Since monitoring of physician treatment decisions is a necessary prerequisite in a pay-for performance scheme, and also an important factor influencing the information structure in the market, disentangling the effect of a change in the information regime from a change in financial incentives is difficult. By means of a laboratory experiment we are able to identify the ceteris-paribus effect of a change in information regime. We find that introducing transparency, and making medical students' treatment decisions known to their peers, have a positive impact on patients' health benefit. The results also suggest that disclosure of physician performance increase social welfare.

Goodwin, N. et Naylor, C. (2010). Building high-quality commissioning : What role can external organisations play? Londres King's Fund Institute**:** 76 , tabl., fig.

Commissioning is expected to play a central role in meeting the challenges currently facing the NHS ? developing better quality care and improving productivity. However, it is widely recognised that it has so far failed to become a major driver of improvement. In recognition of this, the Department of Health launched the world class commissioning programme in 2007. This provides commissioners with a vision of what best practice in commissioning looks like, and a set of organisational competencies which commissioners will need to develop if they are to achieve this vision. Since 2009 primary care trusts (PCTs) have been assessed against these competencies on an annual basis. Encouraged by government policy (in particular the framework for procuring external support for commissioners; FESC), NHS commissioners have increasingly turned to the independent sector for support with commissioning. The use of external support is now the norm among PCTs. The economic downturn presents a challenging environment for NHS commissioners seeking to invest in external support. The House of Commons Health Committee, among others, has expressed concern that the use of external support may not always provide value for money and that PCTs may not have the ability to use such support effectively. The primary aim of this research was to examine how external support is being used by PCTs and strategic health authorities (SHAs) and whether it is helping to develop more effective commissioning. The research was based on a mixture of qualitative and quantitative methods, including national surveys, focus groups and semi-structured interviews with people working in PCTs, SHAs and organisations providing support to commissioners.

Goodwin, N., et al. (2010). The quality of care in general practice. Capturing opinions from the front line. Londres King's Fund Institute**:** 11 , fig.
http://www.kingsfund.org.uk/publications/the_quality_of_care.html

The Inquiry into the Quality of General Practice in England, commissioned by The King?s Fund, has been collecting and examining evidence on the quality of care and services provided by GPs and other health professionals working in general practice. The work has focused on key aspects (?dimensions?) of general practice, selected by the inquiry panel as representing core areas for quality improvement. But what do GPs and other primary care professionals think about the quality of care being provided? To answer this question, the Fund conducted an informal, online survey, completed by 843 GPs and other practice-based professionals. They were asked what they thought about the care being provided by their own practice and in primary care more generally and which of the different methods of quality improvement were most likely to improve quality. This paper offers a snapshot of health professionals? views and raises key issues for further debate. Overall, GPs felt that the

quality of the care provided in general practice was high. Almost 60 per cent of respondents believed that providing continuity of care should be the main priority for improving the quality of general practice in England, with management of long-term conditions also identified. Perhaps surprisingly, given the government?s focus on this issue, access was not thought to be a priority. In considering the impact of different methods of quality improvement, the primary care practitioners thought that best practice guidelines and pay-for-performance schemes had the most potential.

Gopffarth, D. (2012). Access, Quality, and Affordability in Health Care in Germany and the United States. Washington American Institute for Contemporary German Studies.**:** 45 , fig.
http://www.aicgs.org/site/wp-content/uploads/2012/06/PR51-Health-Care-Goepffarth.pdf

Despite dramatic differences in the history of their health care systems, the United States and Germany face similar challenges in improving the quality of care while simultaneously expanding access and making health care more affordable. Although the United States and Germany have issued a series of reforms to contain costs while supporting quality improvements, both countries persistently spend more than average on health care while lagging behind in quality

Gravelle, H., et al. (2007). Doctor behaviour under a pay for performance contract : evidence from the quality and outcomes framework. CHE Research Paper Series ; 28. York University of York**:** 26 , tabl., ann.
http://www.york.ac.uk/inst/che/pdf/rp28.pdf

Since 2003, 25% of UK general practitioners? income has been determined by the quality of their care. The 65 clinical quality indicators in this scheme (the Quality and Outcomes Framework) are in the form of ratios, with financial reward increasing linearly with the ratio between a lower and upper threshold. The numerator is the number of patients for whom an indicator is achieved and the denominator is the number of patients the practices declares are suitable for the indicator. The number declared suitable is the number of patients with the relevant condition less the number exception reported by the practice for a specified range of reasons. Exception reporting is designed to avoid harmful treatment resulting from the application of quality targets to patients for whom they were not intended. However, exception reporting also gives GPs the opportunity to exclude patients who should in fact be treated in order to achieve higher financial rewards. This is inappropriate use of exception reporting or ?gaming?. Practices can also increase income if they are below the upper threshold by reducing the number of patients declared with a condition (prevalence), or by increasing reported prevalence if they were above the upper threshold. This study examines the factors affecting delivered quality (the proportion of prevalent patients for indicators were achieved) and tests for gaming of exceptions and for prevalence reporting being responsive to financial incentives.

Gravelle, H., et al. (2008). Doctor Behaviour under a Pay for Performance Contract: Further Evidence from the Quality and Outcomes Framework. CHE Research Paper Series ; 34. York University of York**:** 31 , fig., tabl.
http://www.york.ac.uk/inst/che/pdf/rp34.pdf

Since 2003, 25% of UK general practitioners? income has been determined by the quality of their care. The 65 clinical quality indicators in this scheme (the Quality and Outcomes Framework) are in the form of ratios, with financial reward increasing linearly with the ratio between a lower and upper threshold. The numerator is the number of patients for whom an indicator is achieved and the denominator is the number of patients the practices declare are

suitable for the indicator. The number declared suitable is the number of patients with the relevant condition less the number exception reported by the practice for a specified range of reasons. Exception reporting is designed to avoid harmful treatment resulting from the application of quality targets to patients for whom they were not intended. However, exception reporting also gives GPs the opportunity to exclude patients who should in fact be treated in order to achieve higher financial rewards. This is inappropriate use of exception reporting or ?gaming?. Practices can also increase income if they are below the upper threshold by reducing the number of patients declared with a condition (prevalence), or by increasing reported prevalence if they were above the upper threshold. This study examines the factors affecting delivered quality (the proportion of prevalent patients for indicators were achieved) and tests for gaming of exceptions and for prevalence reporting being responsive to financial incentives.

Green, E. P. (2013). Payment Systems in the Healthcare Industry: An Experimental Study Of Physician Incentives. Working Paper Series ; n° 2013-05. Newark University of Delaware**:** 27 , fig., tabl. http://www.lerner.udel.edu/sites/default/files/ECON/PDFs/RePEc/dlw/WorkingPapers/2013/UDWP13-05.pdf

Policy makers and the healthcare industry have proposed changes to physician payment structures as a way to improve the quality of health care and reduce costs. Several of these proposals require healthcare providers to employ a valuebased purchasing program (also known as pay-for-performance [P4P]). However, the way in which existing payment structures impact physician behavior is unclear and, therefore, predicting how well P4P will perform is difficult. To understand the impact physician payment structures have on physician behavior, I approximate the physician-patient relationship in a real-effort laboratory experiment. I study several prominent physician payment structures including fee for- service, capitation, salary, and P4P. I find that physicians are intrinsically motivated to provide high quality care and relying exclusively on extrinsic incentives to motivate physicians is detrimental to the quality of care and costly for the healthcare industry.

Greene, J. (2013). "An examination of pay-for-performance in general practice in Australia." Health Serv Res **48**(4): 1415-1432.

OBJECTIVE: This study examines the impact of Australia's pay-for-performance (P4P) program for general practitioners (GPs). The voluntary program pays GPs A$40 and A$100 in addition to fee-for-service payment for providing patients recommended diabetes and asthma treatment over a year, and A$35 for screening women for cervical cancer who have not been screened in 4 years. DESIGN: Three approaches were used to triangulate the program's impact: (1) analysis of trends in national claims for incentivized services pre- and postprogram implementation; (2) fixed effects panel regression models examining the impact of GPs' P4P program participation on provision of incentivized services; and (3) in-depth interviews to explore GPs' perceptions of their own response to the program. RESULTS: There was a short-term increase in diabetes testing and cervical cancer screens after program implementation. The increase, however, was for all GPs. Neither signing onto the program nor claiming incentive payments was associated with increased diabetes testing or cervical cancer screening. GPs reported that the incentive did not influence their behavior, largely due to the modest payment and the complexity of tracking patients and claiming payment. IMPLICATIONS: Monitoring and evaluating P4P programs is essential, as programs may not spark the envisioned impact on quality improvement

Giuffrida, A., et al. (2000). "Target payments in primary care: effects on professional practice and health care outcomes." Cochrane Database Syst Rev(3): Cd000531.

BACKGROUND: The method by which physicians are paid may affect their professional practice. Although payment systems may be used to achieve policy objectives (e.g. improving quality of care, cost containment and recruitment to under-served areas), little is known about the effects of different payment systems in achieving these objectives. Target payments are a payment system which remunerate professionals only if they provide a minimum level of care. OBJECTIVES: To evaluate the impact of target payments on the professional practice of primary care physicians (PCPs) and health care outcomes. SEARCH STRATEGY: We searched the Cochrane Effective Practice and Organisation of Care Group specialised register; the Cochrane Controlled Trials Register; MEDLINE (1966 to October 1997); BIDS EMBASE (1980 to October 1997); BIDS ISI (1981 to October 1997); EconLit (1969 to October 1997); HealthStar (1975 to October 1997) Helmis (1984 to October 1997); health economics discussion paper series of the Universities of York, Aberdeen, Sheffield, Bristol, Brunel, and McMaster; Swedish Institute of Health Economics; RAND corporation; and reference lists of articles. SELECTION CRITERIA: Randomised trials, controlled before and after studies and interrupted time series analyses of interventions comparing the impact of target payments to primary care professionals with alternative methods of payment, on patient outcomes, health services utilisation, health care costs, equity of care, and PCP satisfaction with working environment. DATA COLLECTION AND ANALYSIS: Two reviewers independently extracted data and assessed study quality. MAIN RESULTS: Two studies were included involving 149 practices. The use of target payments in the remuneration of PCPs was associated with improvements in immunisation rates, but the increase was statistically significant in only one of the two studies. REVIEWER'S CONCLUSIONS: The evidence from the studies identified in this review is not of sufficient quality or power to obtain a clear answer to the question as to whether target payment remuneration provides a method of improving primary health care. Additional efforts should be directed in evaluating changes in physicians' remuneration systems. Although it would not be difficult to design a randomised controlled trial to evaluate the impact of such payment systems, it would be difficult politically to conduct such trials.

Gosden, T., et al. (2000). "Capitation, salary, fee-for-service and mixed systems of payment: effects on the behaviour of primary care physicians." Cochrane Database Syst Rev(3): Cd002215.

BACKGROUND: It is widely believed that the method of payment of physicians may affect their clinical behaviour. Although payment systems may be used to achieve policy objectives (e.g. cost containment or improved quality of care), little is known about the effects of different payment systems in achieving these objectives. OBJECTIVES: To evaluate the impact of different methods of payment (capitation, salary, fee for service and mixed systems of payment) on the clinical behaviour of primary care physicians (PCPs). SEARCH STRATEGY: We searched the Cochrane Effective Practice and Organisation of Care Group specialised register; the Cochrane Controlled Trials Register; MEDLINE (1966 to October 1997); BIDS EMBASE (1980 to October 1997); BIDS ISI (1981 to October 1997); EconLit (1969 to October 1997); HealthStar (1975 to October 1997) Helmis (1984 to October 1997); health economics discussion paper series of the Universities of York, Aberdeen, Sheffield, Bristol, Brunel, and McMaster; Swedish Institute of Health Economics; RAND corporation; and reference lists of articles. SELECTION CRITERIA: Randomised trials, controlled before and after studies and interrupted time series analyses of interventions comparing the impact of capitation, salary, fee for service (FFS) and mixed systems of payment on primary care physician satisfaction with working environment; cost and quantity of care; type and pattern of care; equity of care; and patient health status and satisfaction. DATA COLLECTION AND ANALYSIS: Two reviewers independently extracted data and assessed study quality. MAIN RESULTS: Four studies were included involving 640 primary care physicians and more than 6400 patients.

There was considerable variation in study setting and the range of outcomes measured. FFS resulted in more primary care visits/contacts, visits to specialists and diagnostic and curative services but fewer hospital referrals and repeat prescriptions compared with capitation. Compliance with a recommended number of visits was higher under FFS compared with capitation payment. FFS resulted in more patient visits, greater continuity of care, higher compliance with a recommended number of visits, but patients were less satisfied with access to their physician compared with salaried payment. REVIEWER'S CONCLUSIONS: It is noteworthy that so few studies met the inclusion criteria. There is some evidence to suggest that the method of payment of primary care physicians affects their behaviour, but the findings' generalisability is unknown. More evaluations of the effect of payment systems on PCP behaviour are needed, especially in terms of the relative impact of salary versus capitation payments.

Haj-Ali, W. et Hutchison, B. (2017). "Establishing a Primary Care Performance Measurement Framework for Ontario." Healthcare Policy **12**(3): 66-79.
http://www.longwoods.com/product/25026

A systematic approach to Primary Care Performance Measurement is needed to provide useful information on a regular basis to inform planning, management and quality improvement at both the practice and system levels. Based on an environmental scan, a summit of primary care stakeholders and a stakeholder survey and supported by Measures and Technical Working Groups, the Ontario Primary Care Performance Measurement Steering Committee, representing 20 stakeholder organizations, identified system- and practice-level measurement priorities and related specific performance measures across nine domains of primary care performance. This initiative addressed measures' selection and technical specification. It did not include data collection. Lessons learned in Ontario can assist other jurisdictions developing frameworks for monitoring and reporting on primary care performance. Cross-country alignment could lead to a coordinated approach to measure and target areas for primary care performance improvement in Canada.

Hansen, X. B., et al. (2013). Do Mixed Reimbursement Schemes Affect Hospital Productivity? An Analysis of the Case of Denmark. Health Economics Paper; 2013/2. Odense University of Southern Denmark**:** 29 , tabl., fig.
http://static.sdu.dk/mediafiles//3/B/4/%7B3B48D0FF-E60B-467F-B63D-2AD2AA5E0B0B%7D20132.pdf

The majority of public hospitals in Scandinavia are reimbursed through a mixture of two prospective reimbursement schemes, block grants (a fixed amount independent of the number of patients treated) and activity-based financing (ABF). This article contributes theoretically to the existing literature with a deeper understanding of such mixed reimbursement systems as well as empirically by identifying key design factors that determines the incentives embedded in such a mixed model. Furthermore, we describe how incentives vary in different designs of the mixed reimbursement scheme and assess whether different incentives affects the performance of hospitals regarding activity and productivity differently. Information on Danish reimbursement schemes has been collected from documents provided by the regional governments and through interviews with regional administrations. The data cover the period from 2007-2010. A theoretical framework identified the key factors in an ABF/block grant model to be the proportion of the national Diagnosis-Related Group (DRG) tariff above and below a predefined production target (i.e. the baseline); baseline calculations; the presence of kinks/ceilings; and productivity requirements. A comparative case study across the five regions in Denmark demonstrated presence of inter-regional variation in the design of reimbursement schemes. This variation

creates different incentives regarding activity and productivity. Using gender-age standardized rates across year and region we show that there have not been any significant changes in the number of hospital discharges for any of the regions from 2007 to 2010 within any of the treatment groups.

Hardin, L., et al. (2017). "Bundled Payments for Care Improvement: Preparing for the Medical Diagnosis-Related Groups." J Nurs Adm **47**(6): 313-319.

BACKGROUND: The Centers for Medicare and Medicaid Services Innovation Center introduced the Bundled Payments for Care Improvement (BPCI) initiative in 2011 as 1 strategy to encourage healthcare organizations and clinicians to improve healthcare delivery for patients, both when they are in the hospital and after they are discharged. Mercy Health Saint Mary's, a large urban academic medical center, engaged in BPCI primarily with a group of medical diagnosis-related groups (DRGs). OBJECTIVES: In this article, we describe our experience creating a system of response for the diverse people and diagnoses that fall into the medical DRG bundles and specifically identify organizational factors for enabling successful implementation of bundled payments. RESULTS: Our experience suggests that interprofessional collaboration enabled program success. CONCLUSIONS: Although still in its early phases, observations from our program's strategies and tactics may provide potential insights for organizations considering engagement in the BPCI initiative.

Harrison, M., et al. (2016). "Incentives in Rheumatology: the Potential Contribution of Physician Responses to Financial Incentives, Public Reporting, and Treatment Guidelines to Health Care Sustainability." Curr Rheumatol Rep **18**(7): 42.

Concerns about the sustainability of current health care expenditure are focusing attention on the cost, quality and value of health care provision. Financial incentives, for example pay-for-performance (P4P), seek to reward quality and value in health care provision. There has long been an expectation that P4P schemes are coming to rheumatology. We review the available evidence about the use of incentives in this setting and provide two emerging examples of P4P schemes which may shape the future of service provision in rheumatology. Currently, there is limited and equivocal evidence in rheumatology about the impact of incentive schemes. However, reporting variation in the quality and provision of rheumatology services has highlighted examples of inefficiencies in the delivery of care. If financial incentives can improve the delivery of timely and appropriate care for rheumatology patients, then they may have an important role to play in the sustainability of health care provision.

Hearld, L. R., et al. (2014). "Pay-for-performance and public reporting program participation and administrative challenges among small- and medium-sized physician practices." Med Care Res Rev **71**(3): 299-312.

A key component of efforts to improve the quality of care in the United States is the use of public reporting and pay-for-performance programs. Little is known, however, about the extent to which small- and medium-sized physician practices are participating in these programs. This study examined the participation of small- and medium-sized physician practices in pay-for-performance and public reporting programs and the characteristics of the participating practices. Using cross-sectional data from a national sample of 1,734 small- and medium-sized physician practices throughout the United States, we found that many practices (61.2%) were participating in at least one program, while far fewer (19.2%) were participating in multiple programs. Among practices participating in multiple programs, relatively few (21.9%) reported high levels of administrative problems due to a lack of

standardization on performance measures. The study also suggests that some structural features are associated with participation and may provide leverage points for fostering participation.

Henning-Schmidt, H., et al. (2009). How Payment Systems Affect Physicians' Provision Behavior - An Experimental Investigation. Rochester Social Science Electronic Publishing**:** 34 , tabl. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1437409

A central concern in health economics is to understand the influence of commonly used physician payment systems. We introduce a controlled laboratory experiment to analyze the influence of fee-for-service (FFS) and capitation (CAP) payments on physicians' behavior. Medical students decide as experimental physicians on the quantity of medical services. Real patients gain a monetary benefit from their choices. Our main findings are that patients are overserved in FFS and underserved in CAP. Financial incentives are not the only motivation for physicians' quantity decisions, though. The patient benefit is of considerable importance as well. Patients are affected differently by the two payment systems. Those in need of a low level of medical services are better off under CAP, whereas patients with a high need of medical services gain more health benefit when physicians are paid by FFS.

Hibbard, J. H., et al. (2015). "Does Compensating Primary Care Providers to Produce Higher Quality Make Them More or Less Patient Centric?" Med Care Res Rev **72**(4): 481-495. http://mcr.sagepub.com/content/72/4/481

Both payment reform and patient engagement are key elements of health care reform. Yet the question of how incentivizing primary care providers (PCPs) on quality outcomes affects the degree to which PCPs are supportive of patient activation and patient self-management has received little attention. In this mixed-methods study, we use in-depth interviews and survey data from PCPs working in a Pioneer Accountable Care Organization that implemented a compensation model in which a large percentage of PCP salary is based on quality performance. We assess how much PCPs report focusing their efforts on supporting patient activation and self-management, and whether or not they become frustrated with patients who do not change their behaviors. The findings suggest that most PCPs do not see the value in investing their own efforts in supporting patient self-management and activation. Most PCPs saw patient behavior as a major obstacle to improving quality and many were frustrated that patient behaviors affected their compensation.

Ho, K. et Pakes, A. (2013). Hospital Choices, Hospital Prices and Financial Incentives to Physicians. NBER Working Paper Series ; 19333. Cambridge NBER**:** 64 , tabl. http://papers.nber.org/papers/W19333

We estimate a preference function which rationalizes hospital referrals for privately-insured birth episodes in California. The function varies across insurers and is additively separable in: a hospital price paid by the insurer, the distance traveled, and plan and severity-specific hospital fixed effects (capturing various dimensions of hospital quality). We use an inequality estimator that allows for errors in price and detailed hospital-severity interactions and obtain markedly different results than those from a logit. The inequality estimator indicates that insurers with more capitated physicians are more responsive to hospital prices. Capitated plans are willing to send patients further to utilize similar-quality lower-priced hospitals; but the trade-off between quality and costs does not vary with capitation rates.

Hsieh, H. M., et al. (2015). "Effects of Changes in Diabetes Pay-for-Performance Incentive Designs on Patient Risk Selection." Health Serv Res: n/a-n/a.

http://dx.doi.org/10.1111/1475-6773.12338

Objective Taiwan's National Health Insurance (NHI) Program implemented a Diabetes Pay-for-Performance Program (P4P) based on process-of-care measures in 2001. In late 2006, that P4P program was reformed to also include achievement of intermediate health outcomes. This study examined how the change in design affected patient risk selection. Designs/Study Populations Study populations were identified from a 2002 to 2003 period (Phase 1) and a 2007 to 2008 period (Phase 2), spanning pre- and postimplementation of reforms in the P4P incentive design. Phase 1 had 74,529 newly enrolled P4P patients and 215,572 non-P4P patients, and Phase 2 had 76,901 newly enrolled P4P patients and 299,573 non-P4P patients. Logistic regression models were used to estimate the effect of changes in design on P4P patient selection. Principal Findings Patients with greater disease severity and comorbidity were more likely to be excluded from the P4P program in both phases. Furthermore, the additional financial incentive for patients' intermediate outcomes moderately worsened patient risk selection. Conclusions Policy makers need to carefully monitor the care of the diabetes patients with more severe and complex disease statuses after the changes of P4P financial incentive design.

Hsieh, H. M., et al. (2015). "Cost-effectiveness of diabetes pay-for-performance incentive designs." Med Care **53**(2): 106-115.

BACKGROUND: Taiwan's National Health Insurance (NHI) Program implemented a diabetes pay-for-performance program (P4P) based on process-of-care measures in 2001. In late 2006, that P4P program was revised to also include achievement of intermediate health outcomes. OBJECTIVES: This study examined to what extent these 2 P4P incentive designs have been cost-effective and what the difference in effect may have been. RESEARCH DESIGN AND METHOD: Analyzing data using 3 population-based longitudinal databases (NHI's P4P dataset, NHI's claims database, and Taiwan's death registry), we compared costs and effectiveness between P4P and non-P4P diabetes patient groups in each phase. Propensity score matching was used to match comparable control groups for intervention groups. Outcomes included life-years, quality-adjusted life-years (QALYs), program intervention costs, cost-savings, and incremental cost-effectiveness ratios. RESULTS: QALYs for P4P patients and non-P4P patients were 2.08 and 1.99 in phase 1 and 2.08 and 2.02 in phase 2. The average incremental intervention costs per QALYs was TWD$335,546 in phase 1 and TWD$298,606 in phase 2. The average incremental all-cause medical costs saved by the P4P program per QALYs were TWD$602,167 in phase 1 and TWD$661,163 in phase 2. The findings indicated that both P4P programs were cost-effective and the resulting return on investment was 1.8:1 in phase 1 and 2.0:1 in phase 2. CONCLUSIONS: We conclude that the diabetes P4P program in both phases enabled the long-term cost-effective use of resources and cost-savings regardless of whether a bonus for intermediate outcome improvement was added to a process-based P4P incentive design.

Hurley, J. et Li, J. (2013). Health Care Funding, Cost-containment, and Quality. Chepa working paper series ; 13-01. Hamilton McMaster University**:** 25 , tabl., fig. http://www.chepa.org/docs/documents/13-01-hurley_funding_sask_jan13_13_wpversion.pdf

This paper reviews the evidence regarding the effectiveness of pay-for-performance, and more generally to consider how funding reform can contribute to achieving the twin aims of improving the quality of care and restraining the growth in health care costs. This is, of course, part of the larger question regarding the use of financial incentives to guide behavior.

Hussey, P. S., et al. (2016). "Episode-Based Approaches to Measuring Health Care Quality." Med Care Res Rev.

> Most currently available quality measures reflect point-in-time provider tasks, providing a limited and fragmented assessment of care. The concept of episodes of care could be used to develop quality measurement approaches that reflect longer periods of care. With input from clinical experts, we constructed episode-of-care frameworks for six illustrative conditions and identified potential gaps and measure development priority areas. Episode-based measures could assess changes in health outcomes ("delta measures"), the amount of time during an episode in which a patient has suboptimal health status ("integral measures"), quality contingent upon events occurring previously ("contingent measures"), and composites of measures throughout the episode. This article identifies a number of challenges that will need to be addressed to advance operationalization of episode-based quality measurement.

Iezzi, E., et al. (2011). The role of GP's compensation schemes in diabetes care: evidence from panel data. Rochester Social Science electronic publishing**:** 34 , tabl.
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1873331

> The design of incentive schemes that improve quality of care is a central issue for the healthcare sector. Nowadays we observe many pay-for-performance programs, where payment is contingent on meeting indicators of provider effort, but also other alternative strategies have been introduced, for example programs rewarding physicians for participation in diseases management plans. Although it has been recognised that incentive-based remuneration schemes can have an impact on GP behaviour, there is still weak empirical evidence on the extent to which such programs influence health outcomes. We investigate the impact of financial incentives in Regional and Local Health Authority contracts for primary care in the Italian Region Emilia Romagna for the years 2003-05. We focus on avoidable hospitalisations (Ambulatory Care Sensitive Conditions) for patients affected by type 2 diabetes mellitus, for which the assumption of respons ibility and the adoption of clinical guidelines are specifically rewarded. We estimate a panel count data model using a Negative Binomial distribution to test the hypothesis that, other things equal, patients under the responsibility of GPs receiving a higher share of their income through these programs are less likely to experience avoidable hospitalisations. Our findings support the hypothesis that financial transfers may contribute to improve quality of care, even when they are not based on the ex-post verification of performances.

Iorio, R., et al. (2017). "Single Institution Early Experience with the Bundled Payments for Care Improvement Initiative." J Bone Joint Surg Am **99**(1): e2.

> The Centers for Medicare & Medicaid Services (CMS) implemented the Bundled Payments for Care Improvement (BPCI) initiative in 2011. Through BPCI, organizations enlisted into payment agreements that include both performance and financial accountability for episodes of care. To succeed, BPCI requires quality maintenance and care delivery at lower costs. This necessitates physicians and hospitals to merge interests. Orthopaedic surgeons must assume leadership roles in cost containment, surgical safety, and quality assurance to deliver cost-effective care. Because most orthopaedic surgeons practice independently and are not employed by hospitals, models of physician-hospital alignment (e.g., physician-hospital organizations) or contracted gainsharing arrangements between practices and hospitals may be necessary for successful bundled pricing. Under BPCI, hospitals, surgeons, or third parties share rewards but assume risks for the bundle.For patients, cost savings must be associated with maintenance or improvement in quality metrics. However, the definition

of quality can vary, as can the rewards for processes and outcomes. Risk stratification for potential complications should be considered in bundled pricing agreements to prevent the exclusion of patients with substantial comorbidities and higher care costs (e.g., hip fractures treated with prostheses). Bundled pricing depends on economies of scale for success; smaller institutions must be cautious, as 1 costly patient could substantially impact the finances of its entire program. CMS recommends a minimum of 100 to 200 cases yearly. We also suggest that participants utilize technologies to maximize efficiency and provide the best possible environment for implementation of bundled payments. Substantial investment in infrastructure is required to develop programs to improve coordination of care, manage quality data, and distribute payments. Smaller institutions may have difficulty devoting resources to these infrastructural changes, although changes may be implemented more thoroughly once initiated. Herein, we discuss our early total joint arthroplasty BPCI experience at our tertiary-care academic medical center.

Jacobs, R. (2009). Investigating patient outcome measures in mental health. CHE Research Paper Series ; 48. York University of York**:** 94 , tabl., fig.
http://www.york.ac.uk/inst/che/pdf/rp48.pdf

This report examines the feasibility of incorporating patient outcomes in mental health into a productivity measure. It examines which outcome measures are most commonly used in mental health, the practical issues about collecting these outcome measures, whether they can be converted into a generic measure, whether there is a time series of data available, and whether the data exists to examine changes in the mix of treatments over time. The criteria that were assumed to be important for an outcome measure to be included in a productivity index, were that it should have wide coverage, should be routinely collected, could readily be linked to activity data, could potentially be converted to a generic outcome measure, and would be available as a time-series. The report focuses predominantly on mental health outcomes within the working age population. Literature searches on outcome measurement in mental health covered numerous databases and retrieved over 1500 records. Around 170 full papers were obtained.

Januleviciute, J., et al. (2016). "How do Hospitals Respond to Price Changes? Evidence from Norway." Health Econ **25**(5): 620-636.
https://www.ncbi.nlm.nih.gov/pubmed/25929559

Many publicly funded health systems use activity-based financing to increase hospital production and efficiency. The aim of this study is to investigate whether price changes for different treatments affect the number of patients treated and the mix of activity provided by hospitals. We exploit the variations in prices created by the changes in the national average treatment cost per diagnosis-related group (DRG) offered to Norwegian hospitals over a period of 5 years (2003-2007). We use the data from Norwegian Patient Register, containing individual-level information on age, gender, type of treatment, diagnosis, number of co-morbidities and the national average treatment costs per DRG. We employ fixed-effect models to examine the changes in the number of patients treated within the DRGs over time. The results suggest that a 10% increase in price leads to about 0.8-1.3% increase in the number of patients treated for DRGs, which are medical (for both emergency and elective patients). In contrast, we find no price effect for DRGs that are surgical (for both emergency and elective patients). Moreover, we find evidence of upcoding. A 10% increase in the ratio of prices between patients with and without complications increases the proportion of patients coded with complications by 0.3-0.4 percentage points.

Janus, K. (2011). "Pay-for performance does not always 'pay'." Eurohealth **17**(4): 31-34.

http://www2.lse.ac.uk/LSEHealthAndSocialCare/publications/eurohealth/eurohealth.aspx

> Pay-for-performance (P4P) has dominated medicine for the last decade although evidence from economics and psychology has shown that it can entail fundamental risks and side effects, especially in knowledge-intensive and complex situations. This article, thus, questions the comparability of medicine to Tayloristic factory work where P4P has been the preferred control mechanism. It then offers alternative solutions to managing motivation of doctors that focus on strengthening competence, autonomy and social relatedness to professional culture.

Jha, A. K. (2013). "Time to get serious about pay for performance." Jama **309**(4): 347-348.

Jha, A. K., et al. (2012). "The long-term effect of premier pay for performance on patient outcomes." New England Journal of Medicine (the) **366**(17): 1606-1615.

Jiang, H., et al. (2017). Improving Patient Access to Care: Performance Incentives and Competition in Healthcare Markets. Working Paper No . 01/2017. Cambridge University of Cambridge**:** 20 ,fig. https://ideas.repec.org/p/jbs/wpaper/201701.html

> Performance-based compensation is gaining popularity as a mechanism for incentivizing providers of health-care services to improve the quality of patient care. This paper investigates the effects of introducing performance-based incentives in a competitive healthcare market. In particular, we consider a market in which a payer (e.g. a government agency) applies a compensation contract to competing healthcare service providers in order to achieve a certain level of patient access to care, as measured by the expected time patients have to wait to receive care. In our model, we use M/M/1 queueing dynamics to describe patient service processes and assume that patient demand for care delivered by a particular provider is increasing in the level of access to care the provider ensures and decreasing in the levels of access to care at competing providers. Our analysis indicates that the presence of competition between providers may signi cantly alter the intended effect of performance-based incentives. In particular, we show that the joint effect of incentives and competition depends on two factors: 1) the aggressiveness of patient access targets that the payer imposes on providers, and 2) patient sensitivity to the level of access to care. When the payer uses a "soft" approach to performance-based compensation by incentivizing but not requiring that providers reach an access-level target, the incentives and competition can produce opposing effects on patient access to care when aggressive service-level targets are used in the presence of access-sensitive patients or when moderate service-level targets are introduced in environments where patients a exhibit low degree of sensitivity to the level of access to care. In particular, we show that while moderate service-level targets can lead to an improvement in patient access to care when applied to a monopolistic provider, competition in settings with access-insensitive patients may diminish or even reverse this improvement. Under the "strict" approach to performance-based compensation, when the payer designs performance incentives to minimize the cost of imposing a common access-level target on all providers, the impact of competition on the level of incentivization required is also influenced by the patient population type: for access-sensitive patients, competitive pressure lowers the level of incentivization required to achieve a particular level of patient access to care, while for patients with low access sensitivity the effect of competition is to increase the incentivization level required. At the same time, the reduction in payers' costs resulting from the presence of competition is more pronounced in environments with access-insensitive patients

Jiang, S., et al. (2012). "The rationale for the french hospital experiment with P4P (IFAQ) : lessons from abroad." Journal De Gestion Et D'economie Medicales **30**(7-8): 435-453, rés., tabl., ann.

[BDSP. Notice produite par ORSRA qGR0xClr. Diffusion soumise à autorisation]. Une initiative relative au paiement à la performance (P4P) a été lancée en 2012 pour les hôpitaux français. Le projet COMPAQ-Hpst a été chargé d'élaborer la méthodologie de cette expérimentation. L'analyse des initiatives étrangères, de leurs forces et faiblesses, a permis de proposer un programme, tenant compte des spécificités françaises, qui a fait l'objet d'une concertation avec les représentants du Ministère de la Santé (Direction Générale de l'Offre de Soins-DGOS), de la Haute Autorité de Santé et les quatre fédérations hospitalières. Cet article présente les leçons tirées de l'étranger, et comment elles ont été ou non adoptées dans le design du P4P français. (résumé d'auteur).

Johar, M., et al. (2014). "What explains the quality and price of gp services? An investigation using linked survey and administrative data." Health Econ **23**(9): 1115-1133.

We examine patient socioeconomic status, the strength of the patient-doctor relationship and local area competition as determinants of the quality and price of GP services. We exploit a large-sample patient data set in Australia and its linkage to administrative databases. The sample contains over 260 000 patients and over 12 600 GPs, observed between 2005 and 2010. Controlling for GP fixed effects and patient health, we find no strong evidence that quality differs by patient age, gender, country of origin, health concession card status and income, but quality is increased by stronger patient-doctor relationship. Using a competition measure that is defined at the individual GP level and not restricted to a local market, we find that competition lowers quality. Price is increasing in patient income, whereas competition has a small impact on price. Copyright (c) 2014 John Wiley & Sons, Ltd

Josephson, E., et al. (2017). "How do performance-based financing programmes measure quality of care? A descriptive analysis of 68 quality checklists from 28 low- and middle-income countries." Health Policy Plan **32**(8): 1120-1126.

This paper seeks to systematically describe the length and content of quality checklists used in performance-based financing programmes, their similarities and differences, and how checklists have evolved over time. We compiled a list of supply-side, health facility-based performance-based financing (PBF) programmes in low- and lower middle-income countries based on a document review. We then solicited PBF manuals and quality checklists from implementers and donors of these PBF mechanisms. We entered each indicator from each quality checklist into a database verbatim in English, and translated into English from French where appropriate, and categorized each indicator according to the Donabedian framework and an author-derived categorization. We extracted 8,490 quality indicators from 68 quality checklists across 32 PBF implementations in 28 countries. On average, checklists contained 125 indicators; within the same program, checklists tend to grow as they are updated. Using the Donabedian framework, 80% of indicators were structure-type, 19% process-type, and less than 1% outcome-type. The author-derived categorization showed that 57% of indicators relate to availability of resources, 24% to managing the facility and 17% assess knowledge and effort. There is a high degree of similarity in a narrow set of indicators used in checklists for common service types such as maternal, neonatal and child health. We conclude that performance-based financing offers an appealing approach to targeting specific quality shortfalls and advancing toward the Sustainable Development Goals of high quality coverage. Currently most indicators focus on structural issues and resource availability. There is scope

to rationalize and evolve the quality checklists of these programs to help achieve national and global goals to improve quality of care.

Ju Kim, S., et al. (2017). "Pay-for-performance reduces healthcare spending and improves quality of care: Analysis of target and non-target obstetrics and gynecology surgeries." Int J Qual Health Care **29**(2): 222-227.

Objective: In Korea, the Value Incentive Program (VIP) was first applied to selected clinical conditions in 2007 to evaluate the performance of medical institutes. We examined whether the condition-specific performance of the VIP resulted in measurable improvement in quality of care and in reduced medical costs. Design: Population-based retrospective observational study. Setting: We used two data set including the results of quality assessment and hospitalization data from National Health Claim data from 2011 to 2014. Participants: Participants who were admitted to the hospital for obstetrics and gynecology were included. A total of 535 289 hospitalizations were included in our analysis. Methods: We used a generalized estimating equation (GEE) model to identify associations between the quality assessment and length of stay (LOS). A GEE model based on a gamma distribution was used to evaluate medical cost. The Poisson regression analysis was used to evaluate readmission. Main Outcome Measures: The outcome variables included LOS, medical costs and readmission within 30 days. Results: Higher condition-specific performance by VIP participants was associated with shorter LOSs, decreases in medical cost, and lower within 30-day readmission rates for target and non-target surgeries. LOS and readmission within 30 days were different by change in quality assessment at each medical institute. Conclusions: Our findings contribute to the body of evidence used by policy-makers for expansion and development of the VIP. The study revealed the positive effects of quality assessment on quality of care. To reduce the between-institute quality gap, alternative strategies are needed for medical institutes that had low performance.

Kahn, C. N., et al. (2006). "Snapshot of hospital quality reporting and pay-for-performance under Medicare." Health Affairs **25**(1): 148-162.

Kahn, C. N., 3rd, et al. (2015). "Assessing Medicare's Hospital Pay-For-Performance Programs And Whether They Are Achieving Their Goals." Health Aff (Millwood) **34**(8): 1281-1288.

Three separate pay-for-performance programs affect the amount of Medicare payment for inpatient services to about 3,400 US hospitals. These payments are based on hospital performance on specified measures of quality of care. A growing share of Medicare hospital payments (6 percent by 2017) are dependent upon how hospitals perform under the Hospital Readmissions Reduction Program, the Value-Based Purchasing Program, and the Hospital-Acquired Condition Reduction Program. In 2015 four of five hospitals subject to these programs will be penalized under one or more of them, and more than one in three major teaching hospitals will be penalized under all three. Interactions among these programs should be considered going forward, including overlap among measures and differences in scoring performance.

Kaplan, R. S., et al. (2014). "Using time-driven activity-based costing to identify value improvement opportunities in healthcare." J Healthc Manag **59**(6): 399-412.

As healthcare providers cope with pricing pressures and increased accountability for performance, they should be rededicating themselves to improving the value they deliver to their patients: better outcomes and lower costs. Time-driven activity-based costing offers the potential for clinicians to redesign their care processes toward that end. This costing

approach, however, is new to healthcare and has not yet been systematically implemented and evaluated. This article describes early time-driven activity-based costing work at several leading healthcare organizations in the United States and Europe. It identifies the opportunities they found to improve value for patients and demonstrates how this costing method can serve as the foundation for new bundled payment reimbursement approaches.

Kantarevic, J. et Kralj, B. (2012). Link between Pay for Performance Incentives and Physician Payment Mechanisms: Evidence from the Diabetes Management Incentive in Ontario. IZA Working Paper; 6474. Bonn IZA**:** 40 , tabl., annexes.
http://ftp.iza.org/dp6474.pdf

Pay for performance (P4P) incentives for physicians are generally designed as additional payments that can be paired with any existing payment mechanism such as salary, fee-for-service, and capitation. However, the link between the physician response to performance incentives and the existing payment mechanisms is still not well understood. This paper studies this link using the recent primary care reform in Ontario as a natural experiment and the Diabetes Management Incentive (DMI) as a case study. Using a comprehensive administrative data and a difference-indifferences matching strategy, it finds that physicians in a blended capitation model are more responsive to the DMI than physicians in an enhanced fee-for-service model. It shows that for a given payment mechanism this result implies that the optimal size of P4P incentives varies negatively with the degree of supply-side cost sharing. These results have important implications for the design of P4P programs and the cost of their implementation.

Kantarevic, J. et Kralj, B. (2013). "Link between pay for performance incentives and physician payment mechanisms: evidence from the diabetes management incentive in ontario." Health Econ **22**(12): 1417-1439.

Pay for performance (P4P) incentives for physicians are generally designed as additional payments that can be paired with any existing payment mechanism such as a salary, fee-for-services and capitation. However, the link between the physician response to performance incentives and the existing payment mechanisms is still not well understood. In this article, we study this link using the recent primary care physician payment reform in Ontario as a natural experiment and the Diabetes Management Incentive as a case study. Using a comprehensive administrative data strategy and a difference-in-differences matching strategy, we find that physicians in a blended capitation model are more responsive to the Diabetes Management Incentive than physicians in an enhanced fee-for-service model. We show that this result implies that the optimal size of P4P incentives vary negatively with the degree of supply-side cost-sharing. These results have important implications for the design of P4P programs and the cost of their implementation. Copyright (c) 2012 John Wiley & Sons, Ltd

Kantarevic, J., et al. (2010). Enhanced Fee-for-Service Model and Access to Physician Services: Evidence from Family Health Groups in Ontario. IZA Discussion Paper ; 4862. Bonn IZA**:** 50 , tabl., fig.
http://ftp.iza.org/dp4862.pdf

We study an enhanced fee-for-service model for primary care physicians in the Family Health Groups (FHG) in Ontario, Canada. In contrast to the traditional fee-for-service (FFS) model, the FHG model includes targeted fee increases, extended hours, performance-based initiatives, and patient enrolment. Using a long panel of claims data, we find that the FHG model significantly increases physician productivity relative to the FFS model, as measured by the number of services, patient visits, and distinct patients seen. We also find that the

FHG physicians have lower referral rates and treat slightly more complex patients than the comparable FFS physicians. These results suggest that the FHG model offers a promising alternative to the FFS model for improving access to physician services.

Karve, A. M., et al. (2008). "Potential unintended financial consequences of pay-for-performance on the quality of care for minority patients." Am Heart J **155**(3): 571-576.

OBJECTIVES: The purpose of this study was to determine whether pay-for-performance (PFP) increases existing racial care disparities. BACKGROUND: Medicare's PFP program provides financial rewards to hospitals whose care performance ranks in the highest quintile relative to peers and reduces funding to hospitals that rank in the lowest quintile. Pay-for-performance is designed to improve care but may disproportionately penalize hospitals caring for large minority populations. METHODS: Using Medicare data, 3449 US hospitals were ranked by performance on PFP process measures for acute myocardial infarction (AMI), community-acquired pneumonia (CAP), and heart failure (HF). These rankings were compared with the percentage of African American (AA) patients in a center. We determined the eligibility for financial bonus (highest quintile ranking) or penalty (lowest quintile) among centers treating large AA populations (> or = 20%) versus not after adjusting for hospital facility (catheterization, percutaneous coronary intervention, surgery), academic status, number of hospital beds, location, patient volume, and region. RESULTS: The percentage of AA patients treated by a center was inversely associated with performance for AMI and CAP (P < .01) but not HF (P = .06). Relative to hospitals with < 20% AA, those with > or = 20% AA were less likely eligible for financial bonuses and more likely to face penalties: for AMI, adjusted odds ratio (OR) 0.7 (95% CI 0.5-1.0) and 1.8 (1.4-2.4), respectively; for CAP, OR 0.5 (95% CI 0.3-0.6) and 2.3 (1.8-2.9), respectively; for HF, OR 1.0 (95% CI 0.7-1.2) and 1.2 (0.9-1.5), respectively. CONCLUSIONS: Hospitals with large minority populations may be at financial risk under PFP. Thus, PFP may worsen existing racial care disparities.

Kasteridis, P., et al. (2014). "The Influence of Primary Care Quality on Hospital Admissions for People with Dementia in England: A Regression Analysis." Plos One **10**(3): 15 , fig., tabl., cartes.

Cet article étudie les liens entre la qualité des soins de santé primaires et la réduction des hospitalisations des personnes démentes au Royaume-Uni. Le nouveau cadre de qualité et de résultats (Quality and Outcomes Framework) est associé à une réduction des admissions non planifiées et des admissions d'urgence pour des conditions sensibles aux soins ambulatoires dans cette population.

Katz, A., et al. (2015). "Does a pay-for-performance program for primary care physicians alleviate health inequity in childhood vaccination rates?" Int J Equity Health **14**(1): 114.

INTRODUCTION: Childhood vaccination rates in Manitoba populations with low socioeconomic status (SES) fall significantly below the provincial average. This study examined the impact of a pay-for-performance (P4P) program called the Physician Integrated Network (PIN) on health inequity in childhood vaccination rates. METHODS: The study used administrative data housed at the Manitoba Centre for Health Policy. We included all children born in Manitoba between 2003 and 2010 who were patients at PIN clinics receiving P4P funding matched with controls at non-participating clinics. We examined the rate of completion of the childhood primary vaccination series by age 2 across income quintiles (Q1-Q5). We estimated the distribution of income using the Gini coefficient, and calculated concentration indices for vaccination to determine whether the P4P program altered SES-related differences in vaccination completion. We compared these measures between study cohorts before and after implementation of the P4P program, and over the course of the P4P

program in each cohort. RESULTS: The PIN cohort included 6,185 children. Rates of vaccination completion at baseline were between 0.53 (Q1) and 0.69 (Q5). Inequality in income distribution was present at baseline and at study end in PIN and control cohorts. SES-related inequity in vaccination completion worsened in non-PIN clinics (difference in concentration index 0.037; 95 % CI 0.013, 0.060), but remained constant in P4P-funded clinics (difference in concentration index 0.006; 95 % CI 0.008, 0.021). CONCLUSIONS: The P4P program had a limited impact on vaccination rates and did not address health inequity.

Kauhanen, A., et al. (2013). Performance Measurement in Healthcare Incentive Plans. ETLA Working Papers No 18. Helsinki ETLA**:** 24 , tabl.
http://www.etla.fi/wp-content/uploads/ETLA-Working-Papers-18.pdf

By using quantitative survey data and conducting a case study, we examine performance measurement of incentive plans in Finnish private sector health care organizations. We find that the performance measures used in the incentive plans are in line with recent economic theories of performance measurement. The findings from the case study emphasize the importance of choosing appropriate performance measures and designing the pay package as a whole. Inadequate performance measurement leads to incentive plans that do not help organizations reach their goals.

Keser, C. et Schnitzler, C. (2013). Money Talks - Paying Physicians for Performance. CEGE Discussion paper series ; 173. Göttingen Center for European Governance and Economic Development Research. (C.E.G.E.). 42 , fig., tabl.
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2357326

Pay-for-performance has been enjoying a growing popularity among healthcare policy makers. It attempts to tie physician payment to quality of care. In a controlled laboratory experiment, we investigate the effect of pay-for-performance on physician provision behavior and patient benefit. For that purpose, we compare two payment systems, a traditional fee-for-service payment system and a hybrid payment system that blends fee-for-service and pay-for-performance incentives. Physicians are found to respond to pay-for-performance incentives. Approximately 89 percent of the participants qualify for a pay-for-performance bonus payment in the experiment. The physicians' relative share of optimal treatment decisions is significantly larger under the hybrid payment system than under fee-for-service. A patient treated under the hybrid payment system is significantly more likely to receive optimal treatment than a fee-for-service patient of matching type and illness. Pay-for-performance in many cases alleviates over- and under-provision behavior relative to fee-for-service. We observe unethical treatment behavior (i.e., the provision of medical services with no benefit to the patient), irrespective of the payment system.

Kessels, R., et al. (2014). How to reform western care payment systems according to physicians, policy makers, healthcare executives and researchers: A discrete choice experiment. Working Paper ; 2014-22. Antwerpen University of Antwerp**:** 27 , tabl., fig.
https://www.uantwerpen.be/images/uantwerpen/container1244/files/TEW%20-%20Onderzoek/Working%20Papers/RPS/2014/RPS-2014-022.pdf

Background: Many developed countries are reforming healthcare payment systems in order to limit costs and improve clinical outcomes. Knowledge on how different groups of professional stakeholders trade off the merits and downsides of healthcare payment systems is limited. Methods: Using a discrete choice experiment we asked a sample of physicians, policy makers, healthcare executives and researchers from Canada, Europe, Oceania, and the United States to choose between profiles of hypothetical outcomes on eleven healthcare

performance objectives which may arise from a healthcare payment system reform. We used a Bayesian D-optimal design with partial profiles, which enables studying a large number of attributes, i.e. the ele ven performance objectives, in the experiment. Results: Our findings suggest that (a) moving from current payment systems to a value-based system is supported by physicians, despite an income trade-off, if effectiveness and long term cost containment improve. (b) Physicians would gain in terms of overall objective fulfillment in Eastern Europe and the US, but not in Canada, Oceania and Western Europe. Finally, (c) such payment reform more closely aligns the overall fulfillment of objectives between stakeholders such as physicians versus healthcare executives. Conclusions: Although the findings should be interpreted with caution due to the potential selection effects of participants, it seems that the value driven nature of newly proposed and/or introduced care payment reforms is more closely aligned with what stakeholders choose in some health systems, but not in others. Future studies, including the use of random samples, should examine the contextual factors that explain su ch differences in values and buy-in.

Kim, S. J., et al. (2016). "The effect of competition on the relationship between the introduction of the DRG system and quality of care in Korea." The European Journal of Public Health **26**(1): 42-47. http://eurpub.oxfordjournals.org/content/eurpub/26/1/42.full.pdf

Background: The diagnosis-related group-based prospective payment programme was introduced in Korea in 1997 as a pilot programme to control health spending. In July 2013, the programme was implemented throughout the nation. The aim of our study is to evaluate the relationship between quality of care and market competition following the introduction of the new payment system in Korea. Methods: We conduct an observational analysis using National Health Insurance claim data from 2011 to 2014. We analyse data on readmission within 30 days, length of stay, and number of outpatient visits for 1742 hospitals and 821 912 cases. We use a generalized estimating equation model to evaluate readmission within 30 days and number of outpatient visits and a multi-level regression model to assess length of stay. Results: Total readmission within 30 days is 10 727 (1.3%). High competition areas present a lower risk of readmission [odds ratio (OR): 0.95, P: 0.0277], a longer length of stay (1%, P < 0.0001), and an increased number of outpatient visits (Relative Risk: 1.11, P: 0.0011) as compared with moderate competition areas. Risk of readmission is higher in low competition areas as compared with moderate competition areas (OR: 1.21, P < 0.0001). Conclusion: The effects of the introduction of the new payment system differed by degree of market competition. Thus, evaluation about the effect of new payment system on hospital performance should be measured in combination with the degree of hospital market structure.

Kirschner, K., et al. (2013). "Assessment of a pay-for-performance program in primary care designed by target users." Fam Pract **30**(2): 161-171. http://fampra.oxfordjournals.org/content/30/2/161.abstract

Background. Evidence for pay-for-performance (P4P) has been searched for in the last decade as financial incentives increased to influence behaviour of health care professionals to improve quality of care. The effectiveness of P4P is inconclusive, though some reviews reported significant effects.Objective. To assess changes in performance after introducing a participatory P4P program.Design. An observational study with a pre- and post-measurement.Setting and subjects. Sixty-five general practices in the south of the Netherlands.Intervention. A P4P program designed by target users containing indicators for chronic care, prevention, practice management and patient experience (general practitionerƒ_Ts [GP] functioning and organization of care). Quality indicators were calculated for each practice. A bonus with a maximum of 6890 Euros per 1000 patients was

determined by comparing practice performance with a benchmark.Main outcome measures. Quality indicators for clinical care (process and outcome) and patient experience.Results. We included 60 practices. After 1 year, significant improvement was shown for the process indicators for all chronic conditions ranging from +7.9% improvement for cardiovascular risk management to +11.5% for asthma. Five outcome indicators significantly improved as well as patientsƒ_T experiences with GPƒ_Ts functioning and organization of care. No significant improvements were seen for influenza vaccination rate and the cervical cancer screening uptake. The clinical process and outcome indicators, as well as patient experience indicators were affected by baseline measures. Smaller practices showed more improvement.Conclusions. A participatory P4P program might stimulate quality improvement in clinical care and improve patient experiences with GPƒ_Ts functioning and the organization of care

Kolozsvari, L. R. et Rurik, I. (2013). "[Quality improvement in primary care. Financial incentives related to quality indicators in Europe]." Orv Hetil **154**(28): 1096-1101.

Quality improvement in primary care has been an important issue worldwide for decades. Quality indicators are increasingly used quantitative tools for quality measurement. One of the possible motivational methods for doctors to provide better medical care is the implementation of financial incentives, however, there is no sufficient evidence to support or contradict their effect in quality improvement. Quality indicators and financial incentives are used in the primary care in more and more European countries. The authors provide a brief update on the primary care quality indicator systems of the United Kingdom, Hungary and other European countries, where financial incentives and quality indicators were introduced. There are eight countries where quality indicators linked to financial incentives are used which can influence the finances/salary of family physicians with a bonus of 1-25%. Reliable data are essential for quality indicators, although such data are lacking in primary care of most countries. Further, improvement of indicator systems should be based on broad professional consensus.

Kolozsvari, L. R. et Rurik, I. (2013). "[Quality improvement in primary care. Financial incentives related to quality indicators in Europe]." Orv Hetil **154**(28): 1096-1101.

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Kondo, K. K., et al. (2016). "Implementation Processes and Pay for Performance in Healthcare: A Systematic Review." J Gen Intern Med **31 Suppl 1**: 61-69.

BACKGROUND: Over the last decade, various pay-for-performance (P4P) programs have been implemented to improve quality in health systems, including the VHA. P4P programs are

complex, and their effects may vary by design, context, and other implementation processes. We conducted a systematic review and key informant (KI) interviews to better understand the implementation factors that modify the effectiveness of P4P. METHODS: We searched PubMed, PsycINFO, and CINAHL through April 2014, and reviewed reference lists. We included trials and observational studies of P4P implementation. Two investigators abstracted data and assessed study quality. We interviewed P4P researchers to gain further insight. RESULTS: Among 1363 titles and abstracts, we selected 509 for full-text review, and included 41 primary studies. Of these 41 studies, 33 examined P4P programs in ambulatory settings, 7 targeted hospitals, and 1 study applied to nursing homes. Related to implementation, 13 studies examined program design, 8 examined implementation processes, 6 the outer setting, 18 the inner setting, and 5 provider characteristics. Results suggest the importance of considering underlying payment models and using statistically stringent methods of composite measure development, and ensuring that high-quality care will be maintained after incentive removal. We found no conclusive evidence that provider or practice characteristics relate to P4P effectiveness. Interviews with 14 KIs supported limited evidence that effective P4P program measures should be aligned with organizational goals, that incentive structures should be carefully considered, and that factors such as a strong infrastructure and public reporting may have a large influence. DISCUSSION: There is limited evidence from which to draw firm conclusions related to P4P implementation. Findings from studies and KI interviews suggest that P4P programs should undergo regular evaluation and should target areas of poor performance. Additionally, measures and incentives should align with organizational priorities, and programs should allow for changes over time in response to data and provider input.

Kotzian, P. (2006). Control and Performance of Health Care Systems. A comparative analysis of 19 OECD countries. Darmstadt Institut für Politikwissenschaft**:** 30 , tabl.
http://www.politikwissenschaft.tu-darmstadt.de/fileadmin/pg/media/working-paper/2006/TUD-IfP_Working-Paper_2006-06_Kotzian.pdf

The paper performs a empirical comparison of Health Care Systems (HCS). HCS are seen as a network of delegation relationships among various principals and agents, subject to agency problems. Citizens as the original principal delegate various tasks to agents. The delivery of health services is delegated to physicians, the organization of collecting and distributing contributions is delegated to the health insurance funds or the state, the exercise of an overall control is delegated to the government. The agents involved may not have an incentive to act in the principals best interest. They may shirk from the task, or even actively extract rents using the citizens? lack of knowledge and information. The physician may over-supply medical services or may provide insufficient quality. Insurance funds may use resources for on the job consumption. The government may renounce the exercise of control, since doing so might lead to political pressure from the well organized groups, while citizens are a latent and inactive group. Following the institutional economics approach, a HCS? productive efficiency ? understood as the ratio of financial input to health output - is seen as determined by the existence and treatment of agency problems. The more agency problems and the less control is used to counteract these, the higher the consumption of resources that is not used to produce

Kotzian, P. (2007). Control and Performance of Health Care Systems. Volume 1: Delegation and Control in 22 OECD Health Care Systems. A Data Handbook. Darmstadt Institut für Politikwissenschaft**:** 390 , tabl.
http://www.ulb.tu-darmstadt.de/docs/eprint_000017/HealthSystemDataHandbook.pdf

Health care systems are set up to fulfill the same functions but differ largely in their organizational design. Moreover, in recent years health care systems are confronted with a range of similar problems to which they respond in different ways. It turns out that they are able to cope with these problems with different degrees of success. This put much focus on how institutional structures in health care systems affect the system?s performance, adaptability and resource consumption. Comparative research is the appropriate research design to obtain answers on these questions. But in practice, empirical comparative research on the effects of institutional structures of health care systems is limited by the lack of comparable, detailed institutional information on the organization of health care systems. This data handbook is intended as a contribution to close this gap. Health care systems are layered networks of delegation relationships: the citizens, in their role as patients as well as voters, delegate the provision of health services, the administration and the overall control of the health care system to agents: medical providers, health insurance funds, health authorities and the state. These agents usually have interests, which diverge from those of the citizen and also have substantial leeway to pursue these interests, at expense of the citizen as the principal. On the conceptual level, the delegation-approach proved to be able to explain differences in performance and achievement at the system level by rational individual behavior. Further, the delegation-approach offers a template on which a comparative analysis and the description of complex systems, like health systems, can be based. This data handbook describes the health care systems of 22 OECD countries for two points in time, 1995 and 2004, on the basis of the institutional economics perspective. In particular from the perspective of the delegation of medical as well as administrative tasks and the control mechanisms implemented in these delegation relationships, which shall avoid opportunistic behavior. The data compiled in this data handbook shall enable researchers to study the impact of institutional structures on aspects of health system performance, like achievements in health levels, responsiveness and productive efficiency.

Krauth, C., et al. (2016). "Would German physicians opt for pay-for-performance programs? A willingness-to-accept experiment in a large general practitioners' sample." Health Policy **120**(2): 148-158.

BACKGROUND: Implementing pay-for-performance (P4P) programs is a non-trivial task. As evaluation studies showed, P4P programs often failed to improve performance quality. A crucial element for the successful implementation of P4P is to gain acceptance with health care providers. OBJECTIVES: The aim of our study was to determine, if (and at what bonus rate) German general practitioners (GPs) would participate in a P4P program. We further examined differences between respondents who would participate in a P4P program (participants) versus respondents who would not participate (non-participants). METHODS: A mail survey was conducted among 2493 general practitioners (GPs) in Lower Saxony (with a response rate of 36.2%). The questionnaire addressed attitudes toward P4P and included a willingness to accept experiment concerning P4P implementation. RESULTS: The participation rate increased from 28% (at a bonus of 2.5%) to 50% (at a bonus of 20%). Participants showed better performance in target achievement and expected higher gains from P4P than non-participants. Major attitude differences were found in assessing feasibility of P4P, incentivizing performance and unintended consequences. The crucial factor for (not) accepting P4P might be the sense of (un)fairness of P4P. CONCLUSION: To convince GPs to participate in P4P, better evidence for the effectiveness of P4P is required. To address the concerns of GPs, future endeavors should be directed to tailoring P4P programs. Finally, program implementation must be well communicated and thoroughly discussed with health care providers.

Kristensen, S. R. (2017). "Financial Penalties for Performance in Health Care." Health Econ **26**(2): 143-148.
http://onlinelibrary.wiley.com/store/10.1002/hec.3463/asset/hec3463.pdf?v=1&t=iyk1i8qu&s=e461e782c153172bb92a8db2b4a76b3addc55262

Kristensen, S. R., et al. (2013). Who to pay for performance? The choice of organisational level for hospital performance incentives. Health Economics Paper; 2013/5. Odense University of Southern Denmark**:** 23 , tabl., fig.
http://static.sdu.dk/mediafiles//3/F/2/%7B3F2BD73D-46D1-4569-8498-8B68928788BE%7D20135.pdf

When implementing a pay for performance (P4P) scheme, designers must decide to whom the financial incentive for performance should be directed. This paper compares department level hospital reported performance on the Danish Case Management Scheme at hospitals that did and did not redistribute performance payments to the department level. Across a range of models we find that hospital reported performance at departments that operate under a direct financial incentive is about 5 percentage points higher than performance at departments at hospital where performance payments are not directly redistributed to the department level. This result is in line with the theoretical expectations but due to the non-experimental design of the study, our results only have a causal interpretation under certain assumptions discussed in the paper

Kristensen, S. R., et al. (2016). "Who to pay for performance? The choice of organisational level for hospital performance incentives." The European Journal of Health Economics **17**(4): 435-442.
http://link.springer.com/article/10.1007%2Fs10198-015-0690-0

Financial incentives for quality improvement in hospital care [known as pay for performance (P4P)] can be directed to either the hospital level or redistributed to the department level. Theoretically, performance payments distributed to lower organisational levels are more effective in increasing performance than payments directed to the hospital level, but the empirical evidence for this expectation is scarce. This paper compares the performance of hospital departments at hospitals that do and do not redistribute performance payments to the department level. We study a Danish P4P scheme to provide patients with case managers. Applying difference in differences analysis, we estimate a 5 percentage points higher performance at hospital departments that are subject to a direct financial incentive. Our results suggest that payers can improve the effectiveness of P4P payments by distributing payments to the department level rather than the hospital level.

Kristensen, S. R., et al. (2014). "Long-term effect of hospital pay for performance on mortality in England." N Engl J Med **371**(6): 540-548.
https://www.ncbi.nlm.nih.gov/pubmed/25099578

BACKGROUND: A pay-for-performance program based on the Hospital Quality Incentive Demonstration was introduced in all hospitals in the northwest region of England in 2008 and was associated with a short-term (18-month) reduction in mortality. We analyzed the long-term effects of this program, called Advancing Quality. METHODS: We analyzed 30-day in-hospital mortality among 1,825,518 hospital admissions for eight conditions, three of which were covered by the financial-incentive program. The hospitals studied included the 24 hospitals in the northwest region that were participating in the program and 137 elsewhere in England that were not participating. We used difference-in-differences regression analysis to compare risk-adjusted mortality for an 18-month period before the program was introduced with subsequent mortality in the short term (the first 18 months of

the program) and the longer term (the next 24 months). RESULTS: Throughout the short-term and the long-term periods, the performance of hospitals in the incentive program continued to improve and mortality for the three conditions covered by the program continued to fall. However, the reduction in mortality among patients with these conditions was greater in the control hospitals (those not participating in the program) than in the hospitals that were participating in the program (by 0.7 percentage points; 95% confidence interval [CI], 0.3 to 1.2). By the end of the 42-month follow-up period, the reduced mortality in the participating hospitals was no longer significant (-0.1 percentage points; 95% CI, -0.6 to 0.3). From the short term to the longer term, the mortality for conditions not covered by the program fell more in the participating hospitals than in the control hospitals (by 1.2 percentage points; 95% CI, 0.4 to 2.0), raising the possibility of a positive spillover effect on care for conditions not covered by the program. CONCLUSIONS: Short-term relative reductions in mortality for conditions linked to financial incentives in hospitals participating in a pay-for-performance program in England were not maintained.

Kristensen, S. R., et al. (2014). "Long-term effect of hospital pay for performance on mortality in England." New England Journal of Medicine **371**(6): 540-548.

BACKGROUND: A pay-for-performance program based on the Hospital Quality Incentive Demonstration was introduced in all hospitals in the northwest region of England in 2008 and was associated with a short-term (18-month) reduction in mortality. We analyzed the long-term effects of this program, called Advancing Quality. METHODS: We analyzed 30-day in-hospital mortality among 1,825,518 hospital admissions for eight conditions, three of which were covered by the financial-incentive program. The hospitals studied included the 24 hospitals in the northwest region that were participating in the program and 137 elsewhere in England that were not participating. We used difference-in-differences regression analysis to compare risk-adjusted mortality for an 18-month period before the program was introduced with subsequent mortality in the short term (the first 18 months of the program) and the longer term (the next 24 months). RESULTS: Throughout the short-term and the long-term periods, the performance of hospitals in the incentive program continued to improve and mortality for the three conditions covered by the program continued to fall. However, the reduction in mortality among patients with these conditions was greater in the control hospitals (those not participating in the program) than in the hospitals that were participating in the program (by 0.7 percentage points; 95% confidence interval [CI], 0.3 to 1.2). By the end of the 42-month follow-up period, the reduced mortality in the participating hospitals was no longer significant (-0.1 percentage points; 95% CI, -0.6 to 0.3). From the short term to the longer term, the mortality for conditions not covered by the program fell more in the participating hospitals than in the control hospitals (by 1.2 percentage points; 95% CI, 0.4 to 2.0), raising the possibility of a positive spillover effect on care for conditions not covered by the program. CONCLUSIONS: Short-term relative reductions in mortality for conditions linked to financial incentives in hospitals participating in a pay-for-performance program in England were not maintained

Kristensen, S. R., et al. (2014). Optimal Price-Setting in Pay for Performance Schemes in Health Care. Discussion Papers in Economics; n°14/03. York University of York**:** 28 , tabl. http://www.york.ac.uk/media/economics/documents/discussionpapers/2014/1403.pdf

The increased availability of process measures implies that quality of care is in some areas de facto verifiable. Optimal price-setting for verifiable quality is well-described in the incentive-design literature. We seek to narrow the large gap between actual price-setting behaviour in Pay-For-Performance schemes and the incentive literature. We present a model for setting prices for process measures of quality and show that optimal prices should reflect the

marginal benefit of health gains, providers' altruism and the opportunity cost of public funds. We derive optimal prices for processes incentivised in the Best Practice Tariffs for emergency stroke care in the English National Health Service. Based on published estimates, we compare these to the prices set by the English Department of Health. We find that actual tariffs were lower than optimal, relied on an implausibly high level of altruism, or implied a lower social value of health gains than previously used.

Kristiansen, N. S., et al. (2016). "Off-hours admission and quality of hip fracture care: a nationwide cohort study of performance measures and 30-day mortality." International Journal for Quality in Health Care **28**(3): 324-331.
http://intqhc.oxfordjournals.org/content/intqhc/28/3/324.full.pdf

Objective Higher risks of adverse outcomes have been reported for patients admitted acutely during off-hours. However, in relation to hip fracture, the evidence is inconsistent. We examined whether time of admission influenced compliance with performance measures, surgical delay and 30-day mortality in patients with hip fracture.Design Cohort study.Setting Data from The Danish Multidisciplinary Hip Fracture Registry linked with data from Danish National Registries.Participants Danish patients undergoing hip fracture surgery, aged >65 years, admitted 1 March 2010 to 30 November 2013 (N = 25 305).Exposure Off-hours: weekday evenings and nights, and weekends.Main Outcome Measures Meeting specific performance measures, surgical delay and mortality.Results No differences were found in patient characteristics or in meeting performance measures (RRs from 0.99 [95% CI: 0.98–1.01] to 1.01 [95% CI: 0.99–1.02]. When comparing admission on weekdays (evenings and nights vs. days), off-hours admission was associated with a lower risk of surgical delay (adjusted OR 0.75 [95% CI: 0.66–0.85]) while no differences in 30-day mortality was found (adjusted OR 0.91 [95% CI: 0.80–1.04]. When comparing admission during weekends with admission during weekdays, off-hours admission was associated with a higher risk of surgical delay (adjusted OR 1.19 [95% CI: 1.05–1.37]) and a higher 30-day mortality risk (adjusted OR 1.13 [95% CI: 1.04–1.23]. The risk of surgical delay appeared not to explain the excess 30-day mortality.Conclusions Patients admitted off-hours and on-hours received similar quality of care. The risk of surgical delay and 30 days mortality was higher among patients admitted during weekends; explanations need to be clarified.

Kruse, G. B., et al. (2012). "The impact of hospital pay-for-performance on hospital and Medicare costs." Health Serv Res **47**(6): 2118-2136.

OBJECTIVE: To evaluate the effects of Medicare's hospital pay-for-performance demonstration project on hospital revenues, costs, and margins and on Medicare costs. DATA SOURCES/STUDY SETTING: All health care utilization for Medicare beneficiaries hospitalized for acute myocardial infarction (AMI; ICD-9-CM code 410.x1) in fiscal years 2002-2005 from Medicare claims, containing 420,211 admissions with AMI. STUDY DESIGN: We test for changes in hospital costs and revenues and Medicare payments among 260 hospitals participating in the Medicare hospital pay-for-performance demonstration project and a group of 780 propensity-score-matched comparison hospitals. Effects were estimated using a difference-in-difference model with hospital fixed effects, testing for changes in costs among pay-for-performance hospitals above and beyond changes in comparison hospitals. PRINCIPAL FINDINGS: We found no significant effect of pay-for-performance on hospital financials (revenues, costs, and margins) or Medicare payments (index hospitalization and 1 year after admission) for AMI patients. CONCLUSIONS: Pay-for-performance in the CMS hospital demonstration project had minimal impact on hospital financials and Medicare payments to providers. As P4P extends to all hospitals under the Affordable Care Act, these results provide some estimates of the impact of P4P and emphasize our need for a better

understanding of the financial implications of P4P on providers and payers if we want to create sustainable and effective programs to improve health care value

Kuhn, M. (2003). Quality in primary care : economic approaches to analysing quality-related physician behaviour. Londres OHE**:** 153 , 159 graph., tabl.

Ce rapport tente de comprendre quelles sont les incitations qui peuvent encourager les médecins à accroître la qualité de leurs soins et comment celles-ci sont également modelées par l'organisation des soins primaires dans les systèmes de santé. Les trois premières parties sont générales : soins primaires dans les systèmes de santé européennes, conceptualisation de la qualité en soins primaires, vue d'ensemble des intérêts des médecins et des incitations à la qualité. Les chapitres suivants analysent différents types d'incitations ou de déterminants qui peuvent jouer en matière de qualité de soins : réponse à la demande et compétition (asymétrie d'information médecin - patient, possibilité de changer de médecin?) ; rémunération des médecins et répercussions sur la qualité (budgets fixes, salaire, capitation, paiement à l'acte) ; régulation (rémunération individuelle à la performance, guides cliniques et variations de pratique) ; motivations intrinsèques et sociales (altruisme, satisfaction professionnelle, statut social?) ; auto-régulation et gouvernance clinique (réputation collective, autocontrôle individuel, auto-régulation de la profession, contrôle externe?) ; implications de l'organisation du secteur des soins primaires sur la qualité (selon une dimension horizontale ou verticale du système de santé).

Langdown, C. et Peckham, S. (2014). "The use of financial incentives to help improve health outcomes: is the quality and outcomes framework fit for purpose? A systematic review." J Public Health (Oxf) **36**(2): 251-258.

BACKGROUND: The quality and outcomes framework (QOF) is one of the world's largest pay-for-performance schemes, rewarding general practitioners for the quality of care they provide. This review examines the evidence on the efficacy of the scheme for improving health outcomes, its impact on non-incentivized activities and the robustness of the clinical targets adopted in the scheme. METHODS: The review was conducted using six electronic databases, six sources of grey literature and bibliography searches from relevant publications. Studies were identified using a comprehensive search strategy based on MeSH terms and keyword searches. A total of 21,543 references were identified of which 32 met the eligibility criteria with 11 studies selected for the review. RESULTS: Findings provide strong evidence that the QOF initially improved health outcomes for a limited number of conditions but subsequently fell to the pre-existing trend. There was limited impact on non-incentivized activities with adverse effects for some sub-population groups. CONCLUSION: The QOF has limited impact on improving health outcomes due to its focus on process-based indicators and the indicators' ceiling thresholds. Further research is required to strengthen the quality of evidence available on the QOF's impact on population health to ensure that the incentive scheme is both clinically and cost-effective.

Layton, T. J. et Ryan, A. M. (2015). "Higher Incentive Payments in Medicare Advantage's Pay-for-Performance Program Did Not Improve Quality But Did Increase Plan Offerings." Health Serv Res. http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12409/abstract

OBJECTIVE: To evaluate the effects of the size of financial bonuses on quality of care and the number of plan offerings in the Medicare Advantage Quality Bonus Payment Demonstration. DATA SOURCES: Publicly available data from CMS from 2009 to 2014 on Medicare Advantage plan quality ratings, the counties in the service area of each plan, and the benchmarks used to construct plan payments. STUDY DESIGN: The Medicare Advantage Quality Bonus

Payment Demonstration began in 2012. Under the Demonstration, all Medicare Advantage plans were eligible to receive bonus payments based on plan-level quality scores (star ratings). In some counties, plans were eligible to receive bonus payments that were twice as large as in other counties. We used this variation in incentives to evaluate the effects of bonus size on star ratings and the number of plan offerings in the Demonstration using a differences-in-differences identification strategy. We used matching to create a comparison group of counties that did not receive double bonuses but had similar levels of the preintervention outcomes. PRINCIPAL FINDINGS: Results from the difference-in-differences analysis suggest that the receipt of double bonuses was not associated with an increase in star ratings. In the matched sample, the receipt of double bonuses was associated with a statistically insignificant increase of +0.034 (approximately 1 percent) in the average star rating ($p > .10$, 95 percent CI: -0.015, 0.083). In contrast, the receipt of double bonuses was associated with an increase in the number of plans offered. In the matched sample, the receipt of double bonuses was associated with an overall increase of +0.814 plans (approximately 5.8 percent) ($p < .05$, 95 percent CI: 0.078, 1.549). We estimate that the double bonuses increased payments by $3.43 billion over the first 3 years of the Demonstration. CONCLUSIONS: At great expense to Medicare, double bonuses in the Medicare Advantage Quality Bonus Payment Demonstration were not associated with improved quality but were associated with more plan offerings.

Lee, T. H., et al. (2012). "How geisinger structures its physicians' compensation to support improvements in quality, efficiency, and volume." Health Aff.(Millwood.) **31**(9): 2068-2073.

The movement of US physicians toward working as employees rather than working as private practitioners is increasing interest in compensation systems that drive improved quality and efficiency without compromising the productivity of existing fee-for-service payment systems. We describe the approach of Geisinger Health System, an integrated delivery system in Pennsylvania that assigns about 20 percent of total expected physician compensation to incentives that support improvements in quality and efficiency along with growth in clinical volume. We believe that dedicating a moderate portion of physician compensation to achieving strategic goals, such as maximizing quality and efficiency, is improving the value of care provided at Geisinger. At the same time, because most of Geisinger's clinical care is still delivered and paid for on a fee-for-service basis, the incentives for clinical volume are enabling Geisinger to achieve the financial viability to pursue its mission

Lester, H., et al. (2010). "The impact of removing financial incentives from clinical quality indicators: longitudinal analysis of four Kaiser Permanente indicators." Bmj (Clinical Research Ed.) **340**: 1-5.

OBJECTIVE : To evaluate the effect of financial incentives on four clinical quality indicators common to pay for performance plans in the United Kingdom and at Kaiser Permanente in California. DESIGN : Longitudinal analysis. SETTING : 35 medical facilities of Kaiser Permanente Northern California, 1997-2007. PARTICIPANTS : 2 523 659 adult members of Kaiser Permanente Northern California. Main outcomes measures Yearly assessment of patient level glycaemic control (HbA(1c). RESULTS : Incentives for two indicators-screening for diabetic retinopathy and for cervical cancer-were removed during the study period. During the five consecutive years when financial incentives were attached to screening for diabetic retinopathy (1999-2003), the rate rose from 84.9% to 88.1%. This was followed by four years without incentives when the rate fell year on year to 80.5%. During the two initial years when financial incentives were attached to cervical cancer screening (1999-2000), the screening rate rose slightly, from 77.4% to 78.0%. During the next five years when financial incentives were removed, screening rates fell year on year to 74.3%. Incentives were then

reattached for two years (2006-7) and screening rates began to increase. Across the 35 facilities, the removal of incentives was associated with a decrease in performance of about 3% per year on average for screening for diabetic retinopathy and about 1.6% per year for cervical cancer screening. CONCLUSION : Policy makers and clinicians should be aware that removing facility directed financial incentives from clinical indicators may mean that performance levels decline.

Li, J., et al. (2011). Physician Response to Pay-for-Performance: Evidence from a Natural Experiment. NBER Working Paper Series ; n° 16909. Cambridge NBER**:** 75 ,fig., tabl.,annexes. http://www.nber.org/papers/w16909

Explicit financial incentives, especially pay-for-performance (P4P) incentives, have been extensively employed in recent years by health plans and governments in an attempt to improve the quality of health care services. This study exploits a natural experiment in the province of Ontario, Canada to identify empirically the impact of pay-for-performance (P4P) incentives on the provision of targeted primary care services, and whether physicians? responses differ by age, practice size and baseline compliance level. It uses an administrative data source which covers the full population of the province of Ontario and nearly all the services provided by practicing primary care physicians in Ontario. With an individual-level data set of physicians, it employes a difference-in-differences approach that controls for both ?selection on observables? and ?selection on unobservables? that may cause estimation bias in the identification. It also implemented a set of robustness checks to control for confounding from the other contemporary interventions of the primary care reform in Ontario. The results indicate that, while all responses are of modest size, physicians responded to some of the financial ncentives but not the others. The differential responses appear related to the cost of responding and the strength of the evidence linking a service with quality. Overall, the results provide a cautionary message regarding the effectiveness of pay-for-performance schemes for increasing quality of care.

Li, J., et al. (2013). "Physician response to pay-for-performance: evidence from a natural experiment." Health Economics: n/a-n/a. http://dx.doi.org/10.1002/hec.2971

This study exploits a natural experiment in the province of Ontario, Canada, to identify the impact of pay-for-performance (P4P) incentives on the provision of targeted primary care services and whether physicians' responses differ by age, size of patient population, and baseline compliance level. We use administrative data that cover the full population of Ontario and nearly all the services provided by primary care physicians. We employ a difference-in-differences approach that controls for selection on observables and selection on unobservables that may cause estimation bias. We implement a set of robustness checks to control for confounding from other contemporaneous interventions of the primary care reform in Ontario. The results indicate that responses were modest and that physicians responded to the financial incentives for some services but not others. The results provide a cautionary message regarding the effectiveness of employing P4P to increase the quality of health care. Copyright ¶¸ 2013 John Wiley & Sons, Ltd

Lin, Y., et al. (2015). "Impact of Pay for performance on Behavior of Primary Care Physicians and Patient Outcomes." J Evid Based Med. https://www.ncbi.nlm.nih.gov/pubmed/26667492

BACKGROUND AND OBJECTIVES: Pay-for-performance is a financial incentive which links physicians' income to the quality of their services. Although Pay-for-performance(P4P) is

suggested to be an effective payment method in many pilot countries (i.e. the United Kingdom) and enjoys a wide application in primary health care, researches on it are yet to reach an agreement. Thus a systematic review was conducted on the evidence of impact of P4P on behavior of primary care physicians and patient outcomes aiming to provide a comprehensive and objective evaluation of P4P for decision makers. METHODS: Studies were identified by searching PubMed, EMbase and The Cochrane Library. Electronic search was conducted in the fourth week of January, 2013. As the included studies had significant clinical heterogeneity, a descriptive analysis was conducted. Quality Index was adopted for quality assessment of evidences. RESULTS: Database searches yielded 651 candidate articles, of which 44 studies fulfilled the inclusion criteria. An overall positive effect was found on the management of disease, which varied in accordance with the baseline medical quality and the practice size. Meanwhile, it could bring about new problems regarding the inequity, patients' dissatisfaction and increasing medical cost. CONCLUSIONS: Decision makers should consider the baseline conditions of medical quality and the practice size before new medical policies are enacted. Furthermore, most studies are retrospective and observational with high level of heterogeneity though, the descriptive analysis is still of significance. This article is protected by copyright. All rights reserved.

Lindenauer, P. K., et al. (2007). "Public reporting and pay for performance in hospital quality improvement." N Engl J Med **356**(5): 486-496.

BACKGROUND: Public reporting and pay for performance are intended to accelerate improvements in hospital care, yet little is known about the benefits of these methods of providing incentives for improving care. METHODS: We measured changes in adherence to 10 individual and 4 composite measures of quality over a period of 2 years at 613 hospitals that voluntarily reported information about the quality of care through a national public-reporting initiative, including 207 facilities that simultaneously participated in a pay-for-performance demonstration project funded by the Centers for Medicare and Medicaid Services; we then compared the pay-for-performance hospitals with the 406 hospitals with public reporting only (control hospitals). We used multivariable modeling to estimate the improvement attributable to financial incentives after adjusting for baseline performance and other hospital characteristics. RESULTS: As compared with the control group, pay-for-performance hospitals showed greater improvement in all composite measures of quality, including measures of care for heart failure, acute myocardial infarction, and pneumonia and a composite of 10 measures. Baseline performance was inversely associated with improvement; in pay-for-performance hospitals, the improvement in the composite of all 10 measures was 16.1% for hospitals in the lowest quintile of baseline performance and 1.9% for those in the highest quintile (P<0.001). After adjustments were made for differences in baseline performance and other hospital characteristics, pay for performance was associated with improvements ranging from 2.6 to 4.1% over the 2-year period. CONCLUSIONS: Hospitals engaged in both public reporting and pay for performance achieved modestly greater improvements in quality than did hospitals engaged only in public reporting. Additional research is required to determine whether different incentives would stimulate more improvement and whether the benefits of these programs outweigh their costs.

Llanwarne, N. R., et al. (2013). "Relationship between clinical quality and patient experience: analysis of data from the english quality and outcomes framework and the National GP Patient Survey." Ann Fam Med **11**(5): 467-472.

PURPOSE: Clinical quality and patient experience are both widely used to evaluate the quality of health care, but the relationship between these 2 domains remains uncertain. The aim of this study was to examine this relationship using data from 2 established measures of quality

in primary care in England. METHODS: Practice-level analyses (N = 7,759 practices in England) were conducted on measures of patient experience from the national General Practice Patient Survey (GPPS), and measures of clinical quality from the national pay-for-performance scheme (Quality and Outcomes Framework). Spearman's rank correlation and multiple linear regression were used on practice-level estimates. RESULTS: Although all the correlations between clinical quality summary scores and patient survey scores are positive, and most are statistically significant, the strength of the associations was weak, with the highest correlation coefficient reaching 0.18, and more than one-half were 0.11 or less. Correlations with clinical quality were highest for patient-reported access scores (telephone access 0.16, availability of urgent appointments 0.15, ability to book ahead 0.18, ability to see preferred doctor 0.17) and overall satisfaction (0.15). CONCLUSION: Although there are associations between clinical quality and measures of patient experience, the 2 domains of care quality remain predominantly distinct. The strongest correlations are observed between practice clinical quality and practice access, with very low correlations between clinical quality and interpersonal aspects of care. The quality of clinical care and the quality of interpersonal care should be considered separately to give an overall assessment of medical care.

Loirat, P., et al. (2016). "Should payment for performance depend on mortality?" BMJ **353**.
http://www.bmj.com/content/bmj/353/bmj.i3429.full.pdf

The introduction of the Hospital Value Based Purchasing (HVBP) programme, as shown recently by Jose F Figueroa and colleagues, did not improve 30 day mortality of Medicare beneficiaries admitted to US hospitals for three incentivised conditions. We agree with the authors' conclusion that an "appropriate mix of quality metrics and incentives to improve patient outcomes" has yet …

Maeda, J. L. et Lo Sasso, A. T. (2012). "The relationship between hospital market competition, evidence-based performance measures, and mortality for chronic heart failure." Inquiry **49**(2): 164-175.
http://inq.sagepub.com/content/49/2/164.full.pdf

Using data from the Joint Commission's ORYX initiative and the Medicare Provider Analysis and Review file from 2003 to 2006, this study employed a fixed-effects approach to examine the relationship between hospital market competition, evidence-based performance measures, and short-term mortality at seven days, 30 days, 90 days, and one year for patients with chronic heart failure. We found that, on average, higher adherence with most of the Joint Commission's heart failure performance measures was not associated with lower mortality; the level of market competition also was not associated with any differences in mortality. However, higher adherence with the discharge instructions and left ventricular function assessment indicators at the 80th and 90th percentiles of the mortality distribution was associated with incrementally lower mortality rates. These findings suggest that targeting evidence-based processes of care might have a stronger impact in improving patient outcomes

Magrath, P. et Nichter, M. (2012). "Paying for performance and the social relations of health care provision: An anthropological perspective." Soc Sci.Med **75**(10): 1778-1785.
http://www.sciencedirect.com/science/article/pii/S0277953612005667

Over the past decade, the use of financial incentive schemes has become a popular form of intervention to boost performance in the health sector. Often termed "paying for performance" or P4P, they involve "...the transfer of money or material goods conditional

upon taking a measurable action or achieving a predetermined performance target" (Eldridge & Palmer, 2009, p.160). P4P appear to bring about rapid improvements in some measured indicators of provider performance, at least over the short term. However, evidence for the impact of these schemes on the wider health system remains limited, and even where evaluations have been positive, unintended effects have been identified. These have included: "gaming" the system; crowding out of "intrinsic motivation"; a drop in morale where schemes are viewed as unfair; and the undermining of social relations and teamwork through competition, envy or ill feeling. Less information is available concerning how these processes occur, and how they vary across social and cultural contexts. While recognizing the potential of P4P, the authors argue for greater care in adapting schemes to particular local contexts. We suggest that insights from social science theory coupled with the focused ethnographic methods of anthropology can contribute to the critical assessment of P4P schemes and to their adaptation to particular social environments and reward systems. We highlight the need for monitoring P4P schemes in relation to worker motivation and the quality of social relations, since these have implications both for health sector performance over the long term and for the success and sustainability of a P4P scheme. Suggestions are made for ethnographies, undertaken in collaboration with local stakeholders, to assess readiness for P4P; package rewards in ways that minimize perverse responses; identify process variables for monitoring and evaluation; and build sustainability into program design through linkage with complementary reforms

Malcomson, J. M. (2007). "Hospital cost differences and payment by results." Health Economics Policy and Law **2**(4): 429-433.

Street and Maynard (2007) argue the case for refining the system of payment by results currently being introduced for English hospitals. On the basis of international experience, they recommend, among other things, moving away from setting prices equal to average cost towards setting them equal to best practice costs, adjusting them for quality and using them to signal what activities are desirable. They also discuss how to control total expenditure for primary care trusts (PCTs) under payment by results and question the merits of extending payment by results to mental health services, ambulances, community services, and long-term conditions, 'where it is difficult to describe patient care requirements and cost variations may be high'.

Mandavia, R., et al. (2017). "Effectiveness of UK provider financial incentives on quality of care: a systematic review." Br J Gen Pract **67**(664): e800-e815.

BACKGROUND: Provider financial incentives are being increasingly adopted to help improve standards of care while promoting efficiency. AIM: To review the UK evidence on whether provider financial incentives are an effective way of improving the quality of health care. DESIGN AND SETTING: Systematic review of UK evidence, undertaken in accordance with Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) recommendations. METHOD: MEDLINE and Embase databases were searched in August 2016. Original articles that assessed the relationship between UK provider financial incentives and a quantitative measure of quality of health care were included. Studies showing improvement for all measures of quality of care were defined as 'positive', those that were 'intermediate' showed improvement in some measures, and those classified as 'negative' showed a worsening of measures. Studies showing no effect were documented as such. Quality was assessed using the Downs and Black quality checklist. RESULTS: Of the 232 published articles identified by the systematic search, 28 were included. Of these, nine reported positive effects of incentives on quality of care, 16 reported intermediate effects, two reported no effect, and one reported a negative effect. Quality assessment scores for

included articles ranged from 15 to 19, out of a maximum of 22 points. CONCLUSION: The effects of UK provider financial incentives on healthcare quality are unclear. Owing to this uncertainty and their significant costs, use of them may be counterproductive to their goal of improving healthcare quality and efficiency. UK policymakers should be cautious when implementing these incentives - if used, they should be subject to careful long-term monitoring and evaluation. Further research is needed to assess whether provider financial incentives represent a cost-effective intervention to improve the quality of care delivered in the UK.

Markovitz, A. A. et Ryan, A. M. (2016). "Pay-for-Performance: Disappointing Results or Masked Heterogeneity?" Med Care Res Rev.

Research on the effects of pay-for-performance (P4P) in health care indicates largely disappointing results. This central finding, however, may mask important heterogeneity in the effects of P4P. We conducted a literature review to assess whether hospital and physician performance in P4P vary by patient and catchment area factors, organizational and structural capabilities, and P4P program characteristics. Several findings emerged: organizational size, practice type, teaching status, and physician age and gender modify performance in P4P. For physician practices and hospitals, a higher proportion of poor and minority patients is consistently associated with worse performance. Other theoretically influential characteristics-including information technology and staffing levels-yield mixed results. Inconsistent and contradictory effects of bonus likelihood, bonus size, and marginal costs on performance in P4P suggest organizations have not responded strategically to financial incentives. We conclude that extant heterogeneity in the effects of P4P does not fundamentally alter current assessments about its effectiveness.

Markovitz, A. A., et al. (2017). "Risk Adjustment May Lessen Penalties On Hospitals Treating Complex Cardiac Patients Under Medicare's Bundled Payments." Health Aff (Millwood) **36**(12): 2165-2174.

To reduce variation in spending, Medicare has considered implementing a cardiac bundled payment program for acute myocardial infarction and coronary artery bypass graft. Because the proposed program does not account for patient risk factors when calculating hospital penalties or rewards ("reconciliation payments"), it might unfairly penalize certain hospitals. We estimated the impact of adjusting for patients' medical complexity and social risk on reconciliation payments for Medicare beneficiaries hospitalized for the two conditions in the period 2011-13. Average spending per episode was $29,394. Accounting for medical complexity substantially narrowed the gap in reconciliation payments between hospitals with high medical severity (from a penalty of $1,809 to one of $820, or a net reduction of $989), safety-net hospitals (from a penalty of $217 to one of $87, a reduction of $130), and minority-serving hospitals (from a penalty of $70 to a reward of $56, an improvement of $126) and their counterparts. Accounting for social risk alone narrowed these gaps but had minimal incremental effects after medical complexity was accounted for. Risk adjustment may preserve incentives to care for patients with complex conditions under Medicare bundled payment programs.

Mason, A., et al. (2008). Establishing a Fair Playing for Payment By Results. CHE Research Paper Series ; 39. York University of York**:** 64 , fig., tabl., ann.
http://www.york.ac.uk/inst/che/pdf/rp39.pdf

The English government has encouraged private providers ? known as Independent Sector Treatment Centres (ISTCs) ? to treat publicly funded (NHS) patients. Providers are paid a fixed price per patient treated, adjusted to reflect geographical differences in input costs. But

there may be other legitimate cost variations between providers. This report considers the regulatory and production-process constraints that could cause public and private providers costs to differ. Most of these exogenous cost differentials can be rectified by adjustments to the regulatory system or to the payment method. We find evidence that ISTCs are treating different types of patients than NHS hospitals. If these differences drive costs, payments for treatment might need to be differentiated by setting.

Masters, S. et Brown, L. (2016). "Pay for performance: Australian landscape, international efforts, and impact on practice." RESEARCH ROUNDup **47**: 2.
http://www.phcris.org.au/publications/researchroundup/issues/47.php

Fee-for-service (FFS) funding continues to dominate primary health care in Australia despite calls for reform. FFS, where providers bill for each service they provide, rewards increased activity. This may lead to over-servicing, increased costs (with no controls on prices charged), and negative impacts on quality of care. In contrast, pay-for-performance (P4P) approaches refer to payments to general practitioners (GPs) or practices, according to the number of times a certain standard of performance is met, and have been shown to improve quality.1; 2 Blended funding models have been trialled in Australia, with the 2011-14 Diabetes Care Project (DCP) incorporating P4P and flexible funding, while retaining FFS components. This article will examine P4P in the Australian primary health care context and provide lessons from both systematic reviews and international experiences of P4P in primary health care.

Maynard, A. (2008). Payment for Performance (P4P): International experience and a cautionary proposal for Estonia. Copenhague OMS Bureau régional de l'Europe**:** 36 , tabl., ann.
http://www.euro.who.int/Document/HSF/P4P_Estonia.pdf

Some health systems in Europe use financial incentives for hospitals and specialist physicians linked to process and outcome indicators of performance in an attempt to improve health gain. This is called paying for performance (P4P). Can Estonia?s health system reward value for money and improved quality in hospital and other specialized care and, if so, how? These questions are discussed in this WHO report.

Maynard, A. (2012). "The powers and pitfalls of payment for performance." Health Economics **21**(1): 3-12.

McDonald, R., et al. (2010). The impact of incentives on the behaviour and performance of primary care professionals. Londres Stationary Office**:** 269 , tabl., annexes.
http://www.sdo.nihr.ac.uk/files/project/158-final-report.pdf

There has been a general trend over the last 15 years to treat incentives in UK public services more explicitly. These initiatives reflect a general shift away from placing implicit trust in individuals and organisations to carry out their duties, towards actively managing their performance. Understanding the impact of different types of incentives on professional behaviour in primary care has been recognised as an urgent need in a context where major changes to incentive structures have been introduced in recent years, including new contractual incentives for the provision of services in primary care. Primary care professionals (PCPs) are also influenced by other policies, which alter incentives structures, such as those associated with developing practice-based commissioning (PBC) and working within wider care strategies in local health economies. It is important to understand the relative impact of incentives, or incentive mixes, in the NHS in order to enable commissioners (Primary Care Trusts or PCTs) to employ an effective repertoire of contractual and noncontractual incentives to influence change. This report details the methods and findings of a three year National Institute of Health Research Service Delivery and Organisation

programme funded project into the impact of incentives on the behaviour and performance of PCPs in the NHS.

McDonald, R. et Roland, M. (2009). "Pay for performance in primary care in England and California : comparison of unintended consequences." Annals of Family Medicine **7**(2): 121-127.

McDonald, R. et Roland, M. (2009). "Pay for performance in primary care in England and California: comparison of unintended consequences." Ann Fam Med **7**(2): 121-127.
https://www.ncbi.nlm.nih.gov/pubmed/19273866

PURPOSE: We undertook an in-depth exploration of the unintended consequences of pay-for-performance programs In England and California. METHODS: We interviewed primary care physicians in California (20) and England (20) and compared unintended consequences in each setting. Interview recordings were transcribed verbatim and subjected to thematic analysis. RESULTS: Unintended consequences reported by physicians varied according to the incentive program. English physicians were much more likely to report that the program changed the nature of the office visit. This change was linked to a larger number of performance measures and heavy reliance on electronic medical records, with computer prompts to facilitate the delivery of performance measures. Californian physicians were more likely to express resentment about pay for performance and appeared less motivated to act on financial incentives, even in the program with the highest rewards. The inability of Californian physicians to exclude individual patients from performance calculations caused frustration, and some physicians reported such undesirable behaviors as forced disenrollment of noncompliant patients. English physicians are assessed using data extracted from their own medical records, whereas in California assessment mostly relies on data collected by multiple third parties that may have different quality targets. Assessing performance based on these data contributes to feelings of resentment, lack of understanding, and lack of ownership reported by Californian physicians. CONCLUSIONS: Our study findings suggest that unintended consequences of incentive programs relate to the way in which these programs are designed and implemented. Although unintended, these consequences are not necessarily unpredictable. When designing incentive schemes, more attention needs to be paid to factors likely to produce unintended consequences.

Meacock, R., et al. (2014). "The cost-effectiveness of using financial incentives to improve provider quality: a framework and application." Health Economics **23**(1): 1-13.
http://dx.doi.org/10.1002/hec.2978

Despite growing adoption of pay-for-performance (P4P) programmes in health care, there is remarkably little evidence on the cost-effectiveness of such schemes. We review the limited number of previous studies and critique the frameworks adopted and the narrow range of costs and outcomes considered, before proposing a new more comprehensive framework, which we apply to the first P4P scheme introduced for hospitals in England. We emphasise that evaluations of cost-effectiveness need to consider who the residual claimant is on any cost savings, the possibility of positive and negative spillovers, and whether performance improvement is a transitory or investment activity. Our application to the Advancing Quality initiative demonstrates that the incentive payments represented less than half of the -£13m total programme costs. By generating approximately 5200 quality-adjusted life years and -£4.4m of savings in reduced length of stay, we find that the programme was a cost-effective use of resources in its first 18â€‰months. Copyright -© 2013 John Wiley & Sons, Ltd

MEDPAC (2009). Improving incentives in the Medicare Program : report to the Congress. Washington MEDPAC**:** 277 , tabl.

http://www.medpac.gov/documents/Jun09_EntireReport.pdf

> Recent studies show that the U.S. health care system is not buying enough recommended care and is buying too much unnecessary care, much of it at very high prices, resulting in a system that costs significantly more per capita than in any other country. These facts strongly indicate that our health care system is not delivering value for its stakeholders. As a major payer, the Medicare program shares in these problems. For decades, researchers have documented the wide variation across the United States in Medicare spending and rates of service use. For example, they find that rates of use for certain kinds of care, referred to as supply-sensitive services (i.e., likely driven by a geographic area?s supply of specialists and technology), differ greatly from one region to another. The higher rates of use are often not associated with better outcomes or quality and instead suggest inefficiencies. One recent analysis shows that, at the state level, no relationship exists between health care spending per capita and mortality amenable to medical care, that an inverse relationship exists between spending and rankings on quality of care, and that spending is highly correlated with both preventable hospitalizations and hospitalizations for ambulatory-care-sensitive conditions. These findings point to inefficient spending patterns that result in poor value for our health care dollars. At the same time, they point to opportunities for improvement. In this report, the Commission discusses a number of issues and challenges for Medicare payment and delivery system reform. The issues range broadly but focus on how incentives in the current Medicare payment systems could be changed to reward value not volume.

Merilind, E., et al. (2015). "The influence of performance-based payment on childhood immunisation coverage." Health Policy.
http://www.healthpolicyjrnl.com/article/S0168-8510(15)00031-7/abstract

> BACKGROUND: Pay-for-performance, also called the quality system (QS) in Estonia, was implemented in 2006 and one indicator for achievement is the childhood immunisation coverage rate. The WHO vaccination coverage in Europe for diphtheria, tetanus and pertussis, and measles in children aged around one year old should meet or exceed 90 per cent. METHODS: The study was conducted using a database from the Estonian Health Insurance Fund. The study compared childhood immunisation coverage rates of all Estonian family physicians in two groups, joined and not joined to the quality system during the observation period 2006-2012. Immunisation coverage was calculated as the percentage of persons in the target age group who received a vaccine dose by a given age. The target level of immunisations in Estonia is set at 90 per cent and higher. RESULTS: Immunisation coverage rates of family doctors (FD) in Estonia showed significant differences between two groups of doctors: joined to the quality system and not joined. Doctors joined to the quality system met the 90 per cent vaccination criterion more frequently compared to doctors not joined to the quality system. Doctors not joined to the quality system were below the 90 per cent vaccination criterion in all vaccinations listed in the Estonian State Immunisation Schedule. CONCLUSION: Pay-for-performance as a financial incentive encourages higher levels of childhood immunisations.

Milstein, A. et SchreyÖGg, J. (2015). A review of pay-for-performance programs in the inpatient sector in OECD countries. hche Research Paper No. 09. Hamburg HCHE**:** 44.
https://www.hche.de/dokumente/hche-online-version-09paper-2015-12-22.pdf

> Background: Across the member countries of the Organisation for Economic Co-operation and Development (OECD), pay-for-performance (P4P) programs have been implemented in the inpatient sector to improve the quality of care provided by hospitals. However, little is known about whether such programs can live up to expectations. Thus far, evaluations and

reviews have focused on the ambulatory care sector in Anglo-Saxon countries. The transferability of lessons learned to the inpatient sector, however, is limited. Objectives: We aimed to provide an overview of existing P4P programs in the inpatient sector in the OECD countries and to assemble information on their effects. Furthermore, we attempted to identify whether evaluations of such programs allow preliminary conclusions to be drawn about the effects of P4P. Methods: We conducted a structured literature search in five databases to identify relevant sources in Danish, English, French, German, Hebrew, Italian, Japanese, Korean, Norwegian, Spanish, Swedish and Turkish. This was complemented by desk-based research. In selected cases, we contacted experts to validate our results and to add further information. Our research was restricted to the inpatient sector in OECD countries. Results: We identified 30 P4P programs in 14 OECD countries. The programs were very heterogeneous in their design. First, they catered to different aims. Some programs followed a narrow approach and focused on improving the quality of care for a single medical condition, whereas others aimed at improving the quality of inpatient care more broadly. Second, the programs blended structural, process and outcome measures that targeted different stages of inpatient care pathways. Third, the financial rewards were designed in various ways. Programs based their rewards either on an absolute or a relative score. Incentives included payment withholds, penalties, bonuses, or a combination thereof. The size of the incentive often amounted to approximately 0.1% of a hospital's budget or less, and never exceeded 4%. Lastly, the results of published evaluations of the P4P programs ranged from no effect to moderately positive effects. In cases where evaluations had positive results, the effect was seldom sustained and the causalities were unclear. Conclusion: The results of our review indicate that P4P has been widely adopted across the OECD and become an integral part of the inpatient sector. The programs are very heterogeneous. The impact of P4P is unclear, and it may be that the moderately positive effects seen for some programs can be attributed to side effects, such as public reporting and increased awareness of data recording. Policy makers must decide whether the potential benefits of introducing a P4P program outweigh the potential risks within their particular national or regional context, and should be aware that P4P programs have yet not lived up to expectations.

Milstein, R. et Schreyoegg, J. (2016). "Pay for performance in the inpatient sector: A review of 34 P4P programs in 14 OECD countries." Health Policy **120**(10): 1125-1140.

Across the member countries of the Organisation for Economic Co-operation and Development (OECD), pay-for-performance (P4P) programs have been implemented in the inpatient sector to improve the quality of care provided by hospitals. This paper provides an overview of 34 existing P4P programs in the inpatient sector in 14 OECD countries based on a structured literature search in five databases to identify relevant sources in Danish, English, French, German, Hebrew, Italian, Japanese, Korean, Norwegian, Spanish, Swedish and Turkish. It assembles information on the design and effects of these P4P systems and discusses whether evaluations of such programs allow preliminary conclusions to be drawn about the effects of P4P. The programs are very heterogeneous in their aim, the selection of indicators and the design of financial rewards. The impact of P4P is unclear and it may be that the moderately positive effects seen for some programs can be attributed to side effects, such as public reporting and increased awareness of data recording. Policy makers must decide whether the potential benefits of introducing a P4P program outweigh the potential risks within their particular national or regional context, and should be aware that P4P programs have yet not lived up to expectations.

Ministère chargé de la Santé (2015). Une comparaison internationale des paiements à la performance des médecins. Les comptes de la sécurité sociale : Résultats 2014 et prévisions 2015., Paris : Ministère chargé de la santé**:** 132-135, tabl., graph.

http://www.securite-sociale.fr/IMG/pdf/rapport-ccss-juin2015.pdf

> A l'instar de la France, de nombreux pays de l'OCDE expérimentent de nouveaux modes de rémunération comme solutions possibles à l'amélioration de la qualité des soins et de l'efficience des dépenses de santé. A ce titre, le dispositif du paiement à la performance rémunère les médecins selon des résultats obtenus en fonction de l'atteinte d'objectifs de qualité des soins et de missions de santé publique. La mise en place de ce dispositif, relativement récente, est encore difficile à évaluer. Des éléments d'éclairage peuvent cependant être apportés en termes de rémunérations des médecins et de mesure de la qualité clinique.

Miraldo, M., et al. (2006). The incentive effects of payment by results. CHE Research Paper Series ; 19. York University of York**:** 15 , tabl., fig., ann.
http://www.york.ac.uk/inst/che/pdf/rp19.pdf

> Recently the English NHS has introduced an activity-based payment scheme for secondary care - the Payment by Results (PbR) policy. In this paper we discuss, from an economic perspective, the main intended and unintended incentives created by this policy. We also outline the role of different NHS institutions in monitoring and analysing the impact of PbR and consider the information and data requirements for such tasks.

Moon, L., et al. (2003). Stroke care in OECD countries : a comparaison of treatment, costs and outcomes in 17 countries. OECD Health Working Papers ; 5. Paris OCDE**:** 102 , 103 ann., graph, tabl.
http://www.oecd.org/dataoecd/10/46/2957752.pdf
http://www.olis.oecd.org/OLIS/2003DOC.NSF/LINKTO/DELSA-ELSA-WD-HEA(2003)5

> L'étude sur les maladies liées au vieillissement compare les divers systèmes de santé en examinant les tendances en matière de traitements et de résultats par type de maladie. La plupart des décisions prises quotidiennement et qui déterminent la performance des systèmes de soins de santé le sont au moment du traitement d'une maladie spécifique. Ainsi, lors de la comparaison de la performance des systèmes de soins de santé par maladie, le projet des maladies liées au vieillissement effectue une approche du bas vers le haut plutôt que l'approche plus habituelle, et va ainsi au coeur de la performance des systèmes de soins de santé. Ce document présente une telle analyse en ce qui concerne les accidents cérébrovasculaires. Les tendances dans les traitements préconisés varient considérablement d'un pays à l'autre pour les mêmes maladies et peuvent s'expliquer par des différences caractéristiques structurelles propre à chaque système de santé. Une analyse par type de maladie commence par l'examen de ces caractéristiques : les incitations économiques, les politiques et les réglementations qui influencent les décisions prises par des fournisseurs individuels dans le traitement d'une maladie spécifique et qui définissent l'approche de chaque système de santé. Afin d'évaluer correctement la performance des systèmes de santé, cette analyse doit s'accompagner d'un examen des conséquences qui résultent de ces tendances dans le domaine des traitements. Pour finir, l'analyse de la performance des systèmes de santé ne sera pas complète d'un point de vue économique sans une analyse du coût des approches des divers systèmes de santé face au traitement de la maladie (tiré du résumé d'auteur). Ce document est disponible sur le site de l'OCDE : http://www.oecd.org/dataoecd/10/46/2957752.pdf

Morgan, D., et al. (2009). Obtenir un meilleur rapport qualité-prix dans les soins de santé. Paris OCDE**:** 182 , ann., graph., tabl.
http://browse.oecdbookshop.org/oecd/pdfs/browseit/8109172E.PDF

La hausse des dépenses publiques de santé reste un problème dans pratiquement tous les pays de l'OCDE et de l'Union européenne. C'est pourquoi l'attention se porte de plus en plus sur les mesures qui atténueront ces pressions en améliorant la performance des systèmes de santé. Ce rapport présente un ensemble de politiques pouvant aider les pays à améliorer l'efficience des systèmes de santé et ainsi à obtenir un meilleur rapport qualité-prix dans les soins. Un large éventail d'instruments d'action est examiné en tirant parti de données et d'études de cas portant sur de nombreux pays. Les thèmes suivants sont traités : le rôle de la concurrence sur les marchés de la santé ; les possibilités d'amélioration de la coordination des soins ; une tarification plus adaptée des produits pharmaceutiques ; un contrôle plus poussé de la qualité s'appuyant sur une utilisation plus intensive des technologies de l?information et de la communication pour les soins ; et un plus large partage des coûts.

Morin, L., et al. (2010). "Modalités d'application du "disease management" concernant l'organisation et la rémunération des professionnels aux USA, en Allemagne et en Angleterre : perspectives pour la France." Sante Publique **22**(5): 581-592, graph.

[BDSP. Notice produite par EHESP BR0xsoIF. Diffusion soumise à autorisation]. Ledisease management développé aux États-Unis dans les années 90, est une démarche globale qui cherche à intégrer toutes les étapes de la prise en charge de la maladie chronique, de la prévention à l'éducation pour la santé. Sa mise en oeuvre se traduit aux États-Unis par le concept de Medical Home en Allemagne par des contrats incitant les médecins généralistes et les caisses de sécurité sociale à prendre en charge les patients atteints de pathologies chroniques, et au Royaume-Uni par des dispositifs favorisant la délégation de tâches et la coopération entre professionnels des soins primaires. En France, ce concept fait progressivement partie intégrante de la stratégie d'accroissement de la qualité des soins développée par l'Assurance Maladie en promouvant son développement encore expérimental sur les soins de premier recours. (R.A.).

Muller, K. J., et al. (2009). Can You Get What You Pay For? Pay-For-Performance and the Quality of Healthcare Providers. NBER Working Paper Series ; n° 14886. Cambridge NBER**:** 30 , tabl., fig., annexes.
http://www.nber.org/papers/w14886

Despite the popularity of pay-for-performance (P4P) among health policymakers and private insurers as a tool for improving quality of care, there is little empirical basis for its effectiveness. We use data from published performance reports of physician medical groups contracting with a large network HMO to compare clinical quality before and after the implementation of P4P, relative to a control group. We consider the effect of P4P on both rewarded and unrewarded dimensions of quality. In the end, we fail to find evidence that a large P4P initiative either resulted in major improvement in quality or notable disruption in care.

Nielsen, M., et al. (2016). The Patient-Centered Medical Home's Impact on Cost and Quality. Annual Review of Evidence 2014-2015. Washington DC Patient-Centered Primary Care Collaborative**:** 40 , tabl.
https://www.pcpcc.org/resource/patient-centered-medical-homes-impact-cost-and-quality-2014-2015

Le Patient-Centred Primary Care Collaborative (PCPCC) est une initiative américaine de prestation des soins de santé primaires qui met l'accent sur une approche « maison médicale » pour améliorer les soins centrés sur le patient tout en réduisant les coûts des soins. Cette revue des évidences présente un résumé des coûts et de l'utilisation des « maisons

médicales » estimés dans des études, des rapports de l'industrie et des évaluations du gouvernement.

Nolan, A., et al. (2011). The Potential Role of Pay for Performance in Irish Health Care. Dublin ESRI**:** 36 , tabl.
http://www.esri.ie/UserFiles/publications/EC004.pdf

The current recession dictates that large decreases in public expenditure are required. As the second largest component of public expenditure, health is particularly vulnerable to the effects of the further cuts in expenditure that are required over the period 2012-2014. In the context of diminishing financial resources, there is increasing emphasis on maximising the value of expenditure by achieving efficient delivery of high-quality health-care services. In addition, the Irish health system is characterised by a complex set of financial incentives which have important implications for efficiency and equity. This paper examines international evidence on pay for performance (P4P) schemes to inform policymakers on the potential for implementing P4P in the Irish health-care system. In P4P, payments are tied to performance. P4P is becoming increasingly common in international health-care systems despite the lack of evidence on its effectiveness and a lack of consensus on how to design and implement such programmes. It is therefore important to understand the implications of existing P4P programmes before recommending their introduction in the Irish context. This study provides an overview of the literature relating to large-scale P4P schemes, focusing on programmes that have been instituted by national public sector organisations. The literature highlights the poor quality of evidence on P4P schemes, stemming partly from technical challenges inherent in evaluating P4P schemes. Notwithstanding these technical difficulties, the available evidence does not provide a clear answer to the question of whether P4P should be implemented. Limitations include difficulties in obtaining valid performance indicators, unintended consequences, and the absence of evidence on cost effectiveness of P4P schemes. It assessed how a P4P scheme would interact with the payment structures already in place in the Irish health-care system. It concludes that while there is an obvious need for greater efficiency and quality in the system, there are reasons why P4P initiatives are not recommended at this stage at least until the many complexities in provider reimbursement, public/private interaction, and patient access to the system are resolved.

Nolte, E., et al. (2011). Informing the development of a resource allocation framework in the German healthcare system. Santa Monica Rand corporation**:** 85 , tabl., annexes.
http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR946.pdf

In the German statutory health insurance (SHI) system, the payment of office-based physicians in the ambulatory care sector is based on a complex system involving national and regional stakeholders. Payment rates are derived from a national relative value scale but, as budgets are negotiated at the regional level, conversion factors for the relative values and thus prices for the same service can vary by region. Against this background, the National Association of Statutory Health Insurance Physicians (KBV) in Germany is looking to develop a national approach that allocates funds according to a unified framework, while taking account of regional characteristics. As part of this new approach, the KBV seeks to incorporate quality indicators into the allocation formula so as to improve the overall quality of care provided by SHI physicians. This report aims to inform the development of the quality component of the proposed national resource allocation framework in the German statutory healthcare system by providing an overview of quality indicator systems and quality measurement approaches, including criteria for selecting measures of quality currently used for 'high stakes' assessment in high-income countries globally. High stakes uses of performance measures mean that the provider's performance scores are used for public

accountability (making results transparent through public reporting) and/or for differentially allocating resources (pay-for-performance or P4P).

Nuckols, T. K., et al. (2013). "The effects of quality of care on costs: a conceptual framework." Milbank Q **91**(2): 316-353.

CONTEXT: The quality of health care and the financial costs affected by receiving care represent two fundamental dimensions for judging health care performance. No existing conceptual framework appears to have described how quality influences costs. METHODS: We developed the Quality-Cost Framework, drawing from the work of Donabedian, the RAND/UCLA Appropriateness Method, reports by the Institute of Medicine, and other sources. FINDINGS: The Quality-Cost Framework describes how health-related quality of care (aspects of quality that influence health status) affects health care and other costs. Structure influences process, which, in turn, affects proximate and ultimate outcomes. Within structure, subdomains include general structural characteristics, circumstance-specific (e.g., disease-specific) structural characteristics, and quality-improvement systems. Process subdomains include appropriateness of care and medical errors. Proximate outcomes consist of disease progression, disease complications, and care complications. Each of the preceding subdomains influences health care costs. For example, quality improvement systems often create costs associated with monitoring and feedback. Providing appropriate care frequently requires additional physician visits and medications. Care complications may result in costly hospitalizations or procedures. Ultimate outcomes include functional status as well as length and quality of life; the economic value of these outcomes can be measured in terms of health utility or health-status-related costs. We illustrate our framework using examples related to glycemic control for type 2 diabetes mellitus or the appropriateness of care for low back pain. CONCLUSIONS: The Quality-Cost Framework describes the mechanisms by which health-related quality of care affects health care and health status-related costs. Additional work will need to validate the framework by applying it to multiple clinical conditions. Applicability could be assessed by using the framework to classify the measures of quality and cost reported in published studies. Usefulness could be demonstrated by employing the framework to identify design flaws in published cost analyses, such as omitting the costs attributable to a relevant subdomain of quality

Nuffield Trust (2012). Reforming payment for health care in Europe to achieve better value. Londres Nuffield Trust**:** 40 , fig., tabl., annexes.
http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/120823_reforming-payment-for-health-care-in-europev2.pdf

This report compares different payment systems for health care used across Europe and examines their role in improving the efficiency and quality of care. Findings are based on discussions at the Nuffield Trust and KPMG summit for European health leaders, held in January 2012.

OCDE (2014). OECD Reviews of Health Care Quality: Czech Republic 2014: Raising Standards. Paris OCDE**:** 158 , tabl., fig.
http://www.oecd-ilibrary.org/social-issues-migration-health/oecd-reviews-of-health-care-quality-czech-republic-2014_9789264208605-en

This book presents a comprehensive review of health care quality in the Czech Republic. It finds that over the past 20 years, the Czech Republic witnessed the unprecedented gains in quality of health care and life expectancy and successfully transferred its Semaschko system into the modern accessible health care system with private-public mix of providers.

Nevertheless the health care system in the Czech Republic still has some way to go to achieve the outcomes of the best performing OECD members. While some of the gap might be caused by the one of the lowest levels of health care expenditures among OECD countries (7.2% GDP in 2011) there are possibilities to improve the outcomes without incurring much of the additional costs. The Czech authorities should reach a consensus on the development of quality of care and data infrastructure and aim for sustainable long-term initiatives undisturbed by the political cycles in both of these areas. While the adverse events reporting and voluntary accreditation are the good steps towards the accountability of the providers, the government should do more in this area, undertake the effort to broaden the accreditation process and include outpatient care and link public health authorities to the quality agenda of inpatient care. In the area of data infrastructure more data should be gathered, the process of data gathering should be streamlined and administrative burden for the providers lowered primarily via the merging the data-collecting agencies. Finally, without the active participation of health insurance funds and proper reimbursement mechanisms in place the quality agenda will not be perceived as the priority (résumé de l'éditeur).

OCDE (2016). OECD Reviews of Health Care Quality: United Kingdom 2016: Raising Standards. Paris OCDE**:** 296 , tabl., fig.

Health systems in the United Kingdom have, for many years, made the quality of care a highly visible priority, internationally pioneering many tools and policies to assure and improve the quality of care. A key challenge, however, is to understand why, despite being a global leader in quality monitoring and improvement, the United Kingdom does not consistently demonstrate strong performance on international benchmarks of quality. This report reviews the quality of health care in the England, Scotland, Wales and Northern Ireland, seeking to highlight best practices, and provides a series of targeted assessments and recommendations for further quality gains in health care. To secure continued quality gains, the four health systems will need to balance top-down approaches to quality management and bottom-up approaches to quality improvement; publish more quality and outcomes data disaggregated by country; and, establish a forum where the key officials and clinical leaders from the four health systems responsible for quality of care can meet on a regular basis to learn from each other's innovations.

Odesjo, H., et al. (2015). "Short-term effects of a pay-for-performance programme for diabetes in a primary care setting: an observational study." Scand J Prim Health Care **33**(4): 291-297.

OBJECTIVE: A pay-for-performance (P4P) programme for primary care was introduced in 2011 by a Swedish county (with 1.6 million inhabitants). Effects on register entry practice and comparability of data for patients with diabetes mellitus were assessed. DESIGN AND SETTING: Observational study analysing short-term outcomes before and after introduction of a P4P programme in the study county as compared with a reference county. SUBJECTS: A total of 84 053 patients reported to the National Diabetes Register by 349 primary care units. MAIN OUTCOME MEASURES: Completeness of data, level and target achievement of glycated haemoglobin (HbA1c), blood pressure (BP), and LDL cholesterol (LDL). RESULTS: In the study county, newly recruited patients who were entered during the incentive programme were less well controlled than existing patients in the register - they had higher HbA1c (54.9 [54.5-55.4] vs. 53.7 [53.6-53.9] mmol/mol), BP, and LDL. The percentage of patients with entry of BP, HbA1c, LDL, albuminuria, and smoking increased in the study county but not in the reference county (+26.3% vs -1.5%). In the study county, with an incentive for BP < 130/80 mmHg, BP data entry behaviour was altered with an increased preference for sub-target BP values and a decline in zero end-digit readings (38.3% vs. 33.7%, p < 0.001). CONCLUSION: P4P led to increased register entry, increased completeness of

data, and altered BP entry behaviour. Analysis of newly added patients and data shows that missing patients and data can cause performance to be overestimated. Potential effects on reporting quality should be considered when designing payment programmes. Key points A pay-for-performance programme, with a focus on data entry, was introduced in a primary care region in Sweden. Register data entry in the National Diabetes Register increased and registration behaviour was altered, especially for blood pressure. Newly entered patients and data during the incentive programme were less well controlled. Missing data in a quality register can cause performance to be overestimated.

Ogundeji, Y. K., et al. (2016). "The effectiveness of payment for performance in health care: A meta-analysis and exploration of variation in outcomes." Health Policy **120**(10): 1141-1150. http://dx.doi.org/10.1016/j.healthpol.2016.09.002

?Schemes evaluated based on processes (compared to outcomes) appear to have larger effects.?Larger incentives are likely to have greater effects than smaller incentives.?Better evaluated P4P schemes show smaller estimates of effects.

Oliver-Baxter, J., et al. (2014). Quality improvement financial incentives for general practitioners. Flinders Primary Health Care Research & Information Service**:** 48. http://www.phcris.org.au/phplib/filedownload.php?file=/elib/lib/downloaded_files/publications/pdfs/phcris_pub_8426.pdf

Cette analyse examine les programmes d'incitation financière implantés en Australie, au Royaume-Uni, aux États-Unis et au Canada pour améliorer la qualité des soins de santé primaires. Dans tous les cas, des indicateurs sont utilisés, mais sont accompagnés par des obligations et avantages différents. Les auteurs constatent que la littérature ne reconnait pas de façon explicite si les résultats mesurés sont des améliorations absolues ou relatives.

OPIEC (2014). Nouveaux modes de rémunération : Eclairage international de pratiques économiques innovantes dans le domaine de la santé. Modèles et incidences sur la formation et l'emploi de l'usage du numérique dans les services de l'administration. Annexes du rapport de phase 1 «Modèle opérationnels ». Monographies de l'étude de cas., Paris : OPIIEC**:** 121-140, fig.

Présentation des nouveaux modes de rémunération en France; Modes de rémunération en Grande-Bretagne, Etats-Unis, Pays-Bas.

Paleologou, V., et al. (2006). "Developing and testing an instrument for identifying performance incentives in the Greek health care sector." Bmc Health Services Research **6**(118): 1-28. http://www.biomedcentral.com/1472-6963/6/118

In the era of cost containment, managers are constantly pursuing increased organizational performance and productivity by aiming at the obvious target, i.e. the workforce. The health care sector, in which production processes are more complicated compared to other industries, is not an exception. In light of recent legislation in Greece in which efficiency improvement and achievement of specific performance targets are identified as undisputable health system goals, the purpose of this study was to develop a reliable and valid instrument for investigating the attitudes of Greek physicians, nurses and administrative personnel towards job-related aspects, and the extent to which these motivate them to improve performance and increase productivity. In the era of cost containment, managers are constantly pursuing increased organizational performance and productivity by aiming at the obvious target, i.e. the workforce. The health care sector, in which production processes are more complicated compared to other industries, is not an

exception. In light of recent legislation in Greece in which efficiency improvement and achievement of specific performance targets are identified as undisputable health system goals, the purpose of this study was to develop a reliable and valid instrument for investigating the attitudes of Greek physicians, nurses and administrative personnel towards job-related aspects, and the extent to which these motivate them to improve performance and increase productivity.

Paris, V. (2012). "Les performances comparées des systèmes de santé." Les Tribunes de la santé **35**(2): 43-49.
http://www.cairn.info/revue-les-tribunes-de-la-sante-2012-2-page-43.htm

Paris, V. et Devaux, M. (2013). "Les modes de rémunération des médecins des pays de l'OCDE." Seve : Les Tribunes De La Sante(40): 45-52.

Cet article décrit les principaux modes de rémunération des médecins généralistes et spécialistes dans les pays de l'OCDE. Ceux-ci sont liés aux modes d'organisation des soins, qui eux-mêmes dépendent du système de soins (système national versus assurance obligatoire). Depuis le début des années 2000, de nombreux pays ont complété les modes traditionnels de rémunération (salaire, capitation et paiement à l'acte) par des paiements additionnels visant à accroître la qualité des soins et l'efficience du système (résumé de l'éditeur).

Petersen, L. A., et al. (2006). "Does Pay-for-Performance Improve the Quality of Health Care ?" Annals of Internal Medicine **145**(4): 265-272.

BACKGROUND: Most physicians and hospitals are paid the same regardless of the quality of the health care they provide. This produces no financial incentives and, in some cases, produces disincentives for quality. Increasing numbers of programs link payment to performance. PURPOSE: To systematically review studies assessing the effect of explicit financial incentives for improved performance on measures of health care quality. DATA SOURCES: PubMed search of English-language literature (1 January 1980 to 14 November 2005), and reference lists of retrieved articles. STUDY SELECTION: Empirical studies of the relationship between explicit financial incentives designed to improve health care quality and a quantitative measure of health care quality. DATA EXTRACTION: The authors categorized studies according to the level of the incentive (individual physician, provider group, or health care payment system) and the type of quality measure rewarded. DATA SYNTHESIS: Thirteen of 17 studies examined process-of-care quality measures, most of which were for preventive services. Five of the 6 studies of physician-level financial incentives and 7 of the 9 studies of provider group-level financial incentives found partial or positive effects on measures of quality. One of the 2 studies of incentives at the payment-system level found a positive effect on access to care, and 1 showed evidence of a negative effect on access to care for the sickest patients. In all, 4 studies suggested unintended effects of incentives. The authors found no studies examining the optimal duration of financial incentives for quality or the persistence of their effects after termination. Only 1 study addressed cost-effectiveness. LIMITATIONS: Few empirical studies of explicit financial incentives for quality were available for review. CONCLUSIONS: Ongoing monitoring of incentive programs is critical to determine the effectiveness of financial incentives and their possible unintended effects on quality of care. Further research is needed to guide implementation of financial incentives and to assess their cost-effectiveness.

Polton, D. (2010). "Accroître la qualité et l'efficience du système de santé en s'appuyant sur les soins primaires, la démarche de l'assurance maladie en France." Revue Francaise Des Affaires Sociales(3): 97-101.

Cet article présente la stratégie globale que l'assurance maladie française déploie depuis plusieurs années pour gagner en qualité et en efficience dans le système de soins. Cette démarche s'appuie sur les soins primaires et les médecins traitants, le Contrat d'amélioration des pratiques individuelles (CAPI) en constitue un des éléments.

Porter, M. Z. et al., (2015). OrthoChoice: Bundled Payments in the County of Stockholm (A). Harvard : Harvard Business School.
http://www.senat.fr/rap/r16-668/r16-6685.html

It was the waiting that drew the attention of the Stockholm County Council. In 2008, patients seeking a hip or knee replacement in Stockholm County faced wait times of up to two years of sometimes debilitating pain, intermittent missed work and income, and the trials of disability. Seeking a new model to lower wait times, but also improve patient choice of care, County Council Senior Medical Adviser, Dr. Holger Stalberg, set out to create a bundled payment system for hip and knee replacements in the County. The new model, called OrthoChoice, was set to go into operation on January 1, 2009.

Pouvourville, G. d. (2013). "Paying for performance." European Journal of Health Economics (the) **14**(1): 1-4.

Roberts, E. T., et al. (2017). "High-Price And Low-Price Physician Practices Do Not Differ Significantly On Care Quality Or Efficiency." Health Aff (Millwood) **36**(5): 855-864.

Consolidation of physician practices has intensified concerns that providers with greater market power may be able to charge higher prices without having to deliver better care, compared to providers with less market power. Providers have argued that higher prices cover the costs of delivering higher-quality care. We examined the relationship between physician practice prices for outpatient services and practices' quality and efficiency of care. Using commercial claims data, we classified practices as being high- or low-price. We used national data from the Consumer Assessment of Healthcare Providers and Systems survey and linked claims for Medicare beneficiaries to compare high- and low-price practices in the same geographic area in terms of care quality, utilization, and spending. Compared with low-price practices, high-price practices were much larger and received 36 percent higher prices. Patients of high-price practices reported significantly higher scores on some measures of care coordination and management but did not differ meaningfully in their overall care ratings, other domains of patient experiences (including physician ratings and access to care), receipt of preventive services, acute care use, or total Medicare spending. This suggests an overall weak relationship between practice prices and the quality and efficiency of care and calls into question claims that high-price providers deliver substantially higher-value care.

Robinson, J. C. et Macpherson, K. (2012). "Payers test reference pricing and centers of excellence to steer patients to low-price and high-quality providers." Health Aff.(Millwood.) **31**(9): 2028-2036.

Hospitals frequently exhibit wide variation in their prices, and employers and insurers are now experimenting with the use of incentives to encourage employees to make price-conscious choices. This article examines two major new benefit design instruments being tested. In reference pricing, an employer or insurer makes a defined contribution toward covering the cost of a particular service and the patient pays the remainder. Through centers of excellence, employers or insurers limit coverage or strongly encourage patients to use particular hospitals for such procedures as orthopedic joint replacement, interventional cardiology, and cardiac surgery. We compare these two types of benefit designs with respect

to consumer choice and how they balance price and quality. The article then examines their potential role in the policy debate over appropriate coverage and cost-sharing requirements

Robinson, J. C., et al. (2009). "Measurement of and reward for efficiency in California's pay-for-performance program." Health Affairs **28**(5): 1438-1447.

Roland, M. (2016). "Does pay-for-performance in primary care save lives?" The Lancet **388**(10041): 217-218.
http://dx.doi.org/10.1016/S0140-6736(16)00550-X

Roland, M. et Campbell, S. (2014). "Successes and failures of pay for performance in the United Kingdom." New England Journal of Medicine (the) **370**(20): 1944-1949.

Roland, M., et al. (2006). "Financial incentives to improve the quality of primary care in the UK: predicting the consequences of change." Primary Health Care Research and Development(7): 18-26.

Roland, M. et Campbell, S. M. (2014). "Successes and Failures of Pay for Performance in the United Kingdom." New England Journal of Medicine **370**(20): 1944-1949.
http://dx.doi.org/10.1056/NEJMhpr1316051

In 2004, the United Kingdom introduced a large pay-for-performance program, which tied 25% of family practitioners' income to quality incentive payments. The authors review the changes made to the program and its successes and failures since it was introduced a decade ago

Roland, M. et Dudley, R. A. (2015). "How Financial and Reputational Incentives Can Be Used to Improve Medical Care." Health Serv Res **50 Suppl 2**: 2090-2115.

OBJECTIVES: Narrative review of the impact of pay-for-performance (P4P) and public reporting (PR) on health care outcomes, including spillover effects and impact on disparities. PRINCIPAL FINDINGS: The impact of P4P and PR is dependent on the underlying payment system (fee-for-service, salary, capitation) into which these schemes are introduced. Both have the potential to improve care, but they can also have substantial unintended consequences. Evidence from the behavioral economics literature suggests that individual physicians will vary in how they respond to incentives. We also discuss issues to be considered when including patient-reported outcome measures (PROMs) or patient-reported experience measures into P4P and PR schemes. CONCLUSION: We provide guidance to payers and policy makers on the design of P4P and PR programs so as to maximize their benefits and minimize their unintended consequences. These include involving clinicians in the design of the program, taking into account the payment system into which new incentives are introduced, designing the structure of reward programs to maximize the likelihood of intended outcomes and minimize the likelihood of unintended consequences, designing schemes that minimize the risk of increasing disparities, providing stability of incentives over some years, and including outcomes that are relevant to patients' priorities. In addition, because of the limitations of PR and P4P as effective interventions in their own right, it is important that they are combined with other policies and interventions intended to improve quality to maximize their likely impact.

Rosenthal, M. B. (2008). "Beyond Pay for Performance ? Emerging Models of Provider-Payment Reform." New England Journal of Medicine (the) **359**(12): 1197-1200.
http://content.nejm.org/cgi/reprint/359/12/1197.pdf

Rosenthal, M. B. et Frank, R. G. (2006). "What Is the Empirical Basis for Paying for Quality in Health Care?" Medical Care Research and Review **63**(2): 135-157.
http://journals.sagepub.com/doi/abs/10.1177/1077558705285291

Despite more than a decade of benchmarking and public reporting of quality problems in the health care sector, changes in medical practice have been slow to materialize. To accelerate quality improvement, many private and public payers have begun to offer financial incentives to physicians and hospitals based on their performance on clinical and service quality measures. The authors review the empirical literature on paying for quality in health care and comparable interventions in other sectors. They find little evidence to support the effectiveness of paying for quality. The absence of findings for an effect may be attributable to the small size of the bonuses studied and the fact that payers often accounted for only a fraction of the targeted provider's panel. Even in nonhealth settings, however, where the institutional features are more favorable to a positive impact, the literature contains mixed results on the effectiveness of analogous pay-for-performance schemes.

Rosenthal, M. B., et al. (2016). "Pay for Performance in Medicaid: Evidence from Three Natural Experiments." Health Serv Res **51**(4): 1444-1466.

OBJECTIVE: To examine the impact of pay for performance in Medicaid on the quality and utilization of care. DATA SOURCES: Medicaid claims and encounter data in three intervention states (Pennsylvania, Minnesota, and Alabama) and three comparison states. STUDY DESIGN: Difference-in-difference analysis with propensity score-matched comparison group. Primary outcomes of interest were Healthcare Effectiveness Data and Information Set (HEDIS)-like process measures of quality, utilization by service category, and ambulatory care-sensitive admissions and emergency department visits. PRINCIPAL FINDINGS: In Pennsylvania, there was a statistically significant reduction of 88 ambulatory visits per 1,000 enrollee months compared with Florida. In Minnesota, there was a significant decrease of 7.2 hospital admissions per thousand enrollee months compared with Wisconsin. In Alabama, where incentives were not paid out until the end of a 2-year waiver period, there was a decline of 1.6 hospital admissions per thousand member months, and an increase of 59 ambulatory visits per 1,000 enrollees compared with Georgia. No significant quality improvements in intervention relative to control states. CONCLUSIONS: Our findings are mixed, with no measurable quality improvements across the three states, but reductions in hospital admissions in two programs. As states move to value-based payment for patient-centered medical homes and Accountable Care Organizations, lessons learned from these pioneering states should inform program design.

Rosenthal, M. B. et al. (2006). "What Is the Empirical Basis for Paying for Quality in Health Care ?" Medical Care Research and Review **63**(2): 135-157.

Despite more than a decade of benchmarking and public reporting of quality problems in the health care sector, changes in medical practice have been slow to materialize. To accelerate quality improvement, many private and public payers have begun to offer financial incentives to physicians and hospitals based on their performance on clinical and service quality measures. The authors review the empirical literature on paying for quality in health care and comparable interventions in other sectors. They find little evidence to support the effectiveness of paying for quality. The absence of findings for an effect may be attributable to the small size of the bonuses studied and the fact that payers often accounted for only a fraction of the targeted provider's panel. Even in nonhealth settings, however, where the

institutional features are more favorable to a positive impact, the literature contains mixed results on the effectiveness of analogous pay-for-performance schemes.

Ryan, A. et Blustein, J. (2012). "Making the Best of Hospital Pay for Performance." New England Journal of Medicine (the) **366**(17): 1557-1559.

Ryan, A., et al. (2014). "Does winning a pay-for-performance bonus improve subsequent quality performance? Evidence from the Hospital Quality Incentive Demonstration." Health Serv Res **49**(2): 568-587.
https://www.ncbi.nlm.nih.gov/pubmed/23909992

OBJECTIVE: To test whether receiving a financial bonus for quality in the Premier Hospital Quality Incentive Demonstration (HQID) stimulated subsequent quality improvement. DATA: Hospital-level data on process-of-care quality from Hospital Compare for the treatment of acute myocardial infarction (AMI), heart failure, and pneumonia for 260 hospitals participating in the HQID from 2004 to 2006; receipt of quality bonuses in the first 3 years of HQID from the Premier Inc. website; and hospital characteristics from the 2005 American Hospital Association Annual Survey. STUDY DESIGN: Under the HQID, hospitals received a 1 percent bonus on Medicare payments for scoring between the 80th and 90th percentiles on a composite quality measure, and a 2 percent bonus for scoring at the 90th percentile or above. We used a regression discontinuity design to evaluate whether hospitals with quality scores just above these payment thresholds improved more in the subsequent year than hospitals with quality scores just below the thresholds. In alternative specifications, we examined samples of hospitals scoring within 3, 5, and 10 percentage point "bandwidths" of the thresholds. We used a Generalized Linear Model to estimate whether the relationship between quality and lagged quality was discontinuous at the lagged thresholds required for quality bonuses. PRINCIPAL FINDINGS: There were no statistically significant associations between receipt of a bonus and subsequent quality performance, with the exception of the 2 percent bonus for AMI in 2006 using the 5 percentage point bandwidth (0.8 percentage point increase, p<.01), and the 1 percent bonus for pneumonia in 2005 using all bandwidths (3.7 percentage point increase using the 3 percentage point bandwidth, p<.05). CONCLUSIONS: We found little evidence that hospitals' receipt of quality bonuses was associated with subsequent improvement in performance. This raises questions about whether winning in pay-for-performance programs, such as Hospital Value-Based Purchasing, will lead to subsequent quality improvement.

Ryan, A. M., et al. (2012). "The effect of phase 2 of the premier hospital quality incentive demonstration on incentive payments to hospitals caring for disadvantaged patients." Health Serv.Res. **47**(4): 1418-1436.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3401392/pdf/hesr0047-1418.pdf

OBJECTIVE: The Medicare and Premier Inc. Hospital Quality Incentive Demonstration (HQID), a hospital-based pay-for-performance program, changed its incentive design from one rewarding only high performance (Phase 1) to another rewarding high performance, moderate performance, and improvement (Phase 2). We tested whether this design change reduced the gap in incentive payments among hospitals treating patients across the gradient of socioeconomic disadvantage. DATA: To estimate incentive payments in both phases, we used data from the Premier Inc. website and from Medicare Provider Analysis and Review files. We used data from the American Hospital Association Annual Survey and Centers for Medicare and Medicaid Services Impact File to identify hospital characteristics. STUDY DESIGN: Hospitals were divided into quartiles based on their Disproportionate Share Index

(DSH), from lowest disadvantage (Quartile 1) to highest disadvantage (Quartile 4). In both phases of the HQID, we tested for differences across the DSH quartiles for three outcomes: (1) receipt of any incentive payments; (2) total incentive payments; and (3) incentive payments per discharge. For each of the study outcomes, we performed a hospital-level difference-in-differences analysis to test whether the gap between Quartile 1 and the other quartiles decreased from Phase 1 to Phase 2. PRINCIPAL FINDINGS: In Phase 1, there were significant gaps across the DSH quartiles for the receipt of any payment and for payment per discharge. In Phase 2, the gap was not significant for the receipt of any payment, but it remained significant for payment per discharge. For the receipt of any incentive payment, difference-in-difference estimates showed significant reductions in the gap between Quartile 1 and the other quartiles (Quartile 2, 17.5 percentage points [p < .05]; Quartile 3, 18.1 percentage points [p < .01]; Quartile 4, 28.3 percentage points [p < .01]). For payments per discharge, the gap was also significantly reduced between Quartile 1 and the other quartiles (Quartile 2, $14.92 per discharge [p < .10]; Quartile 3, $17.34 per discharge [p < .05]; Quartile 4, $21.31 per discharge [p < .01]). There were no significant reductions in the gap for total payments. CONCLUSIONS: The design change in the HQID reduced the disparity in the receipt of any incentive payment and for incentive payments per discharge between hospitals caring for the most and least socioeconomically disadvantaged patient populations

Ryan, A. M., et al. (2015). "The Early Effects of Medicare's Mandatory Hospital Pay-for-Performance Program." Health Serv Res **50**(1): 81-97.
http://onlinelibrary.wiley.com/store/10.1111/1475-6773.12206/asset/hesr12206.pdf?v=1&t=ibxhd5q9&s=4a2049d137c4ff92481dc583419758d66515dda2

OBJECTIVE: To evaluate the impact of hospital value-based purchasing (HVBP) on clinical quality and patient experience during its initial implementation period (July 2011-March 2012). DATA SOURCES: Hospital-level clinical quality and patient experience data from Hospital Compare from up to 5 years before and three quarters after HVBP was initiated. STUDY DESIGN: Acute care hospitals were exposed to HVBP by mandate while critical access hospitals and hospitals located in Maryland were not exposed. We performed a difference-in-differences analysis, comparing performance on 12 incentivized clinical process and 8 incentivized patient experience measures between hospitals exposed to the program and a matched comparison group of nonexposed hospitals. We also evaluated whether hospitals that were ultimately exposed to HVBP may have anticipated the program by improving quality in advance of its introduction. PRINCIPAL FINDINGS: Difference-in-differences estimates indicated that hospitals that were exposed to HVBP did not show greater improvement for either the clinical process or patient experience measures during the program's first implementation period. Estimates from our preferred specification showed that HVBP was associated with a 0.51 percentage point reduction in composite quality for the clinical process measures (p > .10, 95 percent CI: -1.37, 0.34) and a 0.30 percentage point reduction in composite quality for the patient experience measures (p > .10, 95 percent CI: -0.79, 0.19). We found some evidence that hospitals improved performance on clinical process measures prior to the start of HVBP, but no evidence of this phenomenon for the patient experience measures. CONCLUSIONS: The timing of the financial incentives in HVBP was not associated with improved quality of care. It is unclear whether improvement for the clinical process measures prior to the start of HVBP was driven by the expectation of the program or was the result of other factors.

Ryan, A. M., et al. (2016). "Long-term evidence for the effect of pay-for-performance in primary care on mortality in the UK: a population study." The Lancet **388**(10041): 268-274.
http://dx.doi.org/10.1016/S0140-6736(16)00276-2

BackgroundIntroduced in 2004, the UK's Quality and Outcomes Framework (QOF) is the world's largest primary care pay-for-performance programme. We tested whether the QOF was associated with reduced population mortality.

Ryan, A. M., et al. (2017). "Changes in Hospital Quality Associated with Hospital Value-Based Purchasing." New England Journal of Medicine **376**(24): 2358-2366.
http://www.nejm.org/doi/full/10.1056/NEJMsa1613412

Starting in fiscal year 2013, the Hospital Value-Based Purchasing (HVBP) program introduced quality performance-based adjustments of up to 1% to Medicare reimbursements for acute care hospitals.
METHODS: We evaluated whether quality improved more in acute care hospitals that were exposed to HVBP than in control hospitals (Critical Access Hospitals, which were not exposed to HVBP). The measures of quality were composite measures of clinical process and patient experience (measured in units of standard deviations, with a value of 1 indicating performance that was 1 standard deviation [SD] above the hospital mean) and 30-day risk-standardized mortality among patients who were admitted to the hospital for acute myocardial infarction, heart failure, or pneumonia. The changes in quality measures after the introduction of HVBP were assessed for matched samples of acute care hospitals (the number of hospitals included in the analyses ranged from 1364 for mortality among patients admitted for acute myocardial infarction to 2615 for mortality among patients admitted for pneumonia) and control hospitals (number of hospitals ranged from 31 to 617). Matching was based on preintervention performance with regard to the quality measures. We evaluated performance over the first 4 years of HVBP.
RESULTS: Improvements in clinical-process and patient-experience measures were not significantly greater among hospitals exposed to HVBP than among control hospitals, with difference-in-differences estimates of 0.079 SD (95% confidence interval [CI], -0.140 to 0.299) for clinical process and -0.092 SD (95% CI, -0.307 to 0.122) for patient experience. HVBP was not associated with significant reductions in mortality among patients who were admitted for acute myocardial infarction (difference-in-differences estimate, -0.282 percentage points [95% CI, -1.715 to 1.152]) or heart failure (-0.212 percentage points [95% CI, -0.532 to 0.108]), but it was associated with a significant reduction in mortality among patients who were admitted for pneumonia (-0.431 percentage points [95% CI, -0.714 to -0.148]).
CONCLUSIONS: In our study, HVBP was not associated with improvements in measures of clinical process or patient experience and was not associated with significant reductions in two of three mortality measures. (Funded by the National Institute on Aging.).

Ryen, L. et Svensson, M. (2014). "The willingness to pay for a quality adjusted life year: a review of the empirical literature." Health Economics(Ahead of pub): n/a-n/a.
http://dx.doi.org/10.1002/hec.3085

There has been a rapid increase in the use of cost-effectiveness analysis, with quality adjusted life years (QALYs) as an outcome measure, in evaluating both medical technologies and public health interventions. Alongside, there is a growing literature on the monetary value of a QALY based on estimates of the willingness to pay (WTP). This paper conducts a review of the literature on the WTP for a QALY. In total, 24 studies containing 383 unique estimates of the WTP for a QALY are identified. Trimmed mean and median estimates amount to 74,159 and 24,226 Euros (2010 price level), respectively. In regression analyses, the results indicate that the WTP for a QALY is significantly higher if the QALY gain comes from life extension rather than quality of life improvements. The results also show that the

WTP for a QALY is dependent on the size of the QALY gain valued. Copyright -© 2014 John Wiley & Sons, Ltd

Sadowski, B. W., et al. (2017). "High-Value, Cost-Conscious Care: Iterative Systems-Based Interventions to Reduce Unnecessary Laboratory Testing." Am J Med **130**(9): 1112.e1111-1112.e1117.

BACKGROUND: Inappropriate testing contributes to soaring healthcare costs within the United States, and teaching hospitals are vulnerable to providing care largely for academic development. Via its "Choosing Wisely" campaign, the American Board of Internal Medicine recommends avoiding repetitive testing for stable inpatients. We designed systems-based interventions to reduce laboratory orders for patients admitted to the wards at an academic facility. METHODS: We identified the computer-based order entry system as an appropriate target for sustainable intervention. The admission order set had allowed multiple routine tests to be ordered repetitively each day. Our iterative study included interventions on the automated order set and cost displays at order entry. The primary outcome was number of routine tests controlled for inpatient days compared with the preceding year. Secondary outcomes included cost savings, delays in care, and adverse events. RESULTS: Data were collected over a 2-month period following interventions in sequential years and compared with the year prior. The first intervention led to 0.97 fewer laboratory tests per inpatient day (19.4%). The second intervention led to sustained reduction, although by less of a margin than order set modifications alone (15.3%). When extrapolating the results utilizing fees from the Centers for Medicare and Medicaid Services, there was a cost savings of $290,000 over 2 years. Qualitative survey data did not suggest an increase in care delays or near-miss events. CONCLUSIONS: This series of interventions targeting unnecessary testing demonstrated a sustained reduction in the number of routine tests ordered, without adverse effects on clinical care.

Saint-Lary, O., et al. (2012). "Performance scores in general practice : a comparison between the clinical versus medication-based approach to identify target populations." Plos One **7**(4): e35721-e35721.
http://www.plosone.org/article/related/info%3Adoi%2F10.1371%2Fjournal.pone.0035721;jsessionid=3B2FB5FF0EA6BC3A9EF73479C37B5D6F

D'un pays à l'autre, les mécanismes de rémunération à la performance diffèrent sur un point important : l'identification des populations cibles. Ce sont ces populations qui servent de base pour le calcul des indicateurs.

Saint-Lary, O., et al. (2015). "Modes de rémunération des médecins généralistes : quelles conséquences ?" Exercer La Revue Francophone De Medecine Generale **26**(119): 52-61.
http://www.exercer.fr/numero/119/page/52/

Les auteurs de cet article se proposent d'effectuer une synthèse des données concernant différentes modalités de rémunération des médecins : le paiement à l'acte, la capitation, le paiement à la performance et le salariat.

Saint-Lary, O. et Sicsic, J. (2015). "Impact of a pay for performance programme on French GPs' consultation length." Health Policy **119**(4): 417-426.
http://www.healthpolicyjrnl.com/article/S0168-8510(14)00265-6/abstract

BACKGROUND: In 2009, a voluntary-based pay for performance scheme targeting general practitioners (GPs) was introduced in France through the 'Contract for Improving Individual

Practices' (CAPI). OBJECTIVE: To study the impact of the CAPI on French GPs' consultation length. METHODS: Univariate analysis, and multilevel regression analyses were performed to disentangle the different sources of the consultation length variability (intra and inter physician). The dependant variable was the logarithm of the consultation length. Independent variables included patient's sociodemographics as well as the characteristics of GPs and their medical activity. RESULTS: Between November 2011 and April 2012, 128 physicians were recruited throughout France and generated 20,779 consultations timed by residents. The average consultation length in the sample was 16.8min. After adjusting for patients' characteristics only, the consultation length of CAPI signatories was 14.1% lower than that observed for non signatories (p<0.001). After adjusting for GPs' characteristics and the case mix, the CAPI was no longer a significant predictor of the consultation length. The results did not change significantly from one type of consultation to another. CONCLUSION: Although the CAPI was extended to all GPs in 2012, our results provide a cautionary message to regulators about its ability to generate higher quality of care.

Scott, A., et al. (2008). The Effect of Financial Incentives on Quality of Care: The Case of Diabetes. Melbourne Institute Working; 12/08. Melbourne Melbourne Institute of Applied economics and social research**:** 27 , tabl., fig.
http://melbourneinstitute.com/wp/wp2008n12.pdf

Australia introduced an incentive payment scheme for general practitioners to ensure systematic and high quality care in chronic disease management. There is little empirical evidence and ambiguous theoretical guidance on which effects to expect on the quality of care. This paper evaluates the impact of the payment incentives on quality of care in diabetes, as measured by the probability of ordering an HbA1c test. The empirical analysis is conducted with a unique data set and a multivariate probit model to control for the simultaneous self-selection process of practices into the payment scheme and larger practices. The study finds that the incentive reform had a positive effect on quality of care in diabetes management and that participation in the scheme is facilitated by the support of Divisions of General Practice.

Scott, A., et al. (2008). The Effects of Financial Incentives on Quality of Care: The Case of Diabetes. HEDG Working Paper; 08/15. York HEDG**:** 30 , tabl., fig.
http://www.york.ac.uk/res/herc/documents/wp/08_15pdf

Australia introduced an incentive payment scheme for general practitioners to ensure systematic and high quality care in chronic disease management. There is little empirical evidence and ambiguous theoretical guidance on which effects to expect on the quality of care. This paper evaluates the impact of the payment incentives on quality of care in diabetes, as measured by the probability of ordering an HbA1c test. The empirical analysis is conducted with a unique data set and a multivariate probit model to control for the simultaneous self-selection process of practices into the payment scheme and larger practices. The study finds that the incentive reform had a positive effect on quality of care in diabetes management and that participation in the scheme is facilitated by the support of Divisions of General Practice.

Scott, A., et al. (2011). "The effect of financial incentives on the quality of health care provided by primary care physicians." Cochrane Database Syst Rev(9): Cd008451.

BACKGROUND: The use of blended payment schemes in primary care, including the use of financial incentives to directly reward 'performance' and 'quality' is increasing in a number of countries. There are many examples in the US, and the Quality and Outcomes Framework

(QoF) for general practitioners (GPs) in the UK is an example of a major system-wide reform. Despite the popularity of these schemes, there is currently little rigorous evidence of their success in improving the quality of primary health care, or of whether such an approach is cost-effective relative to other ways to improve the quality of care. OBJECTIVES: The aim of this review is to examine the effect of changes in the method and level of payment on the quality of care provided by primary care physicians (PCPs) and to identify:i) the different types of financial incentives that have improved quality;ii) the characteristics of patient populations for whom quality of care has been improved by financial incentives; andiii) the characteristics of PCPs who have responded to financial incentives. SEARCH STRATEGY: We searched the Cochrane Effective Practice and Organisation of Care (EPOC) Trials Register, Cochrane Central Register of Controlled Trials (CENTRAL) and Cochrane Database of Systematic Reviews (CDSR) (The Cochrane Library), MEDLINE, HealthSTAR, EMBASE, CINAHL, PsychLIT, and ECONLIT. Searches of Internet-based economics and health economics working paper collections were also conducted. Finally, studies were identified through the reference lists of retrieved articles, websites of key organisations, and from direct contact with key authors in the field. Articles were included if they were published from 2000 to August 2009. SELECTION CRITERIA: Randomised controlled trials (RCT), controlled before and after studies (CBA), and interrupted time series analyses (ITS) evaluating the impact of different financial interventions on the quality of care delivered by primary healthcare physicians (PCPs). Quality of care was defined as patient reported outcome measures, clinical behaviours, and intermediate clinical and physiological measures. DATA COLLECTION AND ANALYSIS: Two review authors independently extracted data and assessed study quality, in consultation with two other review authors where there was disagreement. For each included study, we reported the estimated effect sizes and confidence intervals. MAIN RESULTS: Seven studies were included in this review. Three of the studies evaluated single-threshold target payments, one examined a fixed fee per patient achieving a specified outcome, one study evaluated payments based on the relative ranking of medical groups' performance (tournament-based pay), one study examined a mix of tournament-based pay and threshold payments, and one study evaluated changing from a blended payments scheme to salaried payment. Three cluster RCTs examined smoking cessation; one CBA examined patients' assessment of the quality of care; one CBA examined cervical screening, mammography screening, and HbA1c; one ITS focused on four outcomes in diabetes; and one controlled ITS (a difference-in-difference design) examined cervical screening, mammography screening, HbA1c, childhood immunisation, chlamydia screening, and appropriate asthma medication. Six of the seven studies showed positive but modest effects on quality of care for some primary outcome measures, but not all. One study found no effect on quality of care. Poor study design led to substantial risk of bias in most studies. In particular, none of the studies addressed issues of selection bias as a result of the ability of primary care physicians to select into or out of the incentive scheme or health plan. AUTHORS' CONCLUSIONS: The use of financial incentives to reward PCPs for improving the quality of primary healthcare services is growing. However, there is insufficient evidence to support or not support the use of financial incentives to improve the quality of primary health care. Implementation should proceed with caution and incentive schemes should be more carefully designed before implementation. In addition to basing incentive design more on theory, there is a large literature discussing experiences with these schemes that can be used to draw out a number of lessons that can be learned and that could be used to influence or modify the design of incentive schemes. More rigorous study designs need to be used to account for the selection of physicians into incentive schemes. The use of instrumental variable techniques should be considered to assist with the identification of treatment effects in the presence of selection bias and other sources of unobserved heterogeneity. In randomised trials, care must be taken in using the correct unit of analysis and more attention should be paid to blinding. Studies should also examine the potential unintended consequences of incentive schemes by

having a stronger theoretical basis, including a broader range of outcomes, and conducting more extensive subgroup analysis. Studies should more consistently describe i) the type of payment scheme at baseline or in the control group, ii) how payments to medical groups were used and distributed within the groups, and iii) the size of the new payments as a percentage of total revenue. Further research comparing the relative costs and effects of financial incentives with other behaviour change interventions is also required.

Serumaga, B., et al. (2011). "Effect of pay for performance on the management and outcomes of hypertension in the United Kingdom: interrupted time series study." BMJ **342**: d108. https://www.ncbi.nlm.nih.gov/pubmed/21266440

OBJECTIVE: To assess the impact of a pay for performance incentive on quality of care and outcomes among UK patients with hypertension in primary care. DESIGN: Interrupted time series. SETTING: The Health Improvement Network (THIN) database, United Kingdom. PARTICIPANTS: 470 725 patients with hypertension diagnosed between January 2000 and August 2007. INTERVENTION: The UK pay for performance incentive (the Quality and Outcomes Framework), which was implemented in April 2004 and included specific targets for general practitioners to show high quality care for patients with hypertension (and other diseases). MAIN OUTCOME MEASURES: Centiles of systolic and diastolic blood pressures over time, rates of blood pressure monitoring, blood pressure control, and treatment intensity at monthly intervals for baseline (48 months) and 36 months after the implementation of pay for performance. Cumulative incidence of major hypertension related outcomes and all cause mortality for subgroups of newly treated (treatment started six months before pay for performance) and treatment experienced (started treatment in year before January 2001) patients to examine different stages of illness. RESULTS: After accounting for secular trends, no changes in blood pressure monitoring (level change 0.85, 95% confidence interval -3.04 to 4.74, P=0.669 and trend change -0.01, -0.24 to 0.21, P=0.615), control (-1.19, -2.06 to 1.09, P=0.109 and -0.01, -0.06 to 0.03, P=0.569), or treatment intensity (0.67, -1.27 to 2.81, P=0.412 and 0.02, -0.23 to 0.19, P=0.706) were attributable to pay for performance. Pay for performance had no effect on the cumulative incidence of stroke, myocardial infarction, renal failure, heart failure, or all cause mortality in both treatment experienced and newly treated subgroups. CONCLUSIONS: Good quality of care for hypertension was stable or improving before pay for performance was introduced. Pay for performance had no discernible effects on processes of care or on hypertension related clinical outcomes. Generous financial incentives, as designed in the UK pay for performance policy, may not be sufficient to improve quality of care and outcomes for hypertension and other common chronic conditions.

Sharfstein, J. F., et al. (2017). An emergencing approach to payment reform: All-Payer Global Budgets for large Safety-Net Hospital systems. Washington The Commonwealth Fund**:** 16 , tab., graph., fig. http://www.commonwealthfund.org/publications/fund-reports/2017/aug/payment-reform-all-payer-global-budgets-hospital?omnicid=EALERT1258211&mid=suhard@irdes.fr

In 2010, Maryland launched a pilot program in which 10 rural hospitals were each guaranteed a set amount of revenue for the coming year, regardless of the number of inpatient admissions or emergency department visits. After 30 months, potentially preventable complications fell by nearly half, readmission rates dropped even further, and the hospitals had generated hundreds of millions in Medicare savings. The emergence of all-payer global hospital budgeting may represent a solution to the challenge safety-net health care systems face in meeting their communities' needs for expanded primary care, behavioral health, and social services. Unlike fee-for-service reimbursement, global budgeting creates an incentive for hospitals to reorganize care delivery and invest in services

to address preventable health conditions. This report written, a team of experts led by Joshua M. Sharfstein of the Johns Hopkins Bloomberg School of Public Health assesses the potential of all-payer global hospital budgeting to further the mission of safety-net health systems. The authors detail the steps to implementing global budgets while also weighing the pros and cons of pursuing global budgeting over alternative value-based payment arrangements.

Shen, Y. (2003). "Selection incentives in a performance-based contracting system." Health Serv Res **38**(2): 535-552.
https://www.ncbi.nlm.nih.gov/pubmed/12785560

OBJECTIVE: To investigate whether a performance-based contracting (PBC) system provides incentives for nonprofit providers of substance abuse treatment to select less severe clients into treatment. DATA SOURCES: The Maine Addiction Treatment System (MATS) standardized admission and discharge data provided by the Maine Office of Substance Abuse (OSA) for fiscal years 1991-1995, provides demographic, substance abuse, and social functional information on clients of programs receiving public funding. STUDY DESIGN: We focused on OSA clients (i.e., those patients whose treatment cost was covered by the funding from OSA) and Medicaid clients in outpatient programs. Clients were identified as being "most severe" or not. We compared the likelihood for OSA clients to be "most severe" before PBC and after PBC using Medicaid clients as the control. Multivariate regression analysis was employed to predict the marginal effect of PBC on the probability of OSA clients being most severe after controlling for other factors. PRINCIPAL FINDINGS: The percentage of OSA outpatient clients classified as most severe users dropped by 7 percent ($p < = 0.001$) after the innovation of performance-based contracting compared to the increase of 2 percent for Medicaid clients. The regression results also showed that PBC had a significantly negative marginal effect on the probability of OSA clients being most severe. CONCLUSIONS: Performance-based contracting gave providers of substance abuse treatment financial incentives to treat less severe OSA clients in order to improve their performance outcomes. Fewer OSA clients with the greatest severity were treated in outpatient programs with the implementation of PBC. These results suggest that regulators, or payers, should evaluate programs comprehensively taking this type of selection behavior into consideration.

Sherry, T. (2015). "A Note on the Comparative Statics of Pay-for-Performance in Health Care." Health Economics: 1-8.

Pay-for-performance (P4P) is a widely implemented quality improvement strategy in health care that has generated much enthusiasm, but only limited empirical evidence to support its effectiveness. Researchers have speculated that flawed program designs or weak financial incentives may be to blame, but the reason for P4P's limited success may be more fundamental. When P4P rewards multiple services, it creates a special case of the well-known multitasking problem, where incentives to increase some rewarded activities are blunted by countervailing incentives to focus on other rewarded activities: these incentives may cancel each other out with little net effect on quality. This paper analyzes the comparative statics of a P4P model to show that when P4P rewards multiple services in a setting of multitasking and joint production, the change in both rewarded and unrewarded services is generally ambiguous. This result contrasts with the commonly held intuition that P4P should increase rewarded activities.

Sherry, T. B. (2016). "A Note on the Comparative Statics of Pay-for-Performance in Health Care." Health Economics **25**(5): 637-644.
http://dx.doi.org/10.1002/hec.3169

Pay-for-performance (P4P) is a widely implemented quality improvement strategy in health care that has generated much enthusiasm, but only limited empirical evidence to support its effectiveness. Researchers have speculated that flawed program designs or weak financial incentives may be to blame, but the reason for P4P's limited success may be more fundamental. When P4P rewards multiple services, it creates a special case of the well-known multitasking problem, where incentives to increase some rewarded activities are blunted by countervailing incentives to focus on other rewarded activities: these incentives may cancel each other out with little net effect on quality. This paper analyzes the comparative statics of a P4P model to show that when P4P rewards multiple services in a setting of multitasking and joint production, the change in both rewarded and unrewarded services is generally ambiguous. This result contrasts with the commonly held intuition that P4P should increase rewarded activities. Copyright © 2015 John Wiley & Sons, Ltd.

Shih, T., et al. (2014). "Does pay-for-performance improve surgical outcomes? An evaluation of phase 2 of the Premier Hospital Quality Incentive Demonstration." Ann Surg **259**(4): 677-681.

OBJECTIVE: We sought to determine whether the changes in incentive design in phase 2 of Medicare's flagship pay-for-performance program, the Premier Hospital Quality Incentive Demonstration (HQID), reduced surgical mortality or complication rates at participating hospitals. BACKGROUND: The Premier HQID was initiated in 2003 to reward high-performing hospitals. The program redesigned its incentive structure in 2006 to also reward hospitals that achieved significant improvement. The impact of the change in incentive structure on outcomes in surgical populations is unknown. METHODS: We examined discharge data for patients who underwent coronary artery bypass (CABG), hip replacement, and knee replacement at Premier hospitals and non-Premier hospitals in Hospital Compare from 2003 to 2009 in 12 states (n = 861,411). We assessed the impact of incentive structural changes in 2006 on serious complications and 30-day mortality. In these analyses, we adjusted for patient characteristics using multiple logistic regression models. To account for improvement in outcomes over time, we used difference-in-difference techniques that compare trends in Premier versus non-Premier hospitals. We repeated our analyses after stratifying hospitals into quintiles according to risk-adjusted mortality and serious complication rates. RESULTS: After restructuring incentives in 2006 in Premier hospitals, there were lower risk-adjusted mortality and complication rates for both cardiac and orthopedic patients. However, after accounting for temporal trends in non-Premier hospitals, there were no significant improvements in mortality for CABG [odds ratio (OR) = 1.09; 95% confidence interval (CI), 0.92-1.28] or joint replacement (OR = 0.81; 95% CI, 0.58-1.12). Similarly, there were no significant improvements in serious complications for CABG (OR = 1.05; 95% CI, 0.97-1.14) or joint replacement (OR = 1.12; 95% CI, 1.01-1.23). Analysis of the "worst" quintile hospitals that were targeted in the incentive structural changes also did not reveal a change in mortality [(OR = 1.01; 95% CI, 0.78-1.32) for CABG and (OR = 0.96; 95% CI, 0.22-4.26) for joint replacement] or serious complication rates [(OR = 1.08; 95% CI, 0.88-1.34) for CABG and (OR = 0.92; 95% CI, 0.67-1.28) for joint replacement]. CONCLUSIONS: Despite recent enhancements to incentive structures, the Premier HQID did not improve surgical outcomes at participating hospitals. Unless significantly redesigned, pay-for-performance may not be a successful strategy to improve outcomes in surgery.

Shwartz, M., et al. (2014). "A Probability Metric for Identifying High-Performing Facilities: An Application for Pay-for-Performance Programs." Med Care **52**(12): 1030-1036.

BACKGROUND: Two approaches are commonly used for identifying high-performing facilities on a performance measure: one, that the facility is in a top quantile (eg, quintile or quartile);

and two, that a confidence interval is below (or above) the average of the measure for all facilities. This type of yes/no designation often does not do well in distinguishing high-performing from average-performing facilities. OBJECTIVE: To illustrate an alternative continuous-valued metric for profiling facilities-the probability a facility is in a top quantile-and show the implications of using this metric for profiling and pay-for-performance. METHODS: We created a composite measure of quality from fiscal year 2007 data based on 28 quality indicators from 112 Veterans Health Administration nursing homes. A Bayesian hierarchical multivariate normal-binomial model was used to estimate shrunken rates of the 28 quality indicators, which were combined into a composite measure using opportunity-based weights. Rates were estimated using Markov Chain Monte Carlo methods as implemented in WinBUGS. The probability metric was calculated from the simulation replications. RESULTS: Our probability metric allowed better discrimination of high performers than the point or interval estimate of the composite score. In a pay-for-performance program, a smaller top quantile (eg, a quintile) resulted in more resources being allocated to the highest performers, whereas a larger top quantile (eg, being above the median) distinguished less among high performers and allocated more resources to average performers. CONCLUSION: The probability metric has potential but needs to be evaluated by stakeholders in different types of delivery systems

Sibbald, B. (2010). "Transferts de tâches entre professionnels de santé dans les soins primaires au Royaume-Uni et enseignements de la littérature internationales." Revue Francaise Des Affaires Sociales(3): 35-47, graph.

Directrice du Centre de développement et de recherche en soins primaires (National Primary Care Research and Development Centre ? NPCRDC) de l?université de Manchester, Bonnie Sibbald mène depuis 1995 des recherches sur l'amélioration de la qualité des soins primaires à travers le développement des ressources humaines et le transfert de compétences (skill mix) entre professionnels de santé. Ses travaux portent principalement sur la façon dont le skill mix peut contribuer à améliorer l?efficacité et la performance dans les systèmes de santé. Elle a notamment développé le cadre conceptuel devenu une référence à l'échelle internationale visant à décrire et évaluer les changements en matière de transfert de compétences des professionnels de santé. Cet article présente ici le contexte d'introduction du skill mix dans le secteur des soins primaires au Royaume-Uni et fournit quelques éléments d?évaluation de ces pratiques.

Siciliani, L. (2007). Paying for Performance with altruistic or motivated providers. Discussion Papers in Economics ; n° 2007/33. York University of York**:** 32 , fig., ann.
http://www.york.ac.uk/depts/econ/documents/dp/0733.pdf

We present a model of optimal contracting between a purchaser (a principal) and a provider (an agent). We assume that: a) providers differ in efficiency and there are two types of provider; b) efficiency is private information (adverse selection); c) providers are partially altruistic or intrinsically motivated; d) they have limited liability. Four types of separating equilibrium can emerge, depending on the degree of altruism, characterised as very low, low, high and very high. i) For very low altruism the quantity of the efficient and inefficient types is distorted upwards and downwards respectively; the efficient type makes a positive profit. ii) For low altruism the quantity of the efficient and inefficient types is also distorted respectively upwards and downwards, but profits are zero for both types. iii) For high altruism the first best is attained: no distortions on quantities and zero profits. iv) For very high altruism the quantity of the inefficient type is distorted upwards, and the quantity of the efficient type is distorted either upwards or downwards. The inefficient type might have a positive profit. The quantity of the efficient type is higher than that of the inefficient type in

all four possible equilibria. The transfer for the efficient type can be higher or lower than the inefficient one, unless altruism tends to zero in which case the transfer for the efficient type is higher. The utility of the efficient type is higher than that of the inefficient one when altruism is very low, low or high, though not necessarily when altruism is very high.

Sicsic, J. et Franc, C. (2017). "Impact assessment of a pay-for-performance program on breast cancer screening in France using micro data." Eur J Health Econ **18**(5): 609-621.

BACKGROUND: A voluntary-based pay-for-performance (P4P) program (the CAPI) aimed at general practitioners (GPs) was implemented in France in 2009. The program targeted prevention practices, including breast cancer screening, by offering a maximal amount of euro245 for achieving a target screening rate among eligible women enrolled with the GP. OBJECTIVE: Our objective was to evaluate the impact of the French P4P program (CAPI) on the early detection of breast cancer among women between 50 and 74 years old. METHODS: Based on an administrative database of 50,752 women aged 50-74 years followed between 2007 and 2011, we estimated a difference-in-difference model of breast cancer screening uptake as a function of visit to a CAPI signatory referral GP, while controlling for both supply-side and demand-side determinants (e.g., sociodemographics, health and healthcare use). RESULTS: Breast cancer screening rates have not changed significantly since the P4P program implementation. Overall, visiting a CAPI signatory referral GP at least once in the pre-CAPI period increased the probability of undergoing breast cancer screening by 1.38 % [95 % CI (0.41-2.35 %)], but the effect was not significantly different following the implementation of the contract. CONCLUSION: The French P4P program had a nonsignificant impact on breast cancer screening uptake. This result may reflect the fact that the low-powered incentives implemented in France through the CAPI might not provide sufficient leverage to generate better practices, thus inviting regulators to seek additional tools beyond P4P in the field of prevention and screening.

Singh, P. (2012). Performance Pay in Public Health: Evidence from a Controlled Experiment. Amherst Amherst College**:** 54 , tabl., graph., fig.
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2270751

This paper provides evidence for the effectiveness of performance pay to government health workers and how performance pay interacts with demand-side information. In a controlled experiment covering 145 child day-care centers, I implement three separate treatments. First, I engineer an exogenous change in compensation for childcare workers from fixed wages to performance pay. Second, I only provide mothers with information without incentivizing the workers. Third, I combine the first two treatments. This helps us identify if performance pay and public information are complements or substitutes in reducing child malnutrition. I find that combining incentives to workers and information to mothers reduces weight-for-age malnutrition by 4.2% in 3 months, although individually the effects are negligible. This complementarity is shown to be driven by better mother-worker communication and the mother feeding more calorific food at home. There is also a sustained long-run positive impact of the combined treatment after the experiment concluded.

Siriwardena, A. (2012). "Research on the UK Quality and Outcomes Framework (QOF) and answering wider questions on the effectiveness of pay-for-performance (P4P) in health care." Quality in Primary Care **20**(2): 81-82.

Sochal, K. (2014). Mixed reimbursement of hospitals: Securing high activity and global expenditures control? Health Economics Paper; 2014/3. Odense University of Southern Denmark**:** 34.

http://static.sdu.dk/mediafiles//2/0/4/%7B2042E743-793F-4377-AE4E-0D9E0A65BAE4%7DWP20143.pdf

When introducing Diagnosis-Related Group (DRG) tariffs as the basis for paying hospitals in Europe, one of the major problems was to find a balancing point between the aim of increasing hospital activity and the need to control global expenditures on hospital care. Consequently, in several European countries, DRG-based reimbursement has been mixed with the already existing forms of hospital reimbursement, such as block budgets, instead of replacing the latter entirely. The mixed reimbursement is viewed as a cautious way of introducing DRG-based funding, which offers the potential for achieving activity expansion without jeopardizing global expenditures control. Denmark is one of the countries where DRG tariffs have been added to the system of block budgets coupled with activity targets. The transition to the mixed reimbursement occurred by replacing a part of each hospital's 'old' block budget by a 'new' DRG-based component. The DRG-based component depends on a hospital's case mix and applicable DRG tariffs, which are, however, reduced by, e.g. 30-50% as compared with a monetary value of a full tariff. The usual interpretation is that such a mix of reimbursement methods provides a specific set of incentives that is different from other hospital payment methods. Yet, the exact modus operandi of the mixed reimbursement remains obscure. It is not entirely clear whether and how the unit rate of reimbursement was changed after the transition? Was the entire volume of a hospital's activity affected or only certain treatments and/or higher levels of activity? Another question is what happened with the activity targets that traditionally accompanied the 'old' block budgets? The aim of this article is to provide a comprehensive description of the change in hospital incentive scheme that followed the transition to the mixed reimbursement in Denmark. In doing so, the paper provides a q ualitative assessment of the mixed reimbursement with regard to the asserted exceptionality of its incentive structure, with a particular focus on its ability to balance incentives for activity expansion and global expenditures control. We show that the mixed reimbursement is simply a veiled version of the usual block budget system, which due to certain added complications might even distort activity/efficiency improvements in a new way. The cautions way of implementing DRG–based reimbursement resulted in a system that has hardly moved away from the historical patterns of activity and costs. The sum of the 'new' DRG-based component and the remaining part of the 'old' block budget simply added up to the total of the 'old' block budget (+/- standard annual corrections for inflation, etc.), which allowed hospitals to produce unchanged sort and volume of activity at unchanged unit cost. Only few percent of the annual activity volume is indeed subject to altered rei mbursement incentives. In sum, the mixed reimbursement as implemented in Denmark does not present any innovation. Hence, any empirical research based on the assumption that the incentive scheme for the entire volume of hospital activity was changed by the transition to the mixed reimbursement might produce false conclusions.

Spivack, S. B., et al. (2014). "Hospital cardiovascular outcome measures in federal pay-for-reporting and pay-for-performance programs: a brief overview of current efforts." Circ Cardiovasc Qual Outcomes **7**(5): 627-633.

Srivastava, D., et al. (2016). Better Ways to Pay for Health Care, Paris : OCDE
http://www.oecd.org/health/health-systems/better-ways-to-pay-for-health-care-9789264258211-en.htm

Payers for health care are pursuing a variety of policies as part of broader efforts to improve the quality and efficiency of care. Payment reform is but one policy tool to improve health system performance that requires supportive measures in place such as policies with well-developed stakeholder involvement, information on quality, clear criteria for tariff setting,

and embedding evaluation as part of the policy process. Countries should not, however, underestimate the significant data challenges when looking at price setting processes. Data access and ways to overcome its fragmentation require well-developed infrastructures. Policy efforts highlight a trend towards aligning payer and provider incentives by using evidence-based clinical guidelines and outcomes to inform price setting. There are signs of increasing policy focus on outcomes to inform price setting. These efforts could bring about system-wide effects of using evidence along with a patient-centred focus to improve health care delivery and performance in the long-run

Staat, M. (2003). "The efficiency of treatment strategies of general practitioners. A Malquist index approach." European Journal of Health Economics (the) **4**(3): 227-246.

Tan, S. Y. et Melendez-Torres, G. J. (2018). "Do prospective payment systems (PPSs) lead to desirable providers' incentives and patients' outcomes? A systematic review of evidence from developing countries." Health Policy and Planning **33**(1): 137-153.
http://dx.doi.org/10.1093/heapol/czx151

The reform of provider payment systems, from retrospective to prospective payment, has been heralded as the right move to contain costs in the light of rising health expenditures in many countries. However, there are concerns on quality trade-off. The heightened attention given to prospective payment system (PPS) reforms and the rise of empirical evidence regarding PPS interventions among developing countries suggest that a systematic review is necessary to understand the effects of PPS reforms in developing countries. A systematic search of 14 databases and a hand search of health policy journals and grey literature from October to November 2016 were carried out, guided by a set of inclusion and exclusion criteria. Data were extracted based on the Consolidated Health Economics Evaluation Reporting Standards checklist. Drummond's 10-item checklist for economic evaluation, Cochrane Collaboration's tool in assessing risk of bias for randomized trials, and Risk of Bias in Non-randomized Studies of Interventions were used to critically appraise the evidence. A total of 12 studies reported in China, Thailand and Vietnam were included in this review. Substantial heterogeneity was present in PPS policy design across different localities. PPS interventions were found to have reduced health expenditures on both the supply and demand side, as well as length of stay and readmission rates. In addition, PPS generally improved service quality outcomes by reducing the likelihood or percentage of physicians prescribing unnecessary drugs and diagnostic procedures. PPS is a promising policy tool for middle-income countries to achieve reasonable health policy objectives in terms of cost containment without necessarily compromising the quality of care. More evaluations of PPS will need to be conducted in the future in order to broaden the evidence base beyond middle-income countries.

Tisuka, T., et al. (2017). Pay-for-Performance and Selective Referral in Long-Term Care. Tockyo The University of Tockyo**:** 44 , tab., graph., fig.
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2971560

We examine how pay-for-performance (P4P) affects long-term care (LTC), exploiting a natural experiment in Japan. Matched user/care manager/provider data are used to observe care managers' referral decisions. Care managers/providers can vertically integrate, and P4P creates new incentives for selective referrals. Overall, we found no robust evidence that P4P improves LTC outcomes. However, after P4P, LTC outcomes improved more when care managers referred users to affiliated providers than to non-affiliated providers. Moreover, care managers referred users whose care levels were more likely to improve to affiliated

providers. Selective referrals are apparently explained by vertical integration and a lack of risk adjustment.

Tisuka, T., et al. (2017). Pay-for-Performance and Selective Referral in Long-Term Care. Tockyo The University of Tockyo**:** 44 , tab., graph., fig.
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2971560

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Town, R., et al. (2004). "Assessing the influence of incentives on physicians and medical groups." Medical Care Research and Review **61**(suppl. 3): 80S-118S.

Towse, A. et Garrison, L. P. (2010). "Can't get no satisfaction ? Will pay for performance help ? Toward an economic framework for understanding performance-based risk-sharing agreements for innovative medical products." Pharmacoeconomics **28**(2): 93-102.

Vallee, J. P. (2013). "Paiement à la performance au Royaume-Uni. Annals of Family Medicine, 2012 : impact sur la qualité et les résultats sanitaires." Medecine : Revue De L'unaformec **9**(1): 33-35.

Le UK Quality and Outcomes Framework (QOF) mis en oeuvre en avril 2004 est sans doute l'approche nationale la plus exhaustive au monde de rémunération à la performance (P4P). C'est une intervention complexe intriquant incitations financières et large utilisation des nouvelles technologies de l'information. Il vise à promouvoir des soins structurés, appuyés sur un travail d'équipe, avec pour objectif l'atteinte de « cibles » définies sur des données factuelles, comptabilisée en points (maximum 1 000/an, en majorité indicateurs cliniques dans 20 pathologies chroniques), chacun valant en 2011-2012 130 £ (environ 156 e). En 2009-2010, chacun des 152 Primary Care Trusts du Royaume-Uni, équivalent approximatif (la réalité est beaucoup plus complexe) de pôles ou autres maisons de santé dans le système français, a obtenu entre 878 et 972 points, ce qui a représenté une augmentation de revenu conséquente et discutée pour les professionnels travaillant dans ces structures.

Van Herck, P., et al. (2010). "Systematic review: Effects, design choices, and context of pay-for-performance in health care." BMC Health Serv Res **10**: 247.

BACKGROUND: Pay-for-performance (P4P) is one of the primary tools used to support healthcare delivery reform. Substantial heterogeneity exists in the development and implementation of P4P in health care and its effects. This paper summarizes evidence, obtained from studies published between January 1990 and July 2009, concerning P4P effects, as well as evidence on the impact of design choices and contextual mediators on these effects. Effect domains include clinical effectiveness, access and equity, coordination and continuity, patient-centeredness, and cost-effectiveness. METHODS: The systematic review made use of electronic database searching, reference screening, forward citation tracking and expert consultation. The following databases were searched: Cochrane Library, EconLit, Embase, Medline, PsychINFO, and Web of Science. Studies that evaluate P4P effects

in primary care or acute hospital care medicine were included. Papers concerning other target groups or settings, having no empirical evaluation design or not complying with the P4P definition were excluded. According to study design nine validated quality appraisal tools and reporting statements were applied. Data were extracted and summarized into evidence tables independently by two reviewers. RESULTS: One hundred twenty-eight evaluation studies provide a large body of evidence -to be interpreted with caution- concerning the effects of P4P on clinical effectiveness and equity of care. However, less evidence on the impact on coordination, continuity, patient-centeredness and cost-effectiveness was found. P4P effects can be judged to be encouraging or disappointing, depending on the primary mission of the P4P program: supporting minimal quality standards and/or boosting quality improvement. Moreover, the effects of P4P interventions varied according to design choices and characteristics of the context in which it was introduced.Future P4P programs should (1) select and define P4P targets on the basis of baseline room for improvement, (2) make use of process and (intermediary) outcome indicators as target measures, (3) involve stakeholders and communicate information about the programs thoroughly and directly, (4) implement a uniform P4P design across payers, (5) focus on both quality improvement and achievement, and (6) distribute incentives to the individual and/or team level. CONCLUSIONS: P4P programs result in the full spectrum of possible effects for specific targets, from absent or negligible to strongly beneficial. Based on the evidence the review has provided further indications on how effect findings are likely to relate to P4P design choices and context. The provided best practice hypotheses should be tested in future research.

Van, H. P., et al. (2010). "Systematic review: Effects, design choices, and context of pay-for-performance in health care." BMC Health Serv Res **10**: 247.

BACKGROUND: Pay-for-performance (P4P) is one of the primary tools used to support healthcare delivery reform. Substantial heterogeneity exists in the development and implementation of P4P in health care and its effects. This paper summarizes evidence, obtained from studies published between January 1990 and July 2009, concerning P4P effects, as well as evidence on the impact of design choices and contextual mediators on these effects. Effect domains include clinical effectiveness, access and equity, coordination and continuity, patient-centeredness, and cost-effectiveness. METHODS: The systematic review made use of electronic database searching, reference screening, forward citation tracking and expert consultation. The following databases were searched: Cochrane Library, EconLit, Embase, Medline, PsychINFO, and Web of Science. Studies that evaluate P4P effects in primary care or acute hospital care medicine were included. Papers concerning other target groups or settings, having no empirical evaluation design or not complying with the P4P definition were excluded. According to study design nine validated quality appraisal tools and reporting statements were applied. Data were extracted and summarized into evidence tables independently by two reviewers. RESULTS: One hundred twenty-eight evaluation studies provide a large body of evidence -to be interpreted with caution- concerning the effects of P4P on clinical effectiveness and equity of care. However, less evidence on the impact on coordination, continuity, patient-centeredness and cost-effectiveness was found. P4P effects can be judged to be encouraging or disappointing, depending on the primary mission of the P4P program: supporting minimal quality standards and/or boosting quality improvement. Moreover, the effects of P4P interventions varied according to design choices and characteristics of the context in which it was introduced.Future P4P programs should (1) select and define P4P targets on the basis of baseline room for improvement, (2) make use of process and (intermediary) outcome indicators as target measures, (3) involve stakeholders and communicate information about the programs thoroughly and directly, (4) implement a uniform P4P design across payers, (5) focus on both quality improvement and achievement, and (6) distribute incentives to the individual and/or team level. CONCLUSIONS: P4P

programs result in the full spectrum of possible effects for specific targets, from absent or negligible to strongly beneficial. Based on the evidence the review has provided further indications on how effect findings are likely to relate to P4P design choices and context. The provided best practice hypotheses should be tested in future research

Weeks, W. B., et al. (2017). "Episode-of-Care Characteristics and Costs for Hip and Knee Replacement Surgery in Hospitals Belonging to the High Value Healthcare Collaborative Compared With Similar Hospitals in the Same Health Care Markets." Med Care **55**(6): 583-589.

BACKGROUND: To inform consumers and restrain health care cost growth, efforts to promote transparency and to reimburse for care episodes are accelerating in the United States. OBJECTIVE: To compare characteristics and costs of 30-day episode of care for hip and knee replacement occurring in High Value Healthcare Collaborative (HVHC)-member hospitals to those occurring in like non-HVHC-member hospitals in the same 15 health care markets before interventions by HVHC members to improve health care value for those interventions. RESEARCH DESIGN: This is a retrospective analysis of fee-for-service Medicare data from 2012 and 2013. SUBJECTS: For hip arthroplasty, 4030 HVHC-member and 7572 non-HVHC-member, and for knee arthroplasty, 6542 HVHC-member and 13,900 non-HVHC-member fee-for-service Medicare patients aged 65 and older. MEASURES: Volumes, patient demographics, hospital stay characteristics, and acute and postacute care standardized costs for a 30-day episode of care. RESULTS: HVHC-member hospitals differed from similar non-HVHC-member hospitals in the same health care markets when considering volumes of surgeries, patient demographics, Charlson scores, and patient distance to care during the index admission. There was little variation in acute care costs of hip or knee replacement surgery across health care markets; however, there was substantial variation in postacute care costs across those same markets. We saw less variation in postacute care costs within markets than across markets. Regression analyses showed that HVHC-member status was not associated with shorter lengths of stay, different complication rates, or lower total or postacute care costs for hip or knee replacement. CONCLUSIONS: Health care regions appear to be a more important predictor of episode costs of care than HVHC status.

Witter, S., et al. (2013). "Performance-based financing as a health system reform: mapping the key dimensions for monitoring and evaluation." Bmc Health Services Research **13**(367): 10 , tabl., fig. http://www.biomedcentral.com/content/pdf/1472-6963-13-367.pdf

Background: Performance-based financing is increasingly being applied in a variety of contexts, with the expectation that it can improve the performance of health systems. However, while there is a growing literature on implementation issues and effects on outputs, there has been relatively little focus on interactions between PBF and health systems and how these should be studied. This paper aims to contribute to filling that gap by developing a framework for assessing the interactions between PBF and health systems, focusing on low and middle income countries. In doing so, it elaborates a general framework for monitoring and evaluating health system reforms in general. Methods: This paper is based on an exploratory literature review and on the work of a group of academics and PBF practitioners. The group developed ideas for the monitoring and evaluation framework through exchange of emails and working documents. Ideas were further refined through discussion at the Health Systems Research symposium in Beijing in October 2012, through comments from members of the online PBF Community of Practice and Beijing participants, and through discussion with PBF experts in Bergen in June 2013. Results: The paper starts with a discussion of definitions, to clarify the core concept of PBF and how the different terms are used. It then develops a framework for monitoring its interactions with the health system, structured around five domains of context, the development process, design,

implementation and effects. Some of the key questions for monitoring and evaluation are highlighted, and a systematic approach to monitoring effects proposed, structured according to the health system pillars, but also according to inputs, processes and outputs. Conclusions: The paper lays out a broad framework within which indicators can be prioritised for monitoring and evaluation of PBF or other health system reforms. It highlights the dynamic linkages between the domains and the different pillars. All of these are also framed within inter-sectoral and wider societal contexts. It highlights the importance of differentiating short term and long term effects, and also effects (intended and unintended) at different levels of the health system, and for different sectors and areas of the country. Outstanding work will include using and refining the framework and agreeing on the most important hypotheses to test using it, in relation to PBF but also other purchasing and provider payment reforms, as well as appropriate research methods to use for this task.

Woodson, S. B. (1999). "Making the connection between physician performance and pay." Healthcare Financial Management **53**(2): 39-44.

Woolhandler, S., et al. (2012). "Why pay for performance may be incompatible with quality improvement : Motivation may decrease and gaming of the system is rife." British Medical Journal(345): e5015-5016.

When financial incentives do more good than harm: a checklist.Des chercheurs australiens ont étudié les effets du paiement à la performance (« P4P ») des médecins dans des pays ayant plusieurs années de recul. Leur conclusion est nuancée : le P4P n?améliore pas nécessairement la qualité des soins. Pire, il peut s?avérer contre productif. Cet article n'est que l'éditorial introductif à l'étude complète intitulée : When financial incentives do more good than harm: a checklist.

Woolhandler, S., et al. (2012). "Why pay for performance may be incompatible with quality improvement : Motivation may decrease and gaming of the system is rife." British Medical Journal(345): e5015-e5016.

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Wright, M. (2012). "Pay-for-performance programs. Do they improve the quality of primary care?" Australian Family Physician **41**(12): 989-991, tabl.
http://www.racgp.org.au/download/Documents/AFP/2012/December/201212wright.pdf

The recent release of The Royal Australian College of General Practitioners clinical quality indicators has sparked renewed debate about the role of pay-for-performance (P4P) programs and their potential usefulness in Australian general practice. This article seeks to update recent evidence about the impact of P4P programs on the quality of primary care and presents the evidence based viewpoint that there are potential problems with P4P, which may limit its usefulness. P4P programs are attractive to funders as they suggest a theoretical link between provider performance and improvements in healthcare quality ? and potentially improved control over costs. Although P4P programs in primary care appear to have an effect on the behaviour of general practitioners, there is little evidence that these programs in their current form improve health outcomes or healthcare system quality. Further

research is needed into the effect of these programs on healthcare quality before they are introduced into Australian general practice.

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Wynn, B. O. et Sorbero, M. E. (2008). Pay for Performance in California's Workers Compensation Medical Treatment System : An assessment of Options, Challenges, and Potential Benefits. Rand Occasional Paper. San Franscico Rand Corporation**:** 48 , tabl., fig.
http://www.rand.org/pubs/occasional_papers/2008/RAND_OP229.pdf

Over the past few years, nonoccupational group health-insurance programs and health plans have implemented initiatives to improve the quality and efficiency of care through incentive programs, typically called ?pay for performance,? or P4P. In addition, Medicare program administrators are evaluating how P4P incentives might be incorporated into Medicare payment systems. This paper assesses the options, challenges, and potential benefits of adopting P4P incentives for physician services in California's workers' compensation program. It offers three models that might be able to surmount the challenges, provided that the stakeholders have the commitment and trust to work through the design issues and allow the P4P program to evolve over time. P4P alone will not be sufficient to drive value-based medical care provided to injured workers; rather, it should be considered as part of a multipronged set of strategies designed to increase the efficient delivery of high-quality care that enables rapid and sustained return to work.

Yin, Y., et al. (2013). "The effect of activity-based financing on hospital length of stay for elderly patients suffering from heart diseases in Norway." BMC Health Serv Res **13**(172): 9, fig.

Background: Whether activity-based financing of hospitals creates incentive- s to treat more patients and to reduce the length of each hospital stay is an empirical question that needs investigation. This paper examines how the level of the activity-based component in the financing system of Norwegian hospitals influences the average length of hospital stays for elderly patients suffering from ischemic heart diseases. During the study period, the activity-based component changed several times due to political decisions at the national level. Methods: The repeated cross-section data were extracted from the Norwegian Patient Register in the period from 2000 to 2007, and included patients with angina pectoris, congestive heart failure, and myocardial infarction. Data were analysed with a log-linear regression model at the individual level. Results: The results show a significant, negative association between the level of activity-based financing and length of hospital stays for

elderly patients who were suffering from ischemic heart diseases. The effect is small, but an increase of 10 percentage points in the activity-based component reduced the average length of each hospital stay by 1.28%. Conclusions: In a combined financing system such as the one prevailing in Norway, hospitals appear to respond to economic incentives, but the effect of their responses on inpatient cost is relatively meagre. Our results indicate that hospitals still need to discuss guidelines for reducing hospitalisation costs and for increasing hospital activity in terms of number of patients and efficiency

Yonek, J., et al. (2010). Guide to Achieving High Performance in Multi-Hospital Health Systems. Chicago HRET**:** 24 , fig., annexes.
http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Mar/A%20Guide%20to%20Achieving%20High%20Performance%20in%20MultiHospital%20Health%20Systems.pdf

Multi-hospital health system leaders have a significant impact on the quality of health care in the United States. The 200 largest hospital systems (a hospital system being defined as having 2 or more general acute care hospitals) account for over half of all hospital admissions in the United States. Through generous support from The Commonwealth Fund, the Health Research & Educational Trust (HRET) embarked on a project to identify and disseminate best practices associated with high performing health systems. Through the use of publicly available quality data, interviews with leaders of 45 multi-hospital health systems, and analysis, identified below are three major themes, four major best practice categories and seventeen specific best practices that are associated with high performance.

Impact de la diffusion des résultats des indicateurs sur la qualité des soins

ÉTUDES FRANÇAISES

Bal, G., et al. (2010). "Intérêt des revues de mortalité et de morbidité pour la formation des médecins et l'amélioration de la qualité et de la sécurité des soins : revue de la littérature." Presse Medicale (La) **39**(2): 161-168, tabl.

L'objectif de cet article est de faire une synthèse des études portant sur le fonctionnement, le vécu des participants ou l'efficacité des RMM. Les articles en langue anglaise ou française répondant aux mots clés : mortality et/ou morbidity et/ou conference et/ou rounds et/ou review et/ou meetings et/ou committee ont été recherchés dans les bases MEDLINE et PASCAL. Les articles rapportant une étude originale sur le fonctionnement ou l'évaluation des RMM et publiés entre le 1er janvier 2002 et le 31 décembre 2008 ont été sélectionnés. La sélection a été faite de manière indépendante par 2 lecteurs. Dix-sept articles ont été analysés. Dans 11 cas il s'agissait d'une enquête déclarative, 3 études reposaient sur une analyse documentaire, 2 comportaient le suivi d'indicateurs et 1 étude reposait sur l'observation des RMM. Ces études rapportaient une adhésion des médecins aux RMM et une grande variabilité des modalités de fonctionnement. Les principales caractéristiques qui influencent le contenu des réunions sont la présence ou non des personnels paramédicaux, et le nombre et les critères de sélection des cas analysés. Les rares études ayant montré l'efficacité des RMM portaient sur des domaines particuliers (endoscopie digestive, accouchement).Les études qui ont porté sur les RMM sont hétérogènes dans leurs méthodes et dans leurs objectifs. Les travaux réalisés ont montré l'intérêt des RMM pour la formation des médecins et pour l'amélioration de la qualité et de la sécurité des soins. Cependant, ils

n'ont pas permis d'identifier les modalités de fonctionnement qui optimisent l'efficacité des RMM et cette question devrait rester un sujet de recherches.

Bally, B., et al. (2004). Maîtrise statistique des processus en santé : comprendre et expérimenter. St Denis La Plaine HAS**:** 92 , 93 ann., 24 graph.
http://www.has-sante.fr/anaes/Publications.nsf/nPDFFile/AT_LFAL-6DUJ98/$File/Maitrise_statistique_processus_guide.pdf?OpenElement

L'amélioration continue de la qualité nécessite des données chiffrées pour être rigoureuse et objective. L'utilisation d'indicateurs doit être privilégiée. Une approche processus est la mieux adaptée pour une amélioration continue de la qualité. Une méthode qualité de l'industrie, la maîtrise statistique des processus (MSP) appliquée en santé (MSPS), semble bien adaptée au suivi en continu d'indicateurs pour une amélioration dynamique de la qualité d'un processus. Ce document de vulgarisation sur la MSP a pour but d'inciter les professionnels de la qualité à exploiter leurs données disponibles dans le cadre d'une démarche d'amélioration continue de la qualité des soins. Une première partie décrit les grands principes qui caractérisent la MSP. La deuxième partie est consacrée à l'utilisation de la MSP en santé. Des exemples bibliographiques illustrent le caractère dynamique de la méthode qui s'inscrit au sein d'une démarche d'amélioration continue de la qualité. Enfin, les annexes complétées par la bibliographie et des références Internet présentent aux lecteurs qui le souhaitent des informations complémentaires (d'après l'avertissement et le résumé de l'auteur).

Benkimoun, P., et al. (2009). L'information en santé. Traité d'économie et de gestion de la santé., Paris : Editions de Santé ; Paris : SciencesPo Les Presses**:** 463-491.
http://www.pressesdesciencespo.fr/livre/?GCOI=27246100728790

Cette partie du Traité d'économie et de gestion en santé consacrée à l'information en santé regroupe quatre chapitres : l'information du public, l'information des professionnels, les systèmes d'information au sein des systèmes de santé et l'information publique sur la qualité et le comportement des patients.

Bertillot, H. (2015). Quand l'évaluation modifie les institutions. Comment l'hôpital est transformé par les indicateurs qualité. Paris SciencesPo - LIEPP**:** 6 ,fig.

Ces dernières décennies, le secteur hospitalier français a fait l'objet de nombreuses réformes, dans l'ambition affichée de rationaliser son fonctionnement. Parmi celles-ci, le déploiement de nouveaux instruments de tarification (T2A) fait l'objet de toutes les attentions et de toutes les critiques. Pourtant, dans l'ombre de ces réformes à forte visibilité, se joue depuis la fin des années 1990 un autre mouvement majeur, opérant à bas bruit autour du déploiement d'instruments d'évaluation de la qualité des soins. Ce fascicule prend pour objet le déploiement d'indicateurs qualité (IQ) dans les établissements français depuis le milieu des années 2000. Construits comme une technologie douce pour rationaliser l'hôpital sans faire de vague, ces instruments colonisent les établissements français avec discrétion. Ils y instillent pourtant des changements décisifs : traçabilité accrue du soin, enracinement local de la médecine des preuves et auditabilité croissante de l'hôpital.

Cases, C., et al. (2009). "L'évaluation : pourquoi et comment ?" Actualite Et Dossier En Sante Publique(69): 17-26.

[BDSP. Notice produite par EHESP R0xt9GA8. Diffusion soumise à autorisation]. Que doit être le "bon usage" de l'évaluation en santé publique et les conditions de son développement ?

Ce sont les questions que pose ce dossier. Il présente les concepts d'évaluation et des exemples pratiques réalisés tant aux niveaux nationaux que régionaux. Ce premier article revient sur l'histoire et l'évolution de la culture d'évaluation en France. Développée dans un but de mesurer la performance, l'évaluation en santé publique nous est définie dans sa pluralité : objet de l'évaluation ; conceptualisation de la performance ; but de l'évaluation et le public visé ; et enfin la faisabilité opérationnelle de la démarche.

Caussat, L. et Chemla, O. (2010). "Les programmes de qualité et d'efficience, des instruments au service de l'évaluation des politiques de sécurité sociale et de la mobilisation de leurs acteurs." Revue Francaise Des Affaires Sociales(1-2): 163-185.

[BDSP. Notice produite par MIN-SANTE 7BR0xr99. Diffusion soumise à autorisation]. Les programmes de qualité et d'efficience, qui, depuis 2007, sont une annexe aux projets de loi de financement de la sécurité sociale, ambitionnent d'étendre au domaine des politiques de sécurité sociale la démarche "objectifs indicateur/résultats" mise en oeuvre depuis 2001 dans la procédure d'élaboration et d'examen des projets de loi de finances. Assurément fructueuse pour l'analyse de l'allocation des ressources budgétaires, cette démarche est en revanche plus controversée quant à son pouvoir d'incitation des gestionnaires publics à l'efficience. Dans le cas des politiques de sécurité sociale, elle complète toutefois utilement le dispositif de mesure de la performance du service public de la sécurité sociale prévu depuis 1996 par les conventions d'objectifs et de gestion liant l'État et les organismes nationaux qui en ont la charge.

Chabot, J. M. (2008). "[Public reporting of performance data and patients]." Rev Prat **58**(5): 547-548.

DREES (2009). "La diffusion publique de données relatives à la performance des établissements de santé : revue de la littérature et des sites internet." Serie Etudes Et Recherche - Document De Travail - Drees(88): 71 , tabl., annexes.
http://www.drees.sante.gouv.fr/drees/serieetudes/pdf/serieetud88.pdf

[BDSP. Notice produite par MIN-SANTE 8R0xr8or. Diffusion soumise à autorisation]. Les "Classements" ou "Palmarès" constituent une diffusion publique de données relatives à la qualité et à la performance des établissements de santé. Ils représentent un phénomène récent, mais qui s'est nettement intensifié ces dernières années dans les pays anglo-saxons. D'autres pays ont emboîté le pas plus récemment (notamment le Danemark et l'Allemagne). En France, depuis 2006, le ministère de la santé a mis en place un tableau de bord fondé sur une batterie d'indicateurs relatifs à la lutte contre les infections nosocomiales dans les établissements de santé, chacun des établissements de santé, publics ou privés, fait ainsi l'objet d'un classement de A (très bon) à E (insuffisant). Sans être focalisé sur la qualité, le site Platines représente une première diffusion publique synthétique d'informations déjà disponibles, permettant une comparaison inter-établissement.

Duhamel, G., et al. (2009). Evaluer et améliorer la qualité des soins dans les établissements de santé. Traité d'économie et de gestion de la santé., Paris : Editions de Santé ; Paris : SciencesPo Les Presses**:** 306-314.
http://www.pressesdesciencespo.fr/livre/?GCOI=27246100728790

Gardel, C. et Minvielle, E. (2008). "Évaluation des pratiques professionnelles, certification et performance hospitalière." Journal D'economie Medicale **26**(4): 190-194, tabl.

[BDSP. Notice produite par ORSRA BBkmR0xr. Diffusion soumise à autorisation]. Les professionnels des établissements de santé sont concernés par plusieurs dispositifs

réglementaires en matière d'évaluation des pratiques professionnelles (EPP). La procédure de Certification des établissements de santé demande aux établissements de mener des actions d'évaluation à travers 215 critères sur : la pertinence des hospitalisations et des actes, la sécurité des processus de soins, les modalités de prise en charge des pathologies et problèmes de santé. Dans toutes ces actions, le développement des indicateurs est préconisé, l'objectif étant à terme d'intégrer des indicateurs de qualité dans la procédure de certification. Le projet de recherche COMPAQH (Coordination pour la mesure de la performance et l'amélioration de la qualité hospitalière) a pour objectif de concevoir et valider des indicateurs de performance en matière de qualité des soins.

Ghadi, V. et Naiditch, M. (2001). "L'information de l'usager/consommateur sur la performance du système de soins. Revue bibliographique." Serie Etudes - Document De Travail - Drees(13): 25 , ann.

[BDSP. Notice produite par ORSRA 0slkR0xw. Diffusion soumise à autorisation]. Cette étude s'intéresse à la diffusion auprès du grand public de données d'évaluation de la qualité des soins. Cette démarche, encore peu courante en France, existe depuis plus de 15 ans aux Etats-Unis et dans d'autres pays. L'objectif de ce rapport est, à partir d'une analyse bibliographique, d'identifier les différents arguments développés par ceux qui militent en faveur de cette démarche, de décrire les principales expériences de diffusion publique d'information sur le système de soins, d'évaluer l'impact de ce type de publication sur les professionnels, sur les consommateurs mais aussi l'usage qui en a été fait par les financeurs et les régulateurs.

HAS (2015). Programme d'actions communes HAS-ANAP. Axe 5 : indicateurs, suivi et évaluation « Développement d'indicateurs de processus et de résultats pour l'amélioration de la qualité et de la sécurité d'éléments clés du parcours du patient en chirurgie ambulatoire ». Saint-Denis HAS**:** 10. http://www.has-sante.fr/portail/jcms/c_2022569/fr/developpement-dindicateurs-de-processus-et-de-resultats-pour-evaluer-le-parcours-du-patient-en-chirurgie-ambulatoire-note-de-cadrage

Le développement des indicateurs de qualité et sécurité des soins (IQSS), fondés sur l'analyse du parcours du patient –avant-pendant-après- permet d'accompagner le déploiement sécurisé de la chirurgie ambulatoire. L'objectif pour la HAS est de proposer un tableau de bord d'IQSS de processus et de résultats qui mesure, dans le cadre d'une démarche d'amélioration fondée sur les indicateurs, la qualité et la sécurité du parcours du patient en chirurgie ambulatoire sur des points critiques de sa prise en charge.

Hasenbalg-Corabianu, V. (2005). La diffusion publique de données relatives à l'activité, la performance, les résultats des établissements de santé. Etudes et Rapports. Saint Denis HAS**:** 69. http://www.has-sante.fr/portail/upload/docs/application/pdf/2011-02/impact_rapport_fermon_levy_diffusion_publique.pdf

[BDSP. Notice produite par HAS R0x8AsBk. Diffusion soumise à autorisation]. La revue des expériences étrangères de diffusion publique d'indicateurs et de résultats sur la qualité des prestations de soins fait apparaître la diversité des objectifs poursuivis, souvent peu ou mal explicités (démocratie sanitaire, amélioration de la qualité et de l'efficience, repérage des "déviants".). La littérature scientifique ne permet pas de conclure à un impact de la diffusion publique sur les comportements des usagers, qui ont tendance à recourir à d'autres sources d'information pour s'orienter dans le système. En revanche plusieurs études, essentiellement américaines permettent de penser que la diffusion publique d'indicateurs et de résultats sur la qualité des prestation de soins a un impact positif mais modeste sur les comportements des professionnels de santé et la mise en place d'améliorations. Certaines études pointent les risques d'effets adverses : sélection des patients les plus légers et éviction des plus lourds,

crainte de la perte de confiance des patients, apparition de comportements déviants. D'une manière générale, la littérature met en évidence la difficulté à mesurer l'efficacité finale (problèmes de fiabilité et d'imputation des résultats observés).

Hasenbalg-Corabianu, V. (2012). Guide méthodologique de diffusion publique des indicateurs de qualité des soins. Guides méthodologiques. Saint Denis HAS**:** 77. http://www.has-sante.fr/portail/upload/docs/application/pdf/2012-11/guide_methodologique_diffusion_indicateurs.pdf

[BDSP. Notice produite par HAS J87R0xsA. Diffusion soumise à autorisation]. Le guide méthodologique a été élaboré par un groupe de travail de la HAS, avec l'appui de la société GE Performance Solutions. Il repose sur la synthèse bibliographique et l'étude des sites Internet français délivrant au public des informations sur les indicateurs de qualité et sécurité des soins effectué par la HAS, qui a été enrichie au fur et à mesure des retours du retour des acteurs sollicités. Un premier document de travail a été discuté par un groupe de pilotage représentant différents acteurs du système de santé en France concernés par la démarche de diffusion publique d'informations sur la qualité des soins. Une première version du guide a été réalisée après analyse des réflexions de ce groupe, selon une méthode d'obtention de consensus (type DELPHI). Le document a ensuite été discuté avec un groupe représentant des associations d'usagers des soins dont les remarques ont été prises en compte. Enfin, le guide a été modifié en tenant compte des remarques d'un groupe de lecture composé d'autres acteurs concernés par la démarche, avant d'être validé par le Collège de la HAS (VF2).

Lombrail, P., et al. (1997). "Systèmes d'information et assurance de qualité à l'hôpital en France : quel lien. Discussion." Gestions Hospitalieres(369): 670-676.

[BDSP. Notice produite par INIST QHgR0xCR. Diffusion soumise à autorisation].

Mulley, A., et al. (1997). "Avantages et limites des recommandations de pratique clinique dans la prise de décision médicale. Discussion." Gestions Hospitalieres(369): 646-652.

[BDSP. Notice produite par INIST R0xV5c4B. Diffusion soumise à autorisation].

Razanakoto, P. (2014). "Dossier patient informatisé : Vers les enjeux de qualité et de réformes gestionnaires des hôpitaux ?" Gestions Hospitalieres(538): 433-438, graph.

[BDSP. Notice produite par EHESP JsA8DR0x. Diffusion soumise à autorisation]. Le défi de management des hôpitaux avec l'implantation du dossier patient informatisé (DPI) intervient avec la mise en oeuvre des réformes de rationalisation des circuits de soins. A travers l'expérience de deux établissements hospitaliers, l'auteur étudie dans cet environnement technologique innovant du DPI les conditions d'efficacité des réformes gestionnaires des hôpitaux, dont l'exhaustivité des informations médicales, la revalorisation d'acte pluriformes pratiqués et des activités transverses susceptibles d'intérêt public ou général (ambulatoire, urgences.).

Salais, R. (2010). "Usages et mésusages de l'argument statistique : le pilotage des politiques publiques par la performance." Revue Francaise Des Affaires Sociales(1-2): 129-160.

[BDSP. Notice produite par MIN-SANTE DolksR0x. Diffusion soumise à autorisation]. L'article vise à éclairer quelques phénomènes qui émergent de l'usage croissant des indicateurs dans le management et la réforme des politiques publiques. Il se concentre sur les conditions de

validité de l'argument statistique, c'est-à-dire de l'appui de l'argumentation politique sur le chiffre. Il souligne, en prenant comme exemple la stratégie européenne pour l'emploi, les risques et dérives possibles qui pèsent sur la définition et la mise en oeuvre des politiques publiques, en particulier dans le domaine social ; entre autres l'apprentissage rationnel de l'optimisation du résultat chiffré, la difficile conciliation entre performance et justice sociale, le danger que les mauvais indicateurs chassent les bons, la normativité cachée dans les batteries d'indicateurs, l'usage des conventions statistiques comme instruments politiques.

Santé, M. (2011). La diffusion publique des indicateurs de qualité et de sécurité de soins 2010 sur les sites platines : jeudi 22 septembre 2011, Paris : Ministère chargé de la santé http://www.has-sante.fr/portail/upload/docs/application/pdf/2011-09/dp_indicateurs_qualite__platines_22.09.11.pdf

[BDSP. Notice produite par MIN-SANTE 9pR0xDmA. Diffusion soumise à autorisation]. Ce dossier présente les résultats des indicateurs de qualité issus du dossier du patient et les indicateurs du tableau de bord des infections nosocomiales par l'intermédiaire d'un site Platines plus accessible au grand public. En annexe, on trouve les 12 indicateurs généralisés obligatoires et diffusés, le calendrier de généralisation des indicateurs, les résultats 2010 des indicateurs de qualité de prise en charge du patient (QUALAS) ainsi que la présentation du site Platines.

Silber, J. H., et al. (1997). "Des données suffisantes pour l'évaluation des résultats des soins : Composer avec la réalité tout en aspirant à la perfection. Discussion." Gestions Hospitalieres(369): 660-669.

[BDSP. Notice produite par INIST iPOo1R0x. Diffusion soumise à autorisation].

Sohier, R., et al. (2014). "Système d'information hospitalier et épidémiologie." Revue D'epidemiologie Et De Sante Publique **62**(S3): 41.

[BDSP. Notice produite par ORSRA E9plR0xH. Diffusion soumise à autorisation]. Le colloque "Système d'information hospitalier et épidémiologie" a été organisé conjointement par l'Association des épidémiologistes de langue française (Adelf) et l'Association Évaluation, management, organisations, santé (Emois). Il examine la qualité des pratiques et des soins (évaluation, indicateurs, pertinence des actes et des stratégies), le lien PMSI et épidémiologie, les systèmes d'informations et d'aide à la décision, la production et de la confidentialité de l'information médicale, les parcours de soin du sanitaire au médico-social, des rôles dans la chaîne de facturation, l'utilisation de l'information médicale pour le prévision de l'activité (analyse de l'activité, stratégie et contractualisation), les professionnels dans le DIM et leurs rôles. Il analyse également d'autres expériences internationales, d'autres secteurs (activité interne, HAD, SSR, psychiatrie), et le réseau REDSIAM.

Tabet, J., et al. (1997). "De la qualité et de ses perversions." Gestions Hospitalieres(369): 637-642.

[BDSP. Notice produite par INIST 16FR0xMf. Diffusion soumise à autorisation].

Tran, B., Pierre, et al. (2015). "Que peut-on attendre du département d'information médicale pour améliorer l'indice de performance de la durée moyenne de séjour ?" Journal De Gestion Et D'economie Medicales **33**(4-5): 291-299, tabl., graph., rés.

[BDSP. Notice produite par ORSRA Dm7GR0x7. Diffusion soumise à autorisation]. Introduction : L'indice de performance de la durée moyenne de séjour (IP-DMS) dépend

entre autres du codage. Les DMS auxquelles il se réfère sont écrêtées et construites avec les séjours de l'année précédente. L'objectif principal de ce travail était d'étudier l'impact du codage sur l'IP-DMS. Les objectifs secondaires étaient de calculer l'IP-DMS des Hôpitaux Universitaires de Strasbourg (HUS) en 2013 en tenant compte de l'écrêtage des DMS, et de calculer l'IP-DMS de la base nationale 2013. Méthodes : Les séjours des HUS en 2013 ont été étudiés. La qualité du codage a été mesurée avec l'indice standardisé de sévérité (ISS). Des simulations de modification de codage (dont une normalisation de l'ISS), et de mesure d'IP-DMS résultants ont été faites. La valorisation LAMDA 2013 a été comparée à celle liée à une augmentation d'activité à taux d'occupation constant, pour un changement d'IP-DMS équivalent. L'IP-DMS des HUS en 2013 a été recalculé, en excluant les séjours dont la durée dépassait les bornes d'écrêtage de la référence. L'IP-DMS de la base nationale 2013 a été calculé avec comme référence les DMS 2013 écrêtées. Résultats : En ramenant l'ISS des HUS de 1,060 à 1, l'IP-DMS passait de 1,089 à 1,133. La récupération LAMDA a apporté une valorisation de 3 765 169 euros, contre 5 130 128 euros si un gain équivalent d'IP-DMS avait été obtenu par une augmentation d'activité à taux d'occupation des lits constant. L'IP-DMS des HUS hors séjours extrêmes était de 1,043. L'IP-DMS de la base nationale était de 1,026. Discussion/conclusion : Le codage a un effet notable sur l'IP-DMS, mais cet effet reste limité et doit être complété par un effort de diminution des durées de séjour et d'augmentation de l'activité. Le rôle du médecin du département d'information médicale est aussi d'analyser cet indicateur. L'IP-DMS est en effet contestable dans sa construction, puisque le calcul des DMS de référence exclut les séjours extrêmes, ce qui accentue artificiellement la mauvaise performance des établissements.

ÉTUDES INTERNATIONALES

Abdul-Baki, H., et al. (2015). "Public reporting of colonoscopy quality is associated with an increase in endoscopist adenoma detection rate." Gastrointest Endosc **82**(4): 676-682.

BACKGROUND: Colonoscopy is the predominant method for colorectal cancer screening in the United States. Previous studies have documented variation across physicians in colonoscopy quality as measured by the adenoma detection rate (ADR). ADR is the primary quality measure of colonoscopy examinations and an indicator of the likelihood of subsequent colorectal cancer. There is interest in mechanisms to improve the ADR. In Central Illinois, a local employer and a quality improvement organization partnered to publically report physician colonoscopy quality. OBJECTIVE: We assessed whether this initiative was associated with an improvement in the ADR. DESIGN: We compared ADRs before and after public reporting at a private practice endoscopy center with 11 gastroenterologists in Peoria, Illinois, who participated in the initiative. To generate the ADR, colonoscopy and pathology reports from examinations performed over 4 years at the endoscopy center were analyzed by using previously validated natural language processing software. SETTING: A central Illinois endoscopy center. RESULTS: The ADR in the pre-public reporting period was 34.3% and 39.2% in the post-public reporting period (an increase of 4.9%, P < .001). The increase in the right-sided ADR was 5.1% (P < .01), whereas the increase in the left-sided ADR was 2.1% (P < .05). The increase in the ADR was 7.8% for screening colonoscopies (P < 0.05) and 3.5% for nonscreening colonoscopies (P < .05). All but 1 physician's ADR increased (range -2.7% to 10.5%). There was no statistically significant change in the advanced ADR (increase of 0.8%, P = .22). LIMITATIONS: There was no concurrent control group to assess whether the increased ADR was due to a secular trend. CONCLUSION: A public reporting initiative on colonoscopy quality was associated with an increase in ADR.

Barosi, G. (2006). "Strategies for dissemination and implementation of guidelines." Neurol Sci **27 Suppl 3**: S231-234.

Interventions designed to effectively implement and disseminate clinical practice guidelines (CPG) fall into different categories. A systematic review of the effectiveness and costs of different guideline

development, dissemination and implementation strategies was recently undertaken by the Health Technology Assessment (HTA) Programme in UK. Overall, the majority of comparisons reporting dichotomous process data observed improvement in care. However, there was considerable variation in the observed effects both within and across interventions. Evaluation studies provided evidence that adherence of physicians to CPG is a strong predictor of the stroke outcome. Cochrane Collaboration performed a systematic review including studies published up to 2004 that compared integrated clinical pathways (ICP) for stroke care with standard medical care. They found no significant difference between ICP and control groups in terms of death or discharge destination. Patients managed with a care pathway were more dependent at discharge, less likely to suffer a urinary tract infection, less likely to be readmitted and more likely to have neuroimaging. A positive effect was reported from a validation study of a multifaceted strategy for stroke care ICP implementation in Italy.

Barr, J. K., et al. (2006). "Using public reports of patient satisfaction for hospital quality improvement." Health Serv Res **41**(3 Pt 1): 663-682.

OBJECTIVE: To explore the impact of statewide public reporting of hospital patient satisfaction on hospital quality improvement (QI), using Rhode Island (RI) as a case example. DATA SOURCE: Primary data collected through semi-structured interviews between September 2002 and January 2003. STUDY DESIGN: The design is a retrospective study of hospital executives at all 11 general and two specialty hospitals in RI. Respondents were asked about hospital QI activities at several points throughout the public reporting process, as well as about hospital structure and processes to accomplish QI. Qualitative analysis of the interview data proceeded through an iterative process to identify themes and categories in the data. PRINCIPAL FINDINGS: Data from the standardized statewide patient satisfaction survey process were used by hospitals to identify and target new QI initiatives, evaluate performance, and monitor progress. While all hospitals fully participated in the public reporting process, they varied in the stage of development of their QI activities and adoption of the statewide standardized survey for ongoing monitoring of their QI programs. Most hospitals placed responsibility for QI within each department, with results reported to top management, who were perceived as giving strong support for QI. The external environment facilitated QI efforts. CONCLUSION: Public reporting of comparative data on patient views can enhance and reinforce QI efforts in hospitals. The participation of key stakeholders facilitated successful implementation of statewide public reporting. This experience in RI offers lessons for other states or regions as they move to public reporting of hospital quality data.

Beckmann, A., et al. (2015). "Cardiac Surgery in Germany during 2014: A Report on Behalf of the German Society for Thoracic and Cardiovascular Surgery." Thorac Cardiovasc Surg **63**(4): 258-269.

Based on a voluntary registry of the German Society for Thoracic and Cardiovascular Surgery (GSTCVS), data of all heart surgery procedures performed in 78 German cardiac surgical units during the year 2014 are presented. In 2014, a total of 100,398 cardiac surgical procedures (implantable cardioverter-defibrillator and pacemaker procedures excluded) were submitted to the registry. More than 14.2% of the patients were older than 80 years, describing an increase of 0.4% compared with the previous year. The unadjusted in-hospital mortality for 40,006 isolated coronary artery bypass grafting procedures (84.7% on-pump, 15.3% off-pump) was 2.6%. In 31,359 isolated valve procedures (including 9,194 catheter-based procedures), an in-hospital mortality of 4.4% was observed. This annual updated registry of the GSTCVS is published since 1989. It is an important tool for quality assurance and voluntary public reporting by illustrating current standards and actual developments for nearly all cardiac surgical procedures in Germany.

Behrendt, K. et Groene, O. (2016). "Mechanisms and effects of public reporting of surgeon outcomes: A systematic review of the literature." Health Policy **120**(10): 1151-1161.

BACKGROUND: Public reporting of surgeon outcomes has become a key strategy in the English NHS to ensure accountability and improve the quality of care. Much of the evidence that supported the design of the strategy originates from the USA. This report aims to assess how the evidence on public reporting could be harnessed for cross-country translation of this health system strategy; in particular, to gauge the expected results of the UK surgeon outcome initiative and to propose criteria that elucidate that prerequisites and factors that are needed to public reporting effective. METHODS: A systematic search of academic databases was followed by snowballing from the reference lists. Only peer-reviewed articles

and primary studies were included. RESULTS: 25 studies from the USA (n=22) and the UK (n=3) were included. Suggestive evidence of a negative effect on access to surgery was found for high-risk patients and non-whites; one survey indicated presence of gaming. There was anecdotal evidence of quality improvement measures adopted by low-rated hospitals in New York. Most studies reported only on the effectiveness of public reporting, rather than addressing how effects accrue. This limits cross-country transferability of policy lessons. Based on our analysis, we propose factors impacting on the transferability of the evidence underlying the public reporting of surgeon outcomes, which may inform the adoption of this strategy in other health systems. CONCLUSIONS: There is some evidence that public reporting can be an incentive for low performing surgeons to improve quality. Negative incentive on patient selection as suggested in the USA have not yet been observed in the UK.

Bekelis, K., et al. (2015). "The present and future of quality measures and public reporting in neurosurgery." Neurosurg Focus **39**(6): E3.

Quality measurement and public reporting are intended to facilitate targeted outcome improvement, practice-based learning, shared decision making, and effective resource utilization. However, regulatory implementation has created a complex network of reporting requirements for physicians and medical practices. These include Medicare's Physician Quality Reporting System, Electronic Health Records Meaningful Use, and Value-Based Payment Modifier programs. The common denominator of all these initiatives is that to avoid penalties, physicians must meet "generic" quality standards that, in the case of neurosurgery and many other specialties, are not pertinent to everyday clinical practice and hold specialists accountable for care decisions outside of their direct control. The Centers for Medicare and Medicaid Services has recently authorized alternative quality reporting mechanisms for the Physician Quality Reporting System, which allow registries to become subspecialty-reporting mechanisms under the Qualified Clinical Data Registry (QCDR) program. These programs further give subspecialties latitude to develop measures of health care quality that are relevant to the care provided. As such, these programs amplify the power of clinical registries by allowing more accurate assessment of practice patterns, patient experiences, and overall health care value. Neurosurgery has been at the forefront of these developments, leveraging the experience of the National Neurosurgery Quality and Outcomes Database to create one of the first specialty-specific QCDRs. Recent legislative reform has continued to change this landscape and has fueled optimism that registries (including QCDRs) and other specialty-driven quality measures will be a prominent feature of federal and private sector quality improvement initiatives. These physician- and patient-driven methods will allow neurosurgery to underscore the value of interventions, contribute to the development of sustainable health care solutions, and actively participate in meaningful quality initiatives for the benefit of the patients served.

Bennetts, M., et al. (2017). "An appraisal of meta-analysis guidelines: how do they relate to safety outcomes?" Res Synth Methods **8**(1): 64-78.

Although well developed to assess efficacy questions, meta-analyses and, more generally, systematic reviews, have received less attention in application to safety-related questions. As a result, many open questions remain on how best to apply meta-analyses in the safety setting. This appraisal attempts to: (i) summarize the current guidelines for assessing individual studies, systematic reviews, and network meta-analyses; (ii) describe several publications on safety meta-analytic approaches; and (iii) present some of the questions and issues that arise with safety data. A number of gaps in the current quality guidelines are identified along with issues to consider when performing a safety meta-analysis. While some work is ongoing to provide guidance to improve the quality of safety meta-analyses, this review emphasizes the critical need for better reporting and increased transparency regarding safety data in the systematic review guidelines. Copyright (c) 2016 John Wiley & Sons, Ltd.

Berger, Z. D., et al. (2013). "Can public reporting impact patient outcomes and disparities? A systematic review." Patient Educ Couns **93**(3): 480-487.

OBJECTIVE: Recent US healthcare reforms aim to improve quality and access. We synthesized evidence assessing the impact that public reporting (PR), which will be extended to the outpatient setting, has on patient outcomes and disparities. METHODS: A systematic review using PRISMA guidelines identified studies addressing the impact of PR on patient outcomes and disparities. RESULTS: Of the 1970 publications identified, 25 were relevant, spanning hospitals (16), nursing homes (5), emergency rooms

(1), health plans (2), and home health agencies (1). Evidence of effect on patient outcomes was mixed, with 6 studies reporting a favorable effect, 9 a mixed effect, 9 a null effect, and 1 a negative effect. One study found a mixed effect of PR on disparities. CONCLUSION: The evidence of the impact of PR on patient outcomes is lacking, with limited evidence that PR has a favorable effect on outcomes in nursing homes. There is little evidence supporting claims that PR will have an impact on disparities or in the outpatient setting. PRACTICE IMPLICATIONS: Health systems should collect information on patient-relevant outcomes. The lack of evidence does not necessarily imply a lack of effect, and a research gap exists regarding patient-relevant outcomes and PR.

Bishop, T. F., et al. (2012). "Association between physician quality improvement incentives and ambulatory quality measures." Am J Manag Care **18**(4): e126-134.

OBJECTIVES: To determine the prevalence of physician incentives for quality and to test the hypothesis that the quality of ambulatory medical care is better when provided by physicians with these incentives. STUDY DESIGN: Cross-sectional study using data from the National Ambulatory Medical Care Survey. METHODS: We examined the association between 12 measures of high-quality ambulatory care and physician compensation based on quality, physician compensation based on satisfaction, and public reporting of quality measures. RESULTS: Overall, 20.8% of visits were to physicians whose compensation was partially based on quality, 17.7% of visits were to physicians whose compensation was partially based on patient satisfaction, and 10.0% of visits were to physicians who publicly reported quality measures. Quality of ambulatory care varied: weight reduction counseling occurred in 12.0% of preventive care visits by obese patients, whereas no urinalysis in patients with no indication was achieved in 93.0% of preventive care visits. In multivariable analyses, there were no statistically significant associations between compensation for quality and delivery of any of the 12 measures, nor between compensation for satisfaction and 11 of the 12 measures; the exception was body mass index screening in preventive visits (47.8% vs 56.2%, adjusted P = .004). There was also no statistically significant association between public reporting and delivery of 11 of 12 measures; the exception was weight reduction counseling for overweight patients (10.0% vs 25.5%, adjusted P = .01). CONCLUSIONS: We found no consistent association between incentives for quality and 12 measures of high-quality ambulatory care.

Biswal, M., et al. (2015). "Mandatory public reporting of healthcare-associated infections in developed countries: how can developing countries follow?" J Hosp Infect **90**(1): 12-14.

The threat posed by increased transmission of drug-resistant pathogens within healthcare settings and from healthcare settings to the community is very real and alarming. Although the developed world has taken strong steps to curb this menace, there has been little pressure on developing countries to take any corrective action. If the reporting of alarming rates of healthcare-associated infections (HCAIs) from hospitals in India and many other developing countries was made mandatory, it would help to force stakeholders (e.g. healthcare workers, legislators, administrators and policy makers in hospitals) to acknowledge and tackle the problem. This would introduce quality control in a long neglected area of health care, and enable patient empowerment which is practically non-existent in India. Healthcare institutions should commit towards enforcing 'zero tolerance' towards lapses in prevention of HCAIs. Public pressure would force the Indian Government to acknowledge the problem, and to allocate more funds to improve resources and infrastructure; this could substantially elevate the standard of health care given to the average Indian. Despite the numerous challenges, overall public benchmarking of HCAIs is a commendable goal that would go a long way towards tackling this menace in developing countries such as India.

Bogdan-Lovis, E. A. et Sousa, A. (2006). "The contextual influence of professional culture: certified nurse-midwives' knowledge of and reliance on evidence-based practice." Soc Sci Med **62**(11): 2681-2693.

This paper reports research undertaken to assess US certified nurse-midwives' (CNMs) knowledge of, access to, and use of evidence-based medicine (EBM). Findings are presented in the context of interprofessional, institutional, and popular culture. The descriptive study follows concepts of diffusion of innovation, evidence-based patient choice, and authoritative knowledge to analyse incentives and barriers to the implementation of evidence-based midwifery care. Structured interviews were conducted with practicing CNMs in an urban practice site and a regional teaching centre. The analysis of responses explored congruence between practitioner knowledge, professed practice, and published professional as

well as hospital-based internal practice guidelines, for two specific interventions for which there is ample systematic review, epidural and episiotomy. The CNMs demonstrated enthusiasm for their own individual understanding of EBM, but responses to specific questions about EBM-supported practice indicate that many had an incomplete understanding of the concept. Furthermore, in those cases where CNMs demonstrated accurate knowledge of EBM, practice protocols followed subspecialty dictates, thereby preventing their knowledge from translating into adherence to EBM-guided clinical practice guidelines. Finally, patient expectations for technological intervention appeared to influence CNMs' care decisions, even when those expectations lacked sound supporting evidence. If, as conceived by its originators and champions, EBM is to be widely adopted, then practitioners such as CNMs need to accurately understand its concepts and also to be afforded the opportunity to exercise professional control over its implementation. Central to an epistemically balanced EBM is the need to ensure that midwifery knowledge contributes in a robust and ongoing fashion to EBM's scientific research base. Lastly, EBM advocates must identify balanced strategies to both rationally and fairly address consumerist pressures for aggressive health care consumption.

Brand, C. A., et al. (2012). "A review of hospital characteristics associated with improved performance." Int J Qual Health Care **24**(5): 483-494.

PURPOSE: The objective of this review was to critically appraise the literature relating to associations between high-level structural and operational hospital characteristics and improved performance. DATA SOURCES: The Cochrane Library, MEDLINE (Ovid), CINAHL, proQuest and PsychINFO were searched for articles published between January 1996 and May 2010. Reference lists of included articles were reviewed and key journals were hand searched for relevant articles. STUDY SELECTION: and data extraction Studies were included if they were systematic reviews or meta-analyses, randomized controlled trials, controlled before and after studies or observational studies (cohort and cross-sectional) that were multicentre, comparative performance studies. Two reviewers independently extracted data, assigned grades of evidence according to the Australian National Health and Medical Research Council guidelines and critically appraised the included articles. Data synthesis Fifty-seven studies were reported within 12 systematic reviews and 47 observational articles. There was heterogeneity in use and definition of performance outcomes. Hospital characteristics investigated were environment (incentives, market characteristics), structure (network membership, ownership, teaching status, geographical setting, service size) and operational design (innovativeness, leadership, organizational culture, public reporting and patient safety practices, information technology systems and decision support, service activity and planning, workforce design, staff training and education). The strongest evidence for an association with overall performance was identified for computerized physician order entry systems. Some evidence supported the associations with workforce design, use of financial incentives, nursing leadership and hospital volume. CONCLUSION: There is limited, mainly low-quality evidence, supporting the associations between hospital characteristics and healthcare performance. Further characteristic-specific systematic reviews are indicated.

Bridges, J. F. P., et al. (2015). AHRQ Comparative Effectiveness Technical Briefs. Public Reporting of Cost Measures in Health: An Environmental Scan of Current Practices and Assessment of Consumer Centeredness. Rockville (MD), Agency for Healthcare Research and Quality (US).

One of the intended goals of publicly reporting the cost and quality of health care providers is to empower consumers to make informed decisions, thus contributing to improved efficiency of the health care system. While public quality reporting is well documented, less is known about public reporting of costs and the impact it has on consumers. We sought to document current practices for public reporting Web sites that include measures of costs of health care providers, and aimed to assess if these practices are consumer centered. Guided by discussions with Key Informants and a targeted literature review, we collected data from active public reporting Web sites in December 2013. We conducted a systematic scan to identify Web sites that report cost measures, and cataloged these measures. We then assessed the degree to which this cost reporting was consumer centered by applying our novel taxonomy, PRICE, that has five domains: (1) price transparency, (2) real comparisons, (3) information on value, (4) connect to care, and (5) ease of use. We assessed each of these domains across three criteria (for a total score of 15) and summarized the data using averages of the sum of criteria (in total and by domain). We identified 372 Web sites of which 102 were duplicates and 211 were excluded after two stages of review. State departments of health or state hospital associations operated 75 percent of the 59 Web sites that

reported costs at the provider or facility level. All the Web sites reported on inpatient care and 71 percent reported average charges. Only 2 percent of these Web sites reported out-of-pocket costs, 7 percent reported costs using symbols or figures, and 14 percent reported current-year data. The PRICE taxonomy produced a median consumer centeredness score (summed across all domains) of 8 of 15, with a range from 4 to 11. For the included Web sites, ease of use was the highest rated domain (mean of 2.6 out of 3) and information on value was the lowest (0.7 out of 3). Several factors limit the effectiveness of current public reporting of costs practices. These include a focus on charges (rather than consumers' out-of-pocket expenses), heterogeneity and ambiguity in the cost measures and data sources, and a lack of consumer-centered interfaces that allow the customization of searches that are relevant to consumers. Other limiting factors are the paucity of Web sites that provide cost and quality data, a lack of public awareness, and the need for research demonstrating the impact of publicly reported cost measures.

Broc, G. et Edjolo, A. (2017). "[Improving prevention: Integrative model and recommendations intended for public health professionals]." Rev Epidemiol Sante Publique **65**(2): 149-158.

Public health policies aim to diminish people's exposure to negative factors, behaviors or determinants of health. Despite awareness-raising campaigns, health recommendations are still not sufficiently followed. First, the article wondered the reasons behind this observation. In order to do this, we present a theoretical model incorporating: (a) the motivational theories of communication processing; (b) the theories of motivation and volition; (c) self-regulation and self-determination theories. In a second part, the paper describes five principles for improving communication.

Bryant, S. L. et Gray, A. (2006). "Demonstrating the positive impact of information support on patient care in primary care: a rapid literature review." Health Info Libr J **23**(2): 118-125.

AIM: To review the literature on the positive impact of information services, or information resources, on patient care in primary care. OBJECTIVES: To identify and summarize key papers on which librarians might draw in making the case for investment, and to highlight gaps in the research evidence Methodology: A rapid literature review was conducted in the summer of 2005. RESULTS: There is a small body of evidence to demonstrate the positive impact of library and information services on the direct care of patients as well as a beneficial impact on the care of future patients through the application of evidence to multiple patients. CONCLUSIONS: There is relatively limited research evidence of the impact of information, and library services, in primary care, in comparison with hospital settings and the research available is generally reliant on small samples. There is a lack of impact studies conducted with non-clinical staff. The review highlights the value of critical incident technique (CIT). It is possible to gather evidence of the potential for information services to deliver cost savings.

Casalino, L. P., et al. (2013). "Independent practice associations and physician-hospital organizations can improve care management for smaller practices." Health Aff (Millwood) **32**(8): 1376-1382.

Pay-for-performance, public reporting, and accountable care organization programs place pressures on physicians to use health information technology and organized care management processes to improve the care they provide. But physician practices that are not large may lack the resources and size to implement such processes. We used data from a unique national survey of 1,164 practices with fewer than twenty physicians to provide the first information available on the extent to which independent practice associations (IPAs) and physician-hospital organizations (PHOs) might make it possible for these smaller practices to share resources to improve care. Nearly a quarter of the practices participated in an IPA or a PHO that accounted for a significant proportion of their patients. On average, practices participating in these organizations provided nearly three times as many care management processes for patients with chronic conditions as nonparticipating practices did (10.4 versus 3.8). Half of these processes were provided only by IPAs or PHOs. These organizations may provide a way for small and medium-size practices to systematically improve care and participate in accountable care organizations.

Cebul, R. D. (2008). "Using electronic medical records to measure and improve performance." Trans Am Clin Climatol Assoc **119**: 65-75; discussion 75-66.

Clinical performance measurement and public reporting are taking center stage nationwide, linked to transparency initiatives and incentive systems that reward physicians for meeting endorsed quality

standards. While electronic medical records (EMRs) are increasingly available to measure and improve quality of care, performance measurement continues to be dominated by the use of insurance claims. Limitations to claims-based measurement include challenges in assigning attribution of care to specific physicians, inefficient and incomplete sampling methods, and the coarseness of measures frequently available to insurers. Practice improvement using claims-based approaches is further limited by the inability to provide timely and specific feedback to physicians and their patients. Finally, in claims-based approaches, care is not measured for the 47 million uninsured patients in the United States. In the current presentation I describe how these limitations are being addressed using EMRs, highlighting the design and selected preliminary results of a large trial to improve the care of patients with diabetes.

Chatterjee, P., et al. (2012). "Patient experience in safety-net hospitals: implications for improving care and value-based purchasing." Arch Intern Med **172**(16): 1204-1210.

BACKGROUND: Whether safety-net hospitals (SNHs) provide patient-centered care has important implications both for patient outcomes and for how these hospitals will fare under value-based purchasing (VBP). We sought to determine performance and improvement on measures of patient-reported hospital experience among SNHs compared with non-SNHs. METHODS: Our sample consisted of 3096 US hospitals. We defined safety-net hospitals as those hospitals in the highest quartile of the Disproportionate Share Hospital (DSH) index, and we used national data on patient experience from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey in 2007 and 2010 to examine overall hospital performance and improvement over time. RESULTS: Safety-net hospitals had lower performance than non-SNHs on nearly all measures of patient experience. The greatest differences were in overall hospital rating, where patients in SNHs were less likely to rate the hospital a 9 or 10 on a 10-point scale compared with patients in non-SNHs (63.9% vs 69.5%; P < .001). Gaps were also sizeable for the proportion of patients who reported receiving discharge information (2.6 percentage point difference; P < .001) and who thought they always communicated well with physicians (2.2 percentage point difference; P < .001). Although both groups of hospitals improved from 2007 through 2010, the gap between SNHs and non-SNHs increased (3.8% in 2007 vs 5.6% in 2010; P = .08). Finally, SNHs had a 60% lower odds of meeting VBP performance benchmarks for hospital payments (odds ratio, 0.4; 95% CI, 0.3-0.5; P < .001) compared with non-SNHs. CONCLUSIONS: Safety-net hospitals have lower performance than non-SNHs on metrics of patient-reported experience, improved somewhat more slowly under public reporting, and are likely to fare poorly under VBP.

Chen, J., et al. (2013). "A systematic review of the impact of routine collection of patient reported outcome measures on patients, providers and health organisations in an oncologic setting." BMC Health Serv Res **13**: 211.

BACKGROUND: Despite growing interest and urges by leading experts for the routine collection of patient reported outcome (PRO) measures in all general care patients, and in particular cancer patients, there has not been an updated comprehensive review of the evidence regarding the impact of adopting such a strategy on patients, service providers and organisations in an oncologic setting. METHODS: Based on a critical analysis of the three most recent systematic reviews, the current systematic review developed a six-method strategy in searching and reviewing the most relevant quantitative studies between January 2000 and October 2011 using a set of pre-determined inclusion criteria and theory-based outcome indicators. The Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) system was used to rate the quality and importance of the identified publications, and the synthesis of the evidence was conducted. RESULTS: The 27 identified studies showed strong evidence that the well-implemented PROs improved patient-provider communication and patient satisfaction. There was also growing evidence that it improved the monitoring of treatment response and the detection of unrecognised problems. However, there was a weak or non-existent evidence-base regarding the impact on changes to patient management and improved health outcomes, changes to patient health behaviour, the effectiveness of quality improvement of organisations, and on transparency, accountability, public reporting activities, and performance of the health care system. CONCLUSIONS: Despite the existence of significant gaps in the evidence-base, there is growing evidence in support of routine PRO collection in enabling better and patient-centred care in cancer settings.

Chen, L. M., et al. (2013). "Composite quality measures for common inpatient medical conditions." Med Care **51**(9): 832-837.

BACKGROUND: Public reporting on quality aims to help patients select better hospitals. However, individual quality measures are suboptimal in identifying superior and inferior hospitals based on outcome performance. OBJECTIVE: To combine structure, process, and outcome measures into an empirically derived composite quality measure for heart failure (HF), acute myocardial infarction (AMI), and pneumonia (PNA). To assess how well the composite measure predicts future high and low performers, and explains variance in future hospital mortality. RESEARCH DESIGN: Using national Medicare data, we created a cohort of older patients treated at an acute care hospital for HF (n=1,203,595), AMI (n=625,595), or PNA (n=1,234,299). We ranked hospitals on the basis of their July 2005 to June 2008 performance on the composite. We then estimated the odds of future (July to December 2009) 30-day, risk-adjusted mortality at the worst versus best quintile of hospitals. We repeated this analysis using 2005-2008 performance on existing quality indicators, including mortality. RESULTS: The composite (vs. Hospital Compare) explained 68% (vs. 39%) of variation in future AMI mortality rates. In 2009, if an AMI patient had chosen a hospital in the worst versus best quintile of performance using 2005-2008 composite (vs. Hospital Compare) rankings, he or she would have had 1.61 (vs. 1.39) times the odds of dying in 30 days (P-value for difference <0.001). Results were similar for HF and PNA. CONCLUSIONS: Composite measures of quality for HF, AMI, and PNA performed better than existing measures at explaining variation in future mortality and predicting future high and low performers.

Cheng, R., et al. (2010). "Identification of medication safety indicators in acute care settings for public reporting in Ontario." Healthc Q **13 Spec No**: 26-34.

In healthcare settings, indicators are useful tools to assess the structure, process and outcomes of care. Moreover, when used to report to the public, indicators ensure greater transparency for our healthcare system. The purpose of this study was to identify in acute care settings three medication safety indicators that are suitable for public reporting in Ontario. A multi-phase process was developed that included a literature review, compilation and evaluation of possible indicators and a consensus-generation process involving a focus group (modified nominal group technique) with Ontario healthcare experts from various disciplines. More than 300 potential medication safety indicators were identified through the literature review. Two analysts, working independently and using a defined set of selection criteria, narrowed the focus to 49 and subsequently 12 candidate indicators. A focus group of leading experts across the healthcare fields in Ontario was convened and reached consensus on three indicators. These three indicators focused on the areas of venous thromboembolism prevention, acute myocardial infarction discharge medications and medication reconciliation. This report describes a multi-phase process undertaken by the Institute for Safe Medication Practices Canada to identify in acute care settings three medication safety indicators suitable for public reporting in Ontario. These indicators point to important areas in medication safety at which deficiencies can result in significant patient harm. There is a potential for these indicators to provide hospitals and healthcare providers with tangible and realistic mechanisms for measuring performance and, ultimately, improving the quality of care.

Christianson, J. B., et al. (2010). "A report card on provider report cards: current status of the health care transparency movement." J Gen Intern Med **25**(11): 1235-1241.

BACKGROUND: Public reporting of provider performance can assist consumers in their choice of providers and stimulate providers to improve quality. Reporting of quality measures is supported by advocates of health care reform across the political spectrum. OBJECTIVE: To assess the availability, credibility and applicability of existing public reports of hospital and physician quality, with comparisons across geographic areas. APPROACH: Information pertaining to 263 public reports in 21 geographic areas was collected through reviews of websites and telephone and in-person interviews, and used to construct indicators of public reporting status. Interview data collected in 14 of these areas were used to assess recent changes in reporting and their implications. PARTICIPANTS: Interviewees included staff of state and local associations, health plan representatives and leaders of local health care alliances. RESULTS: There were more reports of hospital performance (161) than of physician performance (103) in the study areas. More reports included measures derived from claims data (mean, 7.2 hospital reports and 3.3 physician reports per area) than from medical records data. Typically, reports on physician performance contained measures of chronic illness treatment constructed at the medical group level, with diabetes measures the most common (mean number per non-health plan report, 2.3). Patient experience measures were available in more hospital reports (mean number of reports, 1.2) than

physician reports (mean, 0.7). Despite the availability of national hospital reports and reports sponsored by national health plans, from a consumer standpoint the status of public reporting depended greatly on where one lived and health plan membership. CONCLUSIONS: Current public reports, and especially reports of physician quality of care, have significant limitations from both consumer and provider perspectives. The present approach to reporting is being challenged by the development of new information sources for consumers, and consumer and provider demands for more current information.

Contandriopoulos, D., et al. (2014). "The multiple causal pathways between performance measures' use and effects." Med Care Res Rev **71**(1): 3-20.

In recent decades, there has been a growing interest in the design and implementation of systems using public reporting of performance measures to improve performance. In their simplest form, such interventions rest on the market-based logic of consumers using publicly released information to modify their behavior, thereby penalizing poor performers. However, evidence from large-scale efforts to use public reporting of performance measures as an instrumental performance improvement tool suggests that the causal mechanisms involved are much more complex. This article offers a typology of four different plausible causal pathways linking public reporting of performance measures and performance improvement. This typology rests on a variety of conceptual models and a review of available empirical evidence. We then use this typology to discuss the core elements that need to be taken into account in efforts to use public reporting of performance measures as a performance improvement tool.

Crews, H. R., et al. (2016). "The Use of Claims-Based Data in Inpatient Public Reporting and Pay-for-Performance Programs: Is There Opportunity for Improvement?" J Healthc Qual.

PURPOSE: This study examined whether self-reported, facility-based data validation practices for claims submissions of cases flagged as Patient Safety Indicators (PSIs) match professional and regulatory standards. METHODS: The National Association of Healthcare Quality members who work in an inpatient setting were invited to complete an anonymous survey to self-report their practices around facility-based data validation of PSI cases. RESULTS: The authors found widespread variation in how PSI administrative data are internally validated; inconsistency in the education and training required of staff who participate in this process; and relatively poor compliance with physician query guidelines and documentation amendment standards. CONCLUSIONS: The self-described wide variation and nonadherence to professional and regulatory standards within the facility-based validation process for PSIs raise concerns about the use of these data to make meaningful judgments about quality and safety. The authors recommend a standardized approach to reporting and validation be implemented for use of PSIs in public reporting and pay-for-performance programs.

Crooks, V. A. et Agarwal, G. (2008). "What are the roles involved in establishing and maintaining informational continuity of care within family practice? A systematic review." BMC Fam Pract **9**: 65.

BACKGROUND: Central to establishing continuity of care is the development of a relationship between doctor and patient/caregiver. Transfer of information between these parties facilitates the development of continuity in general; and specifically informational continuity of care. We conducted a systematic review of published literature to gain a better understanding of the roles that different parties - specifically doctors, patients, family caregivers, and technology - play in establishing and maintaining informational continuity of care within family practice. METHODS: Relevant published articles were sought from five databases. Accepted articles were reviewed and appraised in a consistent way. Fifty-six articles were retained following title and abstract reviews. Of these, 28 were accepted for this review. RESULTS: No articles focused explicitly on the roles involved in establishing or maintaining informational continuity of care within family practice. Most informational continuity of care literature focused on the transfer of information between settings and not at the first point of contact. Numerous roles were, however, were interpreted using the data extracted from reviewed articles. Doctors are responsible for record keeping, knowing patients' histories, recalling accumulated knowledge, and maintaining confidentiality. Patients are responsible for disclosing personal and health details, transferring information to other practitioners (including new family doctors), and establishing trust. Both are responsible for developing a relationship of trust. Technology is an important tool of informational continuity of care through holding important information, providing search functions, and providing a space for recorded information. There is a significant gap in our knowledge about the roles that family

caregivers play. CONCLUSION: The number of roles identified and the interrelationships between them indicates that establishing and maintaining informational continuity of care within family practice is a complex and multifaceted process. This synthesis of roles provided serves as an important resource for continuity of care researchers in general, for the development of continuity of care quality indicators, and for the practice of family medicine.

Czarnecki, A., et al. (2015). "Adherence to process of care quality indicators after percutaneous coronary intervention in Ontario, Canada: a retrospective observational cohort study." Open Heart **2**(1): e000200.

BACKGROUND: Public reporting of percutaneous coronary intervention (PCI) outcomes has been established in many jurisdictions to ensure optimal delivery of care. The majority of PCI report cards examine in-hospital mortality, but relatively little is known regarding the adherence to processes of care. METHODS: A modified Delphi panel comprising cardiovascular experts was assembled to develop a set of PCI quality indicators. Indicators such as prescription of aspirin, dual antiplatelet therapy, statins and smoking cessation counselling were identified to represent high-quality PCI care. Chart abstraction was performed at 13 PCI hospitals in Ontario, Canada from 2009 to 2010 with at least 200 PCI patients randomly selected from each hospital. RESULTS: Our study sample included 3041 patients, of whom 18% had stable coronary artery disease (CAD) and 82% had an acute coronary syndrome (ACS). Their mean age was 63+/-12.4 years and 29% of patients were female. Prior to PCI, 89% were prescribed aspirin, and after PCI 98.7% were prescribed aspirin, 95.1% were prescribed dual antiplatelet therapy for 12 months after drug-eluting stents, and 94.9% were prescribed statins. The lowest performing quality indicator was smoking cessation counselling, observed in only 42% of current and past smokers (18% in patients with stable CAD and 47% in ACS). CONCLUSIONS: Our study demonstrates high levels of adherence to most quality indicators for patients undergoing PCI procedures in Ontario. In conclusion, smoking cessation counselling was not consistently performed across hospitals and represents an opportunity for future quality improvement efforts.

Dehmer, G. J., et al. (2016). "The National Cardiovascular Data Registry Voluntary Public Reporting Program: An Interim Report From the NCDR Public Reporting Advisory Group." J Am Coll Cardiol **67**(2): 205-215.

Public reporting of health care data continues to proliferate as consumers and other stakeholders seek information on the quality and outcomes of care. Medicare's Hospital Compare website, the U.S. News & World Report hospital rankings, and several state-level programs are well known. Many rely heavily on administrative data as a surrogate to reflect clinical reality. Clinical data are traditionally more difficult and costly to collect, but more accurately reflect patients' clinical status, thus enhancing the validity of quality metrics. We describe the public reporting effort being launched by the American College of Cardiology and partnering professional organizations using clinical data from the National Cardiovascular Data Registry (NCDR) programs. This hospital-level voluntary effort will initially report process of care measures from the percutaneous coronary intervention (CathPCI) and implantable cardioverter-defibrillator (ICD) registries of the NCDR. Over time, additional process, outcomes, and composite performance metrics will be reported.

DeVore, A. D., et al. (2016). "Has Public Reporting of Hospital Readmission Rates Affected Patient Outcomes?: Analysis of Medicare Claims Data." J Am Coll Cardiol **67**(8): 963-972.

BACKGROUND: In 2009, the Centers for Medicare & Medicaid Services (CMS) began publicly reporting 30-day hospital readmission rates for patients discharged with acute myocardial infarction (MI), heart failure (HF), or pneumonia. OBJECTIVES: This study assessed trends of 30-day readmission rates and post-discharge care since the implementation of CMS public reporting. METHODS: We analyzed Medicare claims data from 2006 to 2012 for patients discharged after a hospitalization for MI, HF, or pneumonia. For each diagnosis, we estimated trends in 30-day all-cause readmissions and post-discharge care (emergency department visits and observation stays) by using hospitalization-level regression models. We modeled adjusted trends before and after the implementation of public reporting. To assess for a change in trend, we tested the difference between the slope before implementation and the slope after implementation. RESULTS: We analyzed 37,829 hospitalizations for MI, 100,189 for HF, and 79,076 for pneumonia from >4,100 hospitals. When considering only recent trends (i.e., since 2009), we found improvements in adjusted readmission rates for MI (-2.3%), HF (-1.8%), and pneumonia (-2.0%), but when comparing the trend before public reporting with the trend after

reporting, there was no difference for MI (p = 0.72), HF (p = 0.19), or pneumonia (p = 0.21). There were no changes in trends for 30-day post-discharge care for MI or pneumonia; however, the trend decreased for HF emergency department visits from 2.3% to -0.8% (p = 0.007) and for observation stays from 15.1% to 4.1% (p = 0.04). CONCLUSIONS: The release of the CMS public reporting of hospital readmission rates was not associated with any measurable change in 30-day readmission trends for MI, HF, or pneumonia, but it was associated with less hospital-based acute care for HF.

Dogherty, E. J., et al. (2014). "Examining the use of facilitation within guideline dissemination and implementation studies in nursing." Int J Evid Based Healthc **12**(2): 105-127.

BACKGROUND: Facilitation is a mechanism for implementing practice guidelines in nursing. Facilitation aims to prepare clinicians and organisations for implementation and to provide support and help in problem-solving as implementation progresses. However, any evidence supporting its effectiveness is limited due to a lack of empirical testing. AIM: : To examine the presence and role of facilitation in studies included in an existing systematic review of guideline dissemination and implementation in nursing. METHODS: Using a descriptive, exploratory approach, we examined 28 studies for elements of facilitation that were included in a review of the effectiveness of interventions to increase the use of practice guidelines in nursing. We conducted a content analysis of a subset of studies that included facilitation activity to gather descriptions of study interventions, characteristics and skills required, use of theory, and effectiveness. Extracted data were analysed using a previously developed taxonomy containing 53 activities related to facilitation. RESULTS: Ten of the 28 studies exhibited evidence of facilitation process and activity. Only two of the 10 studies explicitly referred to 'facilitators,' with just one indicating that facilitators were a part of the implementation intervention being tested. We identified facilitation processes in the eight remaining studies even though the authors did not report it as such. All studies used facilitation activities in combination with other interventions, the most common being educational meetings or distribution of educational materials. We found evidence related to facilitation for 37 of the 53 facilitation activities (70%) in the taxonomy in at least one study or across studies. An additional three novel facilitation-related activities were identified. Most studies exhibited evidence of external facilitation activity whereby researchers outside of the setting assisted nurses to implement guidelines. Theory informed the development or selection of implementation interventions in 60% (n = 6) of the studies. Drawing conclusions regarding effectiveness of interventions involving facilitation was difficult due to the small number of studies that were included. Furthermore, the included studies varied in the detail provided about the intervention or combination of interventions tested and how interventions were delivered. CONCLUSIONS: Using an existing systematic review for the purpose of gaining insight into additional research questions was valuable. Although facilitation process and activities are used in interventions to enhance guideline uptake in nursing, these were not conceptualized or referred to by researchers as 'facilitation.' As such, facilitation may be a broader intervention that includes organizing and delivering other interventions. Further research is required to evaluate the relationship between facilitation and other guideline implementation interventions in nursing. The facilitation uncovered within included studies was located primarily in the context of research as it was the researchers who performed most of the facilitation activities. Future inquiries must explore non-researcher-initiated and delivered facilitation intervention activities by following local groups naturally within clinical contexts.

Du, X., et al. (2015). "Exploring the transparency mechanism and evaluating the effect of public reporting on prescription: a protocol for a cluster randomized controlled trial." BMC Public Health **15**: 277.

BACKGROUND: The public reporting of health outcomes has become one of the most popular topics and is accepted as a quality improvement method in the healthcare field. However, little research has been conducted on the transparency mechanism, and results are mixed with regard to the evaluation of the effect of public reporting on quality improvement. The objectives of this trial are to investigate the transparency mechanism and to evaluate the effect of public reporting on prescription at the level of individual participants. METHODS/DESIGN: This study involves a cluster randomized controlled trial conducted in 20 primary-care facilities (clusters). Eligible clusters are those facilities with excellent hospital information systems and that have agreed to participate in the trial. The 20 clusters are matched into 10 pairs according to Technique for Order Preference by Similarity to Ideal Solution score. As the unit of randomization, each pair of facilities is assigned at random to a control or an intervention group through coin flipping. Prescribed ranking information is publicly reported in the intervention group. The

public materials include the posters of individuals and of facilities, the ranking lists of general practitioners, and brochures of patients, which are updated monthly. The intervention began on 13th November 2013 and lasted for one year. Specifically, participants are surveyed at five points in time (baseline, quarterly following the intervention) through questionnaires, interviews, and observations. These participants include an average of 600 patients, 300 general practitioners, 15 directors, and 6 health bureau administrators. The primary outcomes are the transparency mechanism model and the changes in medicine-prescribe. Subsequently, the modifications in the transparency mechanism constructs are evaluated. The outcomes are measured at the individual participant level, and the professional who analyzes the data is blind to the randomization status. DISCUSSION: This study protocol outlines a design that aims to examine the transparency mechanism and to evaluate the effect of public reporting on prescription. The research design is significant in the field of public policy. Furthermore, this study intends to fill the gap of the investigation of the transparency mechanism and the evaluation of public reporting on prescription.

Du, X., et al. (2015). "How public reporting of prescription quality indicators influence prescribing practices? A survey of general practitioners." J Eval Clin Pract **21**(5): 943-951.

RATIONALE, AIMS AND OBJECTIVES: Public reporting of performance data is one of the most popular topics in health care field. The aim of this study was to investigate the transparency mechanism, that is, how public reporting influenced general practitioners' (GPs) prescribing practices. METHOD: GPs who had the license to prescribe medicine of all 10 primary care institutions were surveyed. Data were collected by an instrument, which exhibited satisfactory reliability and validity (Cronbach's alpha > 0.7; average variance extracted > 0.5; composite reliability > 0.7). Data analysis was conducted by structural equation model. RESULTS: The results showed that GPs' perceived value (GP's overall assessment of the worth of the public reporting) and attitude (the psychological reaction to public reporting) had a significantly direct effect on behavioural intention (r = 0.28; r = 0.36), and were affected by information accessibility (r = 0.63; r = 0.32). Attitude had a significant effect on perceived value(r = 0.45). Perceived risk (the perceptions of the possible loss due to public reporting, e.g. decreasing their income) did not have a significant relationship with information accessibility, attitude and behavioural intention(r = -0.09; r = 0.01; r = -0.07). CONCLUSION: The information accessibility, perceived value and attitude have strong effects on prescribing practices of GPs, whereas perceived risk did not play a role in influencing the prescribing practices. Policymakers need to improve the accessibility of prescription quality indicators and pay attention to the perceived values and attitudes of GPs. Policymakers also need to strengthen the risk education of GPs and attach incentives to transparent regulation.

Duckett, S. J., et al. (2008). "An improvement focus in public reporting: the Queensland approach." Med J Aust **189**(11-12): 616-617.

In many settings, public reporting of health care outcomes still reflects the "name-shame-blame" culture that has permeated large areas of the health care sector for decades. A new approach to public reporting in Queensland, based on statistical process control, emphasises the dynamic nature of performance against specified outcome measures by focusing on the actions that hospitals are taking if their indicators vary from the average. The aim is for public reporting to contribute to, rather than detract from, the creation of an internal culture that emphasises rigorous investigation and improvement rather than merely assigning blame for problems.

Emmert, M., et al. (2012). "[Public reporting in health care: the impact of publicly reported quality data on patient steerage]." Gesundheitswesen **74**(6): e25-41.

BACKGROUND: Public reporting (PR) has been gaining more weight as a mechanism for patient steerage. According to the theory of PR, patients use information about the quality of health care providers before making decisions and selecting health-care providers. This paper contributes further knowledge on the effectiveness of PR and identifies critical success factors. These should be taken into account when implementing PR in the German health care system. METHODOLOGY: The peer-reviewed English, Spanish, and German language literature was searched in the following five databases: The Cochrane Library, Medline (via PubMed), ISI Web of Knowledge, EconLit, and PsycINFO (since 2005). In addition, reference lists of the included studies and reviews were screened in order to identify previously published studies. RESULTS: In total, 21 studies were identified regarding the impact of 12 different PR instruments

on patient steerage. An impact could be demonstrated in 9 studies, 7 studies showed mixed results, while 5 studies could not show any effect on patient steerage. 20 studies were carried out in the US environment, 1 study in Germany. The most researched instrument is the New York State Cardiac Surgery Reporting System (N=8). CONCLUSION: PR can be effective in steering patients when seeking a health-care provider, especially for elective procedures. To be successful, information provided must be reliable, easily understandable, should further represent real news, and be disseminated widely. Besides this, it has to be applicable and modifiable according to individual preferences.

Emmert, M., et al. (2014). "Do German hospital report cards have the potential to improve the quality of care?" Health Policy **118**(3): 386-395.

BACKGROUND: Hospitals report cards have been put in place within the past few years to increase the amount of publicly reported quality information in Germany. OBJECTIVE: The aim of this study was to assess the potential of German hospital report cards to improve quality of care. METHODS: First, a systematic Internet search aimed at identifying available report cards was conducted. Second, cross-sectional data (August/September 2013) were analyzed with respect to awareness, comprehension, and impact of report cards by using descriptive analysis and binary multivariate logistic regression models. RESULTS: Hospital report cards (N=62) have become broadly available. However, awareness remains low, about one third (35.6%) of all respondents (N=2027) were aware of German hospital report card. Regarding comprehensibility, in 60.7% of all experiments (N=6081), respondents selected the hospital with the lowest risk-adjusted mortality; significant differences could be determined between the report cards ($p<.001$) with scores ranging from 27.5% to 77.2%. Binary multivariate logistic regression analysis revealed different significant respondent-related predictors on each report card. Finally, an impact on hospital choice making was determined. CONCLUSIONS: To increase the potential of hospital report cards, health policy makers should promote the availability of report cards. In addition, the comprehensibility of German hospital report cards cannot be regarded as satisfying and should be enhanced in the future.

Emmert, M., et al. (2016). "Do Health Care Providers Use Online Patient Ratings to Improve the Quality of Care? Results From an Online-Based Cross-Sectional Study." J Med Internet Res **18**(9): e254.

BACKGROUND: Physician-rating websites have become a popular tool to create more transparency about the quality of health care providers. So far, it remains unknown whether online-based rating websites have the potential to contribute to a better standard of care. OBJECTIVE: Our goal was to examine which health care providers use online rating websites and for what purposes, and whether health care providers use online patient ratings to improve patient care. METHODS: We conducted an online-based cross-sectional study by surveying 2360 physicians and other health care providers (September 2015). In addition to descriptive statistics, we performed multilevel logistic regression models to ascertain the effects of providers' demographics as well as report card-related variables on the likelihood that providers implement measures to improve patient care. RESULTS: Overall, more than half of the responding providers surveyed (54.66%, 1290/2360) used online ratings to derive measures to improve patient care (implemented measures: mean 3.06, SD 2.29). Ophthalmologists (68%, 40/59) and gynecologists (65.4%, 123/188) were most likely to implement any measures. The most widely implemented quality measures were related to communication with patients (28.77%, 679/2360), the appointment scheduling process (23.60%, 557/2360), and office workflow (21.23%, 501/2360). Scaled-survey results had a greater impact on deriving measures than narrative comments. Multilevel logistic regression models revealed medical specialty, the frequency of report card use, and the appraisal of the trustworthiness of scaled-survey ratings to be significantly associated predictors for implementing measures to improve patient care because of online ratings. CONCLUSIONS: Our results suggest that online ratings displayed on physician-rating websites have an impact on patient care. Despite the limitations of our study and unintended consequences of physician-rating websites, they still may have the potential to improve patient care.

Emmert, M., et al. (2017). "Public reporting of hospital quality shows inconsistent ranking results." Health Policy **121**(1): 17-26.

BACKGROUND: Evidence from the US has demonstrated that hospital report cards might generate confusion for consumers who are searching for a hospital. So far, little is known regarding hospital

ranking agreement on German report cards as well as underlying factors creating disagreement. OBJECTIVE: This study examined the consistency of hospital recommendations on German hospital report cards and discussed underlying reasons for differences. METHODS: We compared hospital recommendations for three procedures on four German hospital report cards. The agreement between two report cards was determined by Cohen's-Kappa. Fleiss' kappa was applied to evaluate the overlap across all four report cards. RESULTS: Overall, 43.40% of all hospitals were labeled equally as low, middle, or top performers on two report cards (hip replacement: 43.2%; knee replacement: 42.8%; percutaneous coronary intervention: 44.3%). In contrast, 8.5% of all hospitals were rated a top performer on one report card and a low performer on another report card. The inter-report card agreement was slight at best between two report cards (kappamax=0.148) and poor between all four report cards (kappamax=0.111). CONCLUSIONS: To increase the benefit of public reporting, increasing the transparency about the concept of - medical - "quality" that is represented on each report card seems to be important. This would help patients and other consumers use the report cards that most represent one's individual preferences.

Epstein, A. M., et al. (2014). "Access to coronary artery bypass graft surgery under pay for performance: evidence from the premier hospital quality incentive demonstration." Circ Cardiovasc Qual Outcomes **7**(5): 727-734.

BACKGROUND: Although pay for performance (P4P) has become common, many worry that P4P will lead providers to avoid offering surgical procedures to the sickest patients out of concern that poor outcomes will lead to financial penalties. METHODS AND RESULTS: We used Medicare data to compare change in rates of coronary artery bypass graft surgery between 2002 to 2003 and 2008 to 2009 among patients with acute myocardial infarction (AMI) admitted to 126 hospitals participating in Medicare's Premier Hospital Quality Incentive Demonstration P4P program with patients in 848 control hospitals participating in public reporting through the Health Quality Alliance. We examined rates for all patients with AMI and those in the top decile of predicted mortality based on demographics, medical comorbidities, and AMI characteristics. We identified 91 393 patients admitted for AMI in Premier hospitals and 502 536 Medicare patients admitted for AMI in control hospitals. Coronary artery bypass graft surgery rates for patients with AMI in Premier decreased from 13.6% in 2002 to 2003 to 10.4% in 2008 to 2009; there was a comparable decrease in non-Premier hospitals (13.6%-10.6%; P value for comparison of changes between Premier and non-Premier, 0.67). Coronary artery bypass graft surgery rates for high-risk patients in Premier decreased from 8.4% in FY 2002 to 203 to 8.2% in 2008 to 2009. Patterns were similar in non-Premier hospitals (8.4%-8.3%; P value for comparison of changes between Premier and non-Premier, 0.82). CONCLUSIONS: Our results show no evidence of a deleterious effect of P4P on access to coronary artery bypass graft surgery for high-risk patients with AMI. These results should be reassuring to those concerned about the potential negative effect of P4P on high-risk patients.

Faber, M., et al. (2009). "Public reporting in health care: how do consumers use quality-of-care information? A systematic review." Med Care **47**(1): 1-8.

BACKGROUND: One of the underlying goals of public reporting is to encourage the consumer to select health care providers or health plans that offer comparatively better quality-of-care. OBJECTIVE: To review the weight consumers give to quality-of-care information in the process of choice, to summarize the effect of presentation formats, and to examine the impact of quality information on consumers' choice behavior. The evidence is organized in a theoretical consumer choice model. DATA SOURCES: English language literature was searched in PubMed, the Cochrane Clinical Trial, and the EPOC Databases (January 1990-January 2008). STUDY SELECTION: Study selection was limited to randomized controlled trails, controlled before-after trials or interrupted time series. Included interventions focused on choice behavior of consumers in health care settings. Outcome measures referred to one of the steps in a consumer choice model. The quality of the study design was rated, and studies with low quality ratings were excluded. RESULTS: All 14 included studies examine quality information, usually CAHPS, with respect to its impact on the consumer's choice of health plans. Easy-to-read presentation formats and explanatory messages improve knowledge about and attitude towards the use of quality information; however, the weight given to quality information depends on other features, including free provider choice and costs. In real-world settings, having seen quality information is a strong determinant for choosing higher quality-rated health plans. CONCLUSIONS: This review contributes to an understanding of consumer choice behavior in health care settings. The small number of included studies limits the strength of our conclusions.

Fontaine, P., et al. (2010). "Systematic review of health information exchange in primary care practices." J Am Board Fam Med **23**(5): 655-670.

BACKGROUND: Unprecedented federal interest and funding are focused on secure, standardized, electronic transfer of health information among health care organizations, termed health information exchange (HIE). The stated goals are improvements in health care quality, efficiency, and cost. Ambulatory primary care practices are essential to this process; however, the factors that motivate them to participate in HIE are not well studied, particularly among small practices. METHODS: We conducted a systematic review of the literature about HIE participation from January 1990 through mid-September 2008 to identify peer-reviewed and non-peer-reviewed publications in bibliographic databases and websites. Reviewers abstracted each publication for predetermined key issues, including stakeholder participation in HIE, and the benefits, barriers, and overall value to primary care practices. We identified themes within each key issue, then grouped themes and identified supporting examples for analysis. RESULTS: One hundred and sixteen peer-reviewed, non-peer-reviewed, and web publications were retrieved, and 61 met inclusion criteria. Of 39 peer-reviewed publications, one-half reported original research. Among themes of cost savings, workflow efficiency, and quality, the only benefits to be reliably documented were those regarding efficiency, including improved access to test results and other data from outside the practice and decreased staff time for handling referrals and claims processing. Barriers included cost, privacy and liability concerns, organizational characteristics, and technical barriers. A positive return on investment has not been documented. CONCLUSIONS: The potential for HIE to reduce costs and improve the quality of health care in ambulatory primary care practices is well recognized but needs further empiric substantiation.

Frolich, A. (2012). "Identifying organisational principles and management practices important to the quality of health care services for chronic conditions." Dan Med J **59**(2): B4387.

BACKGROUND: The quality of health care services offered to people suffering from chronic diseases often fails to meet standards in Denmark or internationally. The population consisting of people with chronic diseases is large and accounts for about 70% of total health care expenses. Given that resources are limited, it is necessary to identify efficient methods to improve the quality of care. Comparing health care systems is a well-known method for identifying new knowledge regarding, for instance, organisational methods and principles. Kaiser Permanente (KP), an integrated health care delivery system in the U.S., is recognized as providing high-quality chronic care; to some extent, this is due to KP's implementation of the chronic care model (CCM). This model recommends a range of evidence-based management practices that support the implementation of evidence-based medicine. However, it is not clear which management practices in the CCM are most efficient and in what combinations. In addition, financial incentives and public reporting of performance are often considered effective at improving the quality of health care services, but this has not yet been definitively proved. AIM: The aim of this dissertation is to describe the effect of determinants, such as organisational structures and management practices including two selected incentives, on the quality of care in chronic diseases. The dissertation is based on four studies with the following purposes: 1) macro- or healthcare system-level identification of organisational structures and principles that affect the quality of health care services, based on a comparison of KP and the Danish health care system; 2) meso- or organisation-level identification of management practices with positive effects on screening rates for hemoglobin A1c and lipid profile in diabetes; 3) evaluation of the effect of the CCM on quality of health care services and continuity of care in a Danish setting; 4) micro- or practice-level evaluation of the effect of financial incentives and public performance reporting on the behaviour of professionals and quality of care. METHODS AND RESULTS: Using secondary data, KP and the Danish health care system were compared in terms of six central dimensions: population, health care professionals, health care organisations, utilization patterns, quality measurements, and costs. Differences existed between the two systems on all dimensions, complicating the interpretation of findings. For instance, observed differences might be due to similar tendencies in the two health care systems that were observed at different times, rather than true structural differences. The expenses in the two health care systems were corrected for differences in the populations served and the purchasing power of currencies. However, no validated methods existed to correct for observed differences in case-mixes of chronic conditions. Data from a population of about half a million patients with diabetes in a large U.S. integrated health care delivery system affiliated with 41 medical centers employing 15 different CCM management practices was the basis for identifying effective management

practices. Through the use of statistical modelling, the management practice of provider alerts was identified as most effective for promoting screening for hemoglobin A1c and lipid profile. The CCM was used as a framework for implementing four rehabilitation programs. The model promoted continuity of care and quality of health care services. New management practices were developed in the study, and known practices were further developed. However, the observational nature of the study limited the generalisability of the findings. In a structured literature survey focusing on the effect of financial incentives and public performance reporting on the quality of health care services, few studies documenting an effect were identified. The results varied, and important program aspects or contextual variables were often omitted. A model describing the effects of the two incentives on the conduct of health care professionals and their interaction with the organisations in which they serve was developed. CONCLUSION: On the macro-level, organisational differences between KP and the Danish health care system related to the primary care sectors, utilization patterns, and the quality of health care services, supporting a hypothesis that KP's focus on primary care is a beneficial form of organisation. On the meso-level, use of the CCM improved quality of health care services, but the effect is complicated and context dependent. The CCM was found to be useful in the Danish health care system, and the model was also further developed in a Danish setting. On the micro-level, quality was improved by financial incentives and disclosure in a complex interplay with other central factors in the work environment of health care professionals.

Frolich, A., et al. (2007). "A behavioral model of clinician responses to incentives to improve quality." Health Policy **80**(1): 179-193.

The use of pay for performance (P4P) and public reporting of performance (PR) in health care is increasing rapidly worldwide. The rationale for P4P and PR comes from experience in other industries and from theories about incentive use from psychology, economics, and organizational behavior. This paper reviews the major themes from this prior research and considers how they might be applied to health care. The resulting conceptual model addresses the dual nature (combining direct financial and reputational incentives) of the initiatives many policymakers are pursuing. It also includes explicit recognition of the key contextual factors (at the levels of the markets and the provider organization) and provider and patient characteristics that can enhance or mitigate response to incentives. Evaluation of the existing literature (through June 2005) about incentive use in health care in light of the conceptual model highlights important weaknesses in the way that trials have been reported to date and suggests future research topics.

Fung, C. H., et al. (2008). "Systematic review: the evidence that publishing patient care performance data improves quality of care." Ann Intern Med **148**(2): 111-123.

BACKGROUND: Previous reviews have shown inconsistent effects of publicly reported performance data on quality of care, but many new studies have become available in the 7 years since the last systematic review. PURPOSE: To synthesize the evidence for using publicly reported performance data to improve quality. DATA SOURCES: Web of Science, MEDLINE, EconLit, and Wilson Business Periodicals (1999-2006) and independent review of articles (1986-1999) identified in a previous systematic review. Only sources published in English were included. STUDY SELECTION: Peer-reviewed articles assessing the effects of public release of performance data on selection of providers, quality improvement activity, clinical outcomes (effectiveness, patient safety, and patient-centeredness), and unintended consequences. DATA EXTRACTION: Data on study participants, reporting system or level, study design, selection of providers, quality improvement activity, outcomes, and unintended consequences were extracted. DATA SYNTHESIS: Forty-five articles published since 1986 (27 of which were published since 1999) evaluated the impact of public reporting on quality. Many focus on a select few reporting systems. Synthesis of data from 8 health plan-level studies suggests modest association between public reporting and plan selection. Synthesis of 11 studies, all hospital-level, suggests stimulation of quality improvement activity. Review of 9 hospital-level and 7 individual provider-level studies shows inconsistent association between public reporting and selection of hospitals and individual providers. Synthesis of 11 studies, primarily hospital-level, indicates inconsistent association between public reporting and improved effectiveness. Evidence on the impact of public reporting on patient safety and patient-centeredness is scant. LIMITATIONS: Heterogeneity made comparisons across studies challenging. Only peer-reviewed, English-language articles were included. CONCLUSION: Evidence is scant, particularly about individual providers and practices. Rigorous evaluation of many major public reporting systems is lacking. Evidence suggests

that publicly releasing performance data stimulates quality improvement activity at the hospital level. The effect of public reporting on effectiveness, safety, and patient-centeredness remains uncertain.

Fung, V., et al. (2010). "Meaningful variation in performance: a systematic literature review." Med Care **48**(2): 140-148.

BACKGROUND: Recommendations for directing quality improvement initiatives at particular levels (eg, patients, physicians, provider groups) have been made on the basis of empirical components of variance analyses of performance. OBJECTIVE: To review the literature on use of multilevel analyses of variability in quality. RESEARCH DESIGN: Systematic literature review of English-language articles (n = 39) examining variability and reliability of performance measures in Medline using PubMed (1949-November 2008). RESULTS: Variation was most commonly assessed at facility (eg, hospital, medical center) (n = 19) and physician (n = 18) levels; most articles reported variability as the proportion of total variation attributable to given levels (n = 22). Proportions of variability explained by aggregated levels were generally low (eg, <19% for physicians), and numerous authors concluded that the proportion of variability at a specific level did not justify targeting quality interventions to that level. Few articles based their recommendations on absolute differences among physicians, hospitals, or other levels. Seven of 12 articles that assessed reliability found that reliability was poor at the physician or hospital level due to low proportional variability and small sample sizes per unit, and cautioned that public reporting or incentives based on these measures may be inappropriate. CONCLUSIONS: The proportion of variability at levels higher than patients is often found to be "low." Although low proportional variability may lead to poor measurement reliability, a number of authors further suggested that it also indicates a lack of potential for quality improvement. Few studies provided additional information to help determine whether variation was, nevertheless, clinically meaningful.

Garcia, Armesto, S., et al. (2008). Information availability for measuring and comparing quality of mental health care across OECD countries. OECD Health Technical Papers ; 20. Paris OCDE**:** 65 , tabl., ann. http://www.oecd.org/dataoecd/53/47/41243838.pdf

Ce document présente un panorama des systèmes d'information sur les soins de santé mentale en place dans 18 pays de l'OCDE avec pour objectif d'examiner les possibilités de mesure de la qualité de ces soins et d'identifier des indicateurs qui pourraient être inclus dans la batterie d'indicateurs de la qualité des soins de santé (HCQI) de l'organisation. Pour étayer cette analyse, une enquête a été effectuée. Le questionnaire s'efforçait de recueillir des informations sur trois domaines d'intérêt permettant de décrire les systèmes nationaux d'information liés aux services de santé mentale : types de données sur la santé mentale disponibles au niveau du système ; sources de données disponibles au niveau national ; modalités institutionnelles régissant la propriété et l'utilisation du système d'information. Une section supplémentaire a été ajoutée pour évaluer les possibilités d'amélioration de la disponibilité des indicateurs recommandées dans le Rapport technique sur la santé n° 17 de l'OCDE.

Gaynor, M., et al. (2012). Free to Choose? Reform and Demand Response in the English National Health Service. . CEP Discussion Paper ; 1179. Center for Economic Performance**:** 58p. http://cep.lse.ac.uk/pubs/download/dp1179.pdf

The impacts of choice in public services are controversial. We exploit a reform in the English National Health Service to assess the impact of relaxing constraints on patient choice. We estimate a demand model to evaluate whether increased choice increased demand elasticity faced by hospitals with regard to clinical quality and waiting time for an important surgical procedure. We find substantial impacts of the removal of restrictions. Patients became more responsive to clinical quality. Sicker patients and better informed patients were more affected. We leverage our model to calculate potential benefits. We find increased demand responsiveness led to a significant reduction in mortality and an increase in patient welfare. The elasticity of demand faced by hospitals increased post-reform, giving hospitals potentially large incentives to improve their quality of care and find suggestive evidence that hospitals responded strongly to the enhanced incentives due to increased demand elasticity. The results suggests greater choice can enhance quality.

Gaynor, M., et al. (2016). "Free to Choose? Reform, Choice, and Consideration Sets in the English National Health Service." American Economic Review **106**(11): 3521-3557.

http://search.ebscohost.com/login.aspx?direct=true&db=ecn&AN=1593849&lang=fr&site=ehost-live
http://www.aeaweb.org/aer/

> Choice in public services is controversial. We exploit a reform in the English National Health Service to assess the effect of removing constraints on patient choice. We estimate a demand model that explicitly captures the removal of the choice constraints imposed on patients. We find that, post-removal, patients became more responsive to clinical quality. This led to a modest reduction in mortality and a substantial increase in patient welfare. The elasticity of demand faced by hospitals increased substantially post-reform and we find evidence that hospitals responded to the enhanced incentives by improving quality. This suggests greater choice can raise quality.

Geraedts, M., et al. (2009). "[Public reporting--forms and effects]." Dtsch Med Wochenschr **134 Suppl 6**: S232-233.

> Since 2004 hospitals in Germany publish structured report cards bi-yearly. Content and scope of these mandatory public reports are still under discussion. Therefore we provide an up to date overview on forms and effects of public reports. By enabling transparency, comparative reports on the quality of health care aim at supporting patients to choose better performing health care providers and motivating health care providers to enhance quality improvement activities. Internationally existing public reports range from reports on national health systems on the whole to reports on the quality of particular procedures of individual health care providers. Contrary to the multitude of public reports, the evidence on the effects of public reporting remains scant. The few existing studies show that hospitals react on the public reports by some quality improvements. However, regarding the selection of providers and the quality of care they only show inconsistent effects of public reporting. Moreover, unsolved methodical problems of pubic reporting and potentially unintended consequences have to be considered. Therefore the question remains whether the expected effects in terms of quality improvements outbalance the unintended consequences in the long run and if the investments in public reporting will be paid off.

Gerring, J., et al. (2013). "Assessing health system performance: A model-based approach." Social Science and Medicine **93**: 21-28.

Gilbert, J. E., et al. (2014). "Creation of a diagnostic wait times measurement framework based on evidence and consensus." J Oncol Pract **10**(5): e373-379.

> PURPOSE: Public reporting of wait times worldwide has to date focused largely on treatment wait times and is limited in its ability to capture earlier parts of the patient journey. The interval between suspicion and diagnosis or ruling out of cancer is a complex phase of the cancer journey. Diagnostic delays and inefficient use of diagnostic imaging procedures can result in poor patient outcomes, both physical and psychosocial. This study was designed to develop a framework that could be adopted for multiple disease sites across different jurisdictions to enable the measurement of diagnostic wait times and diagnostic delay. METHODS: Diagnostic benchmarks and targets in cancer systems were explored through a targeted literature review and jurisdictional scan. Cancer system leaders and clinicians were interviewed to validate the information found in the jurisdictional scan. An expert panel was assembled to review and, through a modified Delphi consensus process, provide feedback on a diagnostic wait times framework. RESULTS: The consensus process resulted in agreement on a measurement framework that identified suspicion, referral, diagnosis, and treatment as the main time points for measuring this critical phase of the patient journey. CONCLUSIONS: This work will help guide initiatives designed to improve patient access to health services by developing an evidence-based approach to standardization of the various waypoints during the diagnostic pathway. The diagnostic wait times measurement framework provides a yardstick to measure the performance of programs that are designed to manage and expedite care processes between referral and diagnosis or ruling out of cancer.

Gillies, R. R., et al. (1997). "Impact des méthodes d'amélioration continue de la qualité dans les hôpitaux américains. Discussion." Gestions Hospitalieres(369): 620-627.

> [BDSP. Notice produite par INIST PW4VDR0x. Diffusion soumise à autorisation].

Goff, S. L., et al. (2015). "A qualitative analysis of hospital leaders' opinions about publicly reported measures of health care quality." Jt Comm J Qual Patient Saf **41**(4): 169-176.

BACKGROUND: Hospital leaders play an important role in the success of quality improvement (QI) initiatives, yet little is known about how leaders engaged in QI currently view quality performance measures. In a follow-up to a quantitative study conducted in 2012, a study employing qualitative content analysis was conducted to (1) describe leaders' opinions about the quality measures reported on the Centers for Medicare & Medicaid Services (CMS) Hospital Compare website, (2) to generate hypotheses about barriers/facilitators to improving hospitals' performance, and (3) to elicit recommendations about how to improve publicly reported quality measures. METHODS: The opinions of leaders from a stratified sample of 630 hospitals across the United States regarding quality measures were assessed with an open-ended prompt that was part of a 21-item questionnaire about quality measures publicly reported by CMS. Their responses were qualitatively analyzed in an iterative process, resulting in the identification of the presence and frequency of major themes and subthemes. RESULTS: Participants from 131 (21%) of the 630 hospitals surveyed replied to the open-ended prompt; 15% were from hospitals with higher-than-average performance scores, and 52% were from hospitals with lower-than-average scores. Major themes included (1) concerns regarding quality measurement (measure validity, importance, and fairness) and/or public reporting; 76%); (2) positive views of quality measurement (stimulate improvement, focus efforts; 13%); and (3) recommendations for improving quality measurement. CONCLUSIONS: Among hospital leaders responding to an open-ended survey prompt, some supported the concept of measuring quality, but the majority criticized the validity and utility of current quality measures. Although quality measures are frequently being reevaluated and new measures developed, the ability of such measures to stimulate improvement may be limited without greater buy-in from hospital leaders.

Goitein, L. (2014). "Virtual quality: the failure of public reporting and pay-for-performance programs." JAMA Intern Med **174**(12): 1912-1913.

Goldman, L. E., et al. (2007). "Public reporting and pay-for-performance: safety-net hospital executives' concerns and policy suggestions." Inquiry **44**(2): 137-145.

Safety-net hospitals (SNHs) may gain little financial benefit from the rapidly spreading adoption of public reporting and pay-for-performance, but may feel compelled to participate (and bear the costs of data collection) to meet public expectations of transparency and accountability. To better understand the concerns that SNH administrators have regarding public reporting and pay-for-performance, we interviewed 37 executives at randomly selected California SNHs. The main concerns noted by SNH executives were that human and financial resource constraints made it difficult for SNHs to accurately measure their performance. Additionally, some executives felt that market-driven public reporting and pay-for-performance may focus on clinical areas and incentive structures that may not be high-priority clinical areas for SNHs. Executives at SNHs suggested several policy responses to these concerns-such as offering training programs for SNH data collectors-that could be relatively inexpensive and might improve the cost-benefit ratio of public reporting and pay-for-performance programs.

Goodrich, K., et al. (2012). "Hospitalist utilization and hospital performance on 6 publicly reported patient outcomes." J Hosp Med **7**(6): 482-488.

BACKGROUND: The increase in hospitalist-provided inpatient care may be accompanied by an expectation of improvement on patient outcomes. To date, the association between utilization of hospitalists and the publicly reported patient outcomes is unknown. OBJECTIVE: Assess the relationship between hospitalist utilization and performance on 6 publicly reported patient outcomes. DESIGN: Cross-sectional study. PARTICIPANTS: Representatives of 598 hospitals in the United States with direct knowledge of inpatient service models. INTERVENTION: Survey of hospital personnel with knowledge of hospitalist use and hospitalist programs. MEASUREMENTS: Six publicly reported quality outcome measures across 3 medical conditions: acute myocardial infarction (AMI), congestive heart failure (HF), and pneumonia. Using multivariable regression models, we assessed the relationship between presence of hospitalists and performance on each outcome measure; we further assessed the relationship between the percentage of patients admitted by hospitalists and each outcome measure. RESULTS: Of 598 respondents, 429 (72%) reported the use of hospitalist services. In the comparison of hospitals with and without hospitalists, there was no statistically significant difference on any of the mortality or readmissions measures with the exception of the risk-stratified readmission rate for heart failure. For

hospitals that used hospitalists, there was no significant change in any of the outcome measures with increasing percentage of patients admitted by hospitalists. CONCLUSIONS: The presence of hospitalists is not an independent predictor of performance on publicly reported mortality and readmissions measures for AMI, HF, or pneumonia. It is likely that broader system or organizational interventions are required to improve performance on patient outcomes.

Grabner-Krauter, S. et Waiguny, M. K. (2015). "Insights into the impact of online physician reviews on patients' decision making: randomized experiment." J Med Internet Res **17**(4): e93.

BACKGROUND: Physician-rating websites combine public reporting with social networking and offer an attractive means by which users can provide feedback on their physician and obtain information about other patients' satisfaction and experiences. However, research on how users evaluate information on these portals is still scarce and only little knowledge is available about the potential influence of physician reviews on a patient's choice. OBJECTIVE: Starting from the perspective of prospective patients, this paper sets out to explore how certain characteristics of physician reviews affect the evaluation of the review and users' attitudes toward the rated physician. We propose a model that relates review style and review number to constructs of review acceptance and check it with a Web-based experiment. METHODS: We employed a randomized 2x2 between-subject, factorial experiment manipulating the style of a physician review (factual vs emotional) and the number of reviews for a certain physician (low vs high) to test our hypotheses. A total of 168 participants were presented with a Web-based questionnaire containing a short description of a dentist search scenario and the manipulated reviews for a fictitious dental physician. To investigate the proposed hypotheses, we carried out moderated regression analyses and a moderated mediation analysis using the PROCESS macro 2.11 for SPSS version 22. RESULTS: Our analyses indicated that a higher number of reviews resulted in a more positive attitude toward the rated physician. The results of the regression model for attitude toward the physician suggest a positive main effect of the number of reviews (mean [low] 3.73, standard error [SE] 0.13, mean [high] 4.15, SE 0.13). We also observed an interaction effect with the style of the review-if the physician received only a few reviews, fact-oriented reviews (mean 4.09, SE 0.19) induced a more favorable attitude toward the physician compared to emotional reviews (mean 3.44, SE 0.19), but there was no such effect when the physician received many reviews. Furthermore, we found that review style also affected the perceived expertise of the reviewer. Fact-oriented reviews (mean 3.90, SE 0.13) lead to a higher perception of reviewer expertise compared to emotional reviews (mean 3.19, SE 0.13). However, this did not transfer to the attitude toward the physician. A similar effect of review style and number on the perceived credibility of the review was observed. While no differences between emotional and factual style were found if the physician received many reviews, a low number of reviews received lead to a significant difference in the perceived credibility, indicating that emotional reviews were rated less positively (mean 3.52, SE 0.18) compared to fact-oriented reviews (mean 4.15, SE 0.17). Our analyses also showed that perceived credibility of the review fully mediated the observed interaction effect on attitude toward the physician. CONCLUSIONS: Physician-rating websites are an interesting new source of information about the quality of health care from the patient's perspective. This paper makes a unique contribution to an understudied area of research by providing some insights into how people evaluate online reviews of individual doctors. Information attributes, such as review style and review number, have an impact on the evaluation of the review and on the patient's attitude toward the rated doctor. Further research is necessary to improve our understanding of the influence of such rating sites on the patient's choice of a physician.

Greenberg, A., et al. (2005). "Development of a set of strategy-based system-level cancer care performance indicators in Ontario, Canada." Int J Qual Health Care **17**(2): 107-114.

OBJECTIVES: To develop a set of scientifically sound and managerially useful system-level cancer care performance indicators for public reporting in Ontario, Canada. IMPLEMENTATION: Using a modified Delphi panel method, comprising a systematic literature review and multiple rounds of structured feedback from 34 experts, the Cancer Quality Council of Ontario developed a set of quality indicators spanning cancer prevention through to end-of-life care. To be useful to decision-makers and providers, indicator selection criteria included a clear focus on the cancer system, relevance to a diversity of cancer providers, a strong link to the mission and strategic objectives of the cancer system, clear directionality of indicator results, presence of targets and/or benchmarks, feasibility of populating the indicator, and credibility of the measure as an indicator of quality. To ensure that the selected indicators would measure

progress over time against specific and widely accepted goals, we created a strategy map based on the five strategic objectives of the Ontario cancer system: (i) to improve the measurement and reporting of cancer quality, (ii) to increase the use of evidence and innovation in decision-making, (iii) to improve access to cancer services and reduce waiting times, (iv) to increase efficiency across the system, (v) to reduce the burden of cancer. An analysis of the mean indicator ratings by experts, and the strategy mapping exercise resulted in the identification of 36 indicators deemed suitable for routine performance measurement of the Ontario cancer system. LESSONS LEARNED: The resulting instrument incorporates a credible evidence basis for performance measurement aligned to the five strategic goals for the Ontario cancer system. It represents the integrating of a management culture, focused on the implementation of a new strategic direction for the cancer system, with the underlying evidence-based culture of clinicians.

Grimshaw, J. M. et Eccles, M. P. (2004). "Is evidence-based implementation of evidence-based care possible?" Med J Aust **180**(6 Suppl): S50-51.

Traditional approaches to disseminating research findings have failed to achieve optimal healthcare. In a systematic review of 235 studies of guideline dissemination and implementation strategies, we observed the following: there was a median 10% improvement across studies, suggesting that it is possible to change healthcare provider behaviour and improve quality of care; most dissemination and implementation strategies resulted in small to moderate improvements in care; multifaceted interventions did not appear more effective than single interventions. The interpretation of our systematic review is hindered by the lack of a robust theoretical base for understanding healthcare provider and organisational behaviour. Future research is required to develop a better theoretical base and to evaluate further guideline dissemination and implementation strategies.

Grimshaw, J. M., et al. (2004). "Effectiveness and efficiency of guideline dissemination and implementation strategies." Health Technol Assess **8**(6): iii-iv, 1-72.

OBJECTIVES: To undertake a systematic review of the effectiveness and costs of different guideline development, dissemination and implementation strategies. To estimate the resource implications of these strategies. To develop a framework for deciding when it is efficient to develop and introduce clinical guidelines. DATA SOURCES: MEDLINE, Healthstar, Cochrane Controlled Trial Register, EMBASE, SIGLE and the specialised register of the Cochrane Effective Practice and Organisation of Care (EPOC) group. REVIEW METHODS: Single estimates of dichotomous process variables were derived for each study comparison based upon the primary end-point or the median measure across several reported end-points. Separate analyses were undertaken for comparisons of different types of intervention. The study also explored whether the effects of multifaceted interventions increased with the number of intervention components. Studies reporting economic data were also critically appraised. A survey to estimate the feasibility and likely resource requirements of guideline dissemination and implementation strategies in UK settings was carried out with key informants from primary and secondary care. RESULTS: In total, 235 studies reporting 309 comparisons met the inclusion criteria; of these 73% of comparisons evaluated multifaceted interventions, although the maximum number of replications of a specific multifaceted intervention was 11 comparisons. Overall, the majority of comparisons reporting dichotomous process data observed improvements in care; however, there was considerable variation in the observed effects both within and across interventions. Commonly evaluated single interventions were reminders, dissemination of educational materials, and audit and feedback. There were 23 comparisons of multifaceted interventions involving educational outreach. The majority of interventions observed modest to moderate improvements in care. No relationship was found between the number of component interventions and the effects of multifaceted interventions. Only 29.4% of comparisons reported any economic data. The majority of studies only reported costs of treatment; only 25 studies reported data on the costs of guideline development or guideline dissemination and implementation. The majority of studies used process measures for their primary end-point, despite the fact that only three guidelines were explicitly evidence based (and may not have been efficient). Respondents to the key informant survey rarely identified existing budgets to support guideline dissemination and implementation strategies. In general, the respondents thought that only dissemination of educational materials and short (lunchtime) educational meetings were generally feasible within current resources. CONCLUSIONS: There is an imperfect evidence base to support decisions about which guideline dissemination and implementation strategies are likely to be efficient under different circumstances. Decision makers need to use considerable judgement about how best to use the limited resources they

have for clinical governance and related activities to maximise population benefits. They need to consider the potential clinical areas for clinical effectiveness activities, the likely benefits and costs required to introduce guidelines and the likely benefits and costs as a result of any changes in provider behaviour. Further research is required to: develop and validate a coherent theoretical framework of health professional and organisational behaviour and behaviour change to inform better the choice of interventions in research and service settings, and to estimate the efficiency of dissemination and implementation strategies in the presence of different barriers and effect modifiers.

Halpin, L. S., et al. (2008). "Public health reporting: the United States perspective." Semin Cardiothorac Vasc Anesth **12**(3): 191-202.

The release of 2 landmark reports by the Institute of Medicine titled, "To Err Is Human: Building a Safer Health System" and "Crossing the Quality Chasm" were instrumental in the identification of safety and quality issues. Since their release, federal and state programs of public reporting of performance measures have attempted to close the quality gap of care that is inappropriate, not timely, or lacking an evidence base. Cardiac surgery has long been the focus of public scrutiny, and now, as we move from an era of managed care to public reporting, reimbursement for cardiac surgery procedures will be tied to performance. However, the question is whether public reporting and pay for performance will ultimately improve the quality of patient care, safety, and provide the consumer with enough information to make surgeon and institutional choices. Will the cost and focus of achieving perfection with performance standards overshadow any real improvement in clinical outcomes?

Hassani, S., et al. (2015). "30-Day Survival Probabilities as a Quality Indicator for Norwegian Hospitals: Data Management and Analysis." Plos One **10**(9): e0136547.

BACKGROUND: The Norwegian Knowledge Centre for the Health Services (NOKC) reports 30-day survival as a quality indicator for Norwegian hospitals. The indicators have been published annually since 2011 on the website of the Norwegian Directorate of Health (www.helsenorge.no), as part of the Norwegian Quality Indicator System authorized by the Ministry of Health. Openness regarding calculation of quality indicators is important, as it provides the opportunity to critically review and discuss the method. The purpose of this article is to describe the data collection, data pre-processing, and data analyses, as carried out by NOKC, for the calculation of 30-day risk-adjusted survival probability as a quality indicator. METHODS AND FINDINGS: Three diagnosis-specific 30-day survival indicators (first time acute myocardial infarction (AMI), stroke and hip fracture) are estimated based on all-cause deaths, occurring in-hospital or out-of-hospital, within 30 days counting from the first day of hospitalization. Furthermore, a hospital-wide (i.e. overall) 30-day survival indicator is calculated. Patient administrative data from all Norwegian hospitals and information from the Norwegian Population Register are retrieved annually, and linked to datasets for previous years. The outcome (alive/death within 30 days) is attributed to every hospital by the fraction of time spent in each hospital. A logistic regression followed by a hierarchical Bayesian analysis is used for the estimation of risk-adjusted survival probabilities. A multiple testing procedure with a false discovery rate of 5% is used to identify hospitals, hospital trusts and regional health authorities with significantly higher/lower survival than the reference. In addition, estimated risk-adjusted survival probabilities are published per hospital, hospital trust and regional health authority. The variation in risk-adjusted survival probabilities across hospitals for AMI shows a decreasing trend over time: estimated survival probabilities for AMI in 2011 varied from 80.6% (in the hospital with lowest estimated survival) to 91.7% (in the hospital with highest estimated survival), whereas it ranged from 83.8% to 91.2% in 2013. CONCLUSIONS: Since 2011, several hospitals and hospital trusts have initiated quality improvement projects, and some of the hospitals have improved the survival over these years. Public reporting of survival/mortality indicators are increasingly being used as quality measures of health care systems. Openness regarding the methods used to calculate the indicators are important, as it provides the opportunity of critically reviewing and discussing the methods in the literature. In this way, the methods employed for establishing the indicators may be improved.

Hearld, L. R., et al. (2014). "Pay-for-performance and public reporting program participation and administrative challenges among small- and medium-sized physician practices." Med Care Res Rev **71**(3): 299-312.

A key component of efforts to improve the quality of care in the United States is the use of public reporting and pay-for-performance programs. Little is known, however, about the extent to which small-

and medium-sized physician practices are participating in these programs. This study examined the participation of small- and medium-sized physician practices in pay-for-performance and public reporting programs and the characteristics of the participating practices. Using cross-sectional data from a national sample of 1,734 small- and medium-sized physician practices throughout the United States, we found that many practices (61.2%) were participating in at least one program, while far fewer (19.2%) were participating in multiple programs. Among practices participating in multiple programs, relatively few (21.9%) reported high levels of administrative problems due to a lack of standardization on performance measures. The study also suggests that some structural features are associated with participation and may provide leverage points for fostering participation.

Herr, A., et al. (2016). "Public reporting and the quality of care of German nursing homes." Health Policy **120**(10): 1162-1170.

OBJECTIVES: Since 2009, German nursing homes have been evaluated regularly by an external institution with quality report cards published online. We follow recent debates and argue that most of the information in the report cards does not reliably measure quality of care. However, a subset of up to seven measures does. Do these measures that reflect "risk factors" improve over time? METHOD: Using a sample of more than 3000 German nursing homes with information on two waves, we assume that the introduction of public reporting is an exogenous institutional change and apply before-after-estimations to obtain estimates for the relation between public reporting and quality. RESULTS: We find a significant improvement of the identified risk factors. Also, the two employed outcome quality indicators improve significantly. The improvements are driven by nursing homes with low quality in the first evaluation. CONCLUSION: To the extent that this can be interpreted as evidence that public reporting positively affects the (reported) quality in nursing homes, policy makers should carefully choose indicators reflecting care-sensitive quality.

Hiatt, R. A., et al. (2015). "Leveraging state cancer registries to measure and improve the quality of cancer care: a potential strategy for California and beyond." J Natl Cancer Inst **107**(5).

Despite recent increased attention to healthcare performance and the burden of disease from cancer, measures of quality of cancer care are not readily available. In 2013, the California HealthCare Foundation convened an expert workgroup to explore the potential for leveraging data in the California Cancer Registry (CCR), one of the world's largest population-based cancer registries, for measuring and improving the quality of cancer care. The workgroup assessed current registry operations, the value to be gained by linking CCR data with health insurance claims or encounter data and clinical data contained in health system electronic health records, and potential barriers to these linkages. The workgroup concluded that: 1) The CCR mandate should be expanded to include use of its data for quality of cancer care measurement and public reporting; and 2) a system should be developed to support linkage of registry data with both claims data and provider electronic health record data.

Hibbard, J. et Pawlson, L. G. (2004). "Why not give consumers a framework for understanding quality?" Jt Comm J Qual Saf **30**(6): 347-351.

BACKGROUND: Consumers care about the quality of medical care but do not pay attention to currently available quality information or use it to make more informed health care choices. According to the theory of constructed preferences, when people are in a situation that is both complex and unfamiliar, they likely do not have fixed ideas about what is important to them. This theory seems to describe the situation of consumers and comparative quality information. The alternative would be to help consumers understand the overall concept of quality and the different elements that make up quality of care. The Institute of Medicine (IOM) report Crossing the Quality Chasm provides a framework for understanding, measuring, and evaluating the quality of medical care. IMPACT OF PROVIDING A FRAMEWORK FOR UNDERSTANDING QUALITY: Focus groups were conducted in 2001 to determine what performance information they would like to see to help them select a physician. The findings indicated that consumers' understanding of health care quality information was expanded to include a broader array of factors when a cogent framework was used to present quality information. USING THE IOM FRAMEWORK FOR ALL PUBLIC REPORTING ON QUALITY: The IOM framework or a modified version should be used for all public reporting on health care quality. The consistent use of some or all of the six IOM categories of

performance reporting will reinforce the message that this is what constitutes high-quality care and it is what the public should expect to know when they make health care choices.

Hibbard, J. H. (2008). "What can we say about the impact of public reporting? Inconsistent execution yields variable results." Ann Intern Med **148**(2): 160-161.

Hibbard, J. H., et al. (2003). "Does publicizing hospital performance stimulate quality improvement efforts?" Health Aff (Millwood) **22**(2): 84-94.

This study evaluates the impact on quality improvement of reporting hospital performance publicly versus privately back to the hospital. Making performance information public appears to stimulate quality improvement activities in areas where performance is reported to be low. The findings from this Wisconsin-based study indicate that there is added value to making this information public.

Higgins, A., et al. (2013). "Provider performance measures in private and public programs: achieving meaningful alignment with flexibility to innovate." Health Aff (Millwood) **32**(8): 1453-1461.

In recent years there has been a significant expansion in the use of provider performance measures for quality improvement, payment, and public reporting. Using data from a survey of health plans, we characterize the use of such performance measures by private payers. We also compare the use of these measures among selected private and public programs. We studied twenty-three health plans with 121 million commercial enrollees--66 percent of the national commercial enrollment. The health plans reported using 546 distinct performance measures. There was much variation in the use of performance measures in both private and public payment and care delivery programs, despite common areas of focus that included cardiovascular conditions, diabetes, and preventive services. We conclude that policy makers and stakeholders who seek less variability in the use of performance measures to increase consistency should balance this goal with the need for flexibility to meet the needs of specific populations and promote innovation.

Hughes, C. F. et Mackay, P. (2006). "Sea change: public reporting and the safety and quality of the Australian health care system." Med J Aust **184**(10 Suppl): S44-47.

The pursuit of demonstrable safety and quality in health care is an evolving process; there has been notable progress in measuring safety and quality in Australia. The first attempts to measure outcomes were in the field of anaesthesia, while national perinatal mortality reports have provided clinically useful information for many years. Nationwide reporting by the Quality in Australian Health Care Study (QAHCS) in 2005 triggered a more systemic approach to safety and quality. Systemic reporting has begun to emerge in anaesthesia and surgery, for implantable devices, perinatal services and sentinel events; in some jurisdictions, statewide incident data are now reported annually. While debate continues about the issue of individual clinician performance, the real issue is the effectiveness of any reporting system to bring about change in both safety and quality.

Ikkersheim, D. E. et Koolman, X. (2012). "Dutch healthcare reform: did it result in better patient experiences in hospitals? A comparison of the consumer quality index over time." BMC Health Serv Res **12**: 76.

BACKGROUND: In 2006, the Dutch hospital market was reformed to create a more efficient delivery system through managed competition. To allow competition on quality, patient experiences were measured using the Consumer Quality index (CQI). We study whether public reporting and competition had an effect on the CQI between 2006 and 2009. METHODS: We analyzed 8,311 respondents covering 31 hospitals in 2006, 22,333 respondents covering 78 hospitals in 2007 and 24,246 respondents covering 94 hospitals in 2009. We describe CQI trends over the period 2006-2009. In addition we compare hospitals that varied in the level of competition they faced and hospitals that were forced to publish CQI results publicly and those that were not. We corrected for observable covariates between hospital respondents using a multi level linear regression. We used the Herfindahl Hirschman Index to indicate the level of competition. RESULTS: Between 2006 and 2009 hospitals showed a CQI improvement of 0.034 ($p < 0.05$) to 0.060 ($p < 0.01$) points on a scale between one and four. Hospitals that were forced to publish their scores showed a further improvement of 0.027 ($p < 0.01$) to 0.030 ($p < 0.05$). Furthermore, hospitals that faced more competition from geographically close competitors showed a more

pronounced improvement of CQI-scores 0.004 to 0.05 than other hospitals (p < 0.001). CONCLUSION: Our results show that patients reported improved experiences measured by the CQI between 2006 and 2009. CQI levels improve at a faster rate in areas with higher levels of competition. Hospitals confronted with forced public publication of their CQI responded by enhancing the experiences of their patients.

Jacobs, R., et al. (2004). Informing the development of performance ratings : a report for the Commission for Health improvement. CHE Technical Paper Series ; 32. York University of York**:** 128 , 179 tabl. http://www.york.ac.uk/inst/che/pdf/tp32.pdf

Performance star ratings were published by the Department of Health for acute NHS Trusts for the first time in 2000/01. Two further sets of ratings have subsequently been published in successive years (by the Department and then by the Commission for Health Improvement) and coverage has expanded to include nonacute Trusts and PCTs. This report presents the results of research to assist the Commission for Health Improvement (CHI) in the development of performance ratings for NHS organisations by facilitating a greater understanding of the relationships underlying the existing ratings for acute Trusts and PCTs. The statistical analysis comprised three stages : first, the influence of key targets and indicators on the star ratings ; second, (more importantly) the influence of other explanatory variables on the star ratings and key indicators, including factors that may be less amenable to management control ; third, the links between PCT and acute trust performance were examined. The rationale for this approach is that organisations should be assessed on aspects of performance over which managers have some control, rather than on the basis of exogenous factors that cannot be

Jha, A. K., et al. (2012). "The long-term effect of premier pay for performance on patient outcomes." N Engl J Med **366**(17): 1606-1615.

BACKGROUND: Pay for performance has become a central strategy in the drive to improve health care. We assessed the long-term effect of the Medicare Premier Hospital Quality Incentive Demonstration (HQID) on patient outcomes. METHODS: We used Medicare data to compare outcomes between the 252 hospitals participating in the Premier HQID and 3363 control hospitals participating in public reporting alone. We examined 30-day mortality among more than 6 million patients who had acute myocardial infarction, congestive heart failure, or pneumonia or who underwent coronary-artery bypass grafting (CABG) between 2003 and 2009. RESULTS: At baseline, the composite 30-day mortality was similar for Premier and non-Premier hospitals (12.33% and 12.40%, respectively; difference, -0.07 percentage points; 95% confidence interval [CI], -0.40 to 0.26). The rates of decline in mortality per quarter at the two types of hospitals were also similar (0.04% and 0.04%, respectively; difference, -0.01 percentage points; 95% CI, -0.02 to 0.01), and mortality remained similar after 6 years under the pay-for-performance system (11.82% for Premier hospitals and 11.74% for non-Premier hospitals; difference, 0.08 percentage points; 95% CI, -0.30 to 0.46). We found that the effects of pay for performance on mortality did not differ significantly among conditions for which outcomes were explicitly linked to incentives (acute myocardial infarction and CABG) and among conditions not linked to incentives (congestive heart failure and pneumonia) (P=0.36 for interaction). Among hospitals that were poor performers at baseline, mortality was similar in the two groups of hospitals at the start of the study (15.12% and 14.73%; difference, 0.39 percentage points; 95% CI, -0.36 to 1.15), with similar rates of improvement per quarter (0.10% and 0.07%; difference, -0.03 percentage points; 95% CI, -0.08 to 0.02) and similar mortality rates at the end of the study (13.37% and 13.21%; difference, 0.15 percentage points; 95% CI, -0.70 to 1.01). CONCLUSIONS: We found no evidence that the largest hospital-based pay-for-performance program led to a decrease in 30-day mortality. Expectations of improved outcomes for programs modeled after Premier HQID should therefore remain modest.

Jolley, R. J., et al. (2017). "Protocol for a scoping review study to identify and classify patient-centred quality indicators." BMJ Open **7**(1): e013632.

INTRODUCTION: The concept of patient-centred care (PCC) is changing the way healthcare is understood, accepted and delivered. The Institute of Medicine has defined PCC as 1 of its 6 aims to improve healthcare quality. However, in Canada, there are currently no nationwide standards in place for measuring and evaluating healthcare from a patient-centred approach. In this paper, we outline our scoping review protocol to systematically review published and unpublished literature specific to patient-centred quality indicators that have been implemented and evaluated across various care settings.

METHODS AND ANALYSIS: Arksey and O'Malley's scoping review methodology framework will guide the conduct of this scoping review. We will search electronic databases (MEDLINE, EMBASE, the Cochrane Library, Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycINFO, Social Work Abstracts, Social Services Abstracts), grey literature sources and the reference lists of key studies to identify studies appropriate for inclusion. 2 reviewers will independently screen all abstracts and full-text studies for inclusion. We will include any study which focuses on quality indicators in the context of PCC. All bibliographic data, study characteristics and indicators will be collected and analysed using a tool developed through an iterative process by the research team. Indicators will be classified according to a predefined conceptual framework and categorised and described using qualitative content analysis. ETHICS AND DISSEMINATION: The scoping review will synthesise patient-centred quality indicators and their characteristics as described in the literature. This review will be the first step to formally identify what quality indicators have been used to evaluate PCC across the healthcare continuum, and will be used to inform a stakeholder consensus process exploring the development of a generic set of patient-centred quality indicators applicable to multiple care settings. The results will be disseminated through a peer-reviewed publication, conference presentations and a one-day stakeholder meeting.

Joynt, K. E., et al. (2012). "Association of public reporting for percutaneous coronary intervention with utilization and outcomes among Medicare beneficiaries with acute myocardial infarction." Jama **308**(14): 1460-1468.

CONTEXT: Public reporting of patient outcomes is an important tool to improve quality of care, but some observers worry that such efforts will lead clinicians to avoid high-risk patients. OBJECTIVE: To determine whether public reporting for percutaneous coronary intervention (PCI) is associated with lower rates of PCI for patients with acute myocardial infarction (MI) or with higher mortality rates in this population. DESIGN, SETTING, AND PATIENTS: Retrospective observational study conducted using data from fee-for-service Medicare patients (49,660 from reporting states and 48,142 from nonreporting states) admitted with acute MI to US acute care hospitals between 2002 and 2010. Logistic regression was used to compare PCI and mortality rates between reporting states (New York, Massachusetts, and Pennsylvania) and regional nonreporting states (Maine, Vermont, New Hampshire, Connecticut, Rhode Island, Maryland, and Delaware). Changes in PCI rates over time in Massachusetts compared with nonreporting states were also examined. MAIN OUTCOME MEASURES: Risk-adjusted PCI and mortality rates. RESULTS: In 2010, patients with acute MI were less likely to receive PCI in public reporting states than in nonreporting states (unadjusted rates, 37.7% vs 42.7%, respectively; risk-adjusted odds ratio [OR], 0.82 [95% CI, 0.71-0.93]; P = .003). Differences were greatest among the 6708 patients with ST-segment elevation MI (61.8% vs 68.0%; OR, 0.73 [95% CI, 0.59-0.89]; P = .002) and the 2194 patients with cardiogenic shock or cardiac arrest (41.5% vs 46.7%; OR, 0.79 [95% CI, 0.64-0.98]; P = .03). There were no differences in overall mortality among patients with acute MI in reporting vs nonreporting states. In Massachusetts, odds of PCI for acute MI were comparable with odds in nonreporting states prior to public reporting (40.6% vs 41.8%; OR, 1.00 [95% CI, 0.71-1.41]). However, after implementation of public reporting, odds of undergoing PCI in Massachusetts decreased compared with nonreporting states (41.1% vs 45.6%; OR, 0.81 [95% CI, 0.47-1.38]; P = .03 for difference in differences). Differences were most pronounced for the 6081 patients with cardiogenic shock or cardiac arrest (prereporting: 44.2% vs 36.6%; OR, 1.40 [95% CI, 0.85-2.32]; postreporting: 43.9% vs 44.8%; OR, 0.92 [95% CI, 0.38-2.22]; P = .03 for difference in differences). CONCLUSIONS: Among Medicare beneficiaries with acute MI, the use of PCI was lower for patients treated in 3 states with public reporting of PCI outcomes compared with patients treated in 7 regional control states without public reporting. However, there was no difference in overall acute MI mortality between states with and without public reporting.

Kaafarani, H. M., et al. (2011). "Validity of selected Patient Safety Indicators: opportunities and concerns." J Am Coll Surg **212**(6): 924-934.

BACKGROUND: The Agency for Healthcare Research and Quality (AHRQ) recently designed the Patient Safety Indicators (PSIs) to detect potential safety-related adverse events. The National Quality Forum has endorsed several of these ICD-9-CM-based indicators as quality-of-care measures. We examined the positive predictive value (PPV) of 3 surgical PSIs: postoperative pulmonary embolus and deep vein thrombosis (pPE/DVT), iatrogenic pneumothorax (iPTX), and accidental puncture and laceration (APL). STUDY DESIGN: We applied the AHRQ PSI software (v.3.1a) to fiscal year 2003 to 2007 Veterans Health Administration (VA) administrative data to identify (flag) patients suspected of having a pPE/DVT, iPTX, or APL. Two trained nurse abstractors reviewed a sample of 336 flagged medical records (112 records per

PSI) using a standardized instrument. Inter-rater reliability was assessed. RESULTS: Of 2,343,088 admissions, 6,080 were flagged for pPE/DVT (0.26%), 1,402 for iPTX (0.06%), and 7,203 for APL (0.31%). For pPE/DVT, the PPV was 43% (95% CI, 34% to 53%); 21% of cases had inaccurate coding (eg, arterial not venous thrombosis); and 36% featured thromboembolism present on admission or preoperatively. For iPTX, the PPV was 73% (95% CI, 64% to 81%); 18% had inaccurate coding (eg, spontaneous pneumothorax), and 9% were pneumothoraces present on admission. For APL, the PPV was 85% (95% CI, 77% to 91%); 10% of cases had coding inaccuracies and 5% indicated injuries present on admission. However, 27% of true APLs were minor injuries requiring no surgical repair (eg, small serosal bowel tear). Inter-rater reliability was >90% for all 3 PSIs. CONCLUSIONS: Until coding revisions are implemented, these PSIs, especially pPE/DVT, should be used primarily for screening and case-finding. Their utility for public reporting and pay-for-performance needs to be reassessed.

Ketelaar, N. A., et al. (2011). "Public release of performance data in changing the behaviour of healthcare consumers, professionals or organisations." Cochrane Database Syst Rev(11): Cd004538.

BACKGROUND: It is becoming increasingly common to release information about the performance of hospitals, health professionals or providers, and healthcare organisations into the public domain. However, we do not know how this information is used and to what extent such reporting leads to quality improvement by changing the behaviour of healthcare consumers, providers and purchasers, or to what extent the performance of professionals and providers can be affected. OBJECTIVES: To determine the effectiveness of the public release of performance data in changing the behaviour of healthcare consumers, professionals and organisations. SEARCH METHODS: We searched the Cochrane Central Register of Controlled Trials (CENTRAL), Cochrane Effective Practice and Organisation of Care (EPOC) Trials Register, MEDLINE Ovid (from 1966), EMBASE Ovid (from 1979), CINAHL, PsycINFO Ovid (from 1806) and DARE up to 2011. SELECTION CRITERIA: We searched for randomised or quasi-randomised trials, interrupted time series and controlled before-after studies of the effects of publicly releasing data regarding any aspect of the performance of healthcare organisations or individuals. The papers had to report at least one main outcome related to selecting or changing care. Other outcome measures were awareness, attitude, views and knowledge of performance data and costs. DATA COLLECTION AND ANALYSIS: Two review authors independently screened studies for eligibility and extracted data. For each study, we extracted data about the target groups (healthcare consumers, healthcare providers and healthcare purchasers), performance data, main outcomes (choice of healthcare provider and improvement by means of changes in care) and other outcomes (awareness, attitude, views, knowledge of performance data and costs). MAIN RESULTS: We included four studies containing more than 35,000 consumers, and 1560 hospitals. Three studies were conducted in the USA and examined consumer behaviour after the public release of performance data. Two studies found no effect of Consumer Assessment of Healthcare Providers and Systems information on health plan choice in a Medicaid population. One interrupted time series study found a small positive effect of the publishing of data on patient volumes for coronary bypass surgery and low-complication outliers for lumbar discectomy, but these effects did not persist longer than two months after each public release. No effects on patient volumes for acute myocardial infarction were found.One cluster-randomised controlled trial, conducted in Canada, studied improvement changes in care after the public release of performance data for patients with acute myocardial infarction and congestive heart failure. No effects for the composite process-of-care indicators for either condition were found, but there were some improvements in the individual process-of-care indicators. There was an effect on the mortality rates for acute myocardial infarction. More quality improvement activities were initiated in response to the publicly-released report cards. No secondary outcomes were reported. AUTHORS' CONCLUSIONS: The small body of evidence available provides no consistent evidence that the public release of performance data changes consumer behaviour or improves care. Evidence that the public release of performance data may have an impact on the behaviour of healthcare professionals or organisations is lacking.

Kimberley, G., et al. (2013). "Motivators and Barriers to Using Patient Experience Reports for Performance Improvement." Medical Care Research and Review **70**(6): 621-635.
http://ejournals.ebsco.com/direct.asp?ArticleID=4FDFA39898A009BD05EA

Increasingly, patient experience surveys are available to provide performance feedback to physician groups. However, limited published literature addresses factors influencing use of these reports for performance improvement. To address this gap, we conducted semistructured interviews with leaders of

Massachusetts physician groups. We asked about factors influencing groups' use of performance data and report characteristics. Motivating characteristics included having group leaders who emphasized a positive patient experience and prioritized patient retention; public reporting was not an important motivator for most groups. Full physician panels were perceived as a barrier to use of reports. Performance reports from a statewide public reporting collaborative were not sufficient for the majority of groups, with many seeking external reports. As policy makers create financial incentives to support performance improvement, assisting leaders to articulate the professional case for patient experience and enhancing the content and timing of performance reports may be important

Klakow-Franck, R. (2014). "[Points of view: the role of quality measurement from the Federal Joint Committee's perspective]." Z Evid Fortbild Qual Gesundhwes **108**(8-9): 456-464.

The Federal Joint Committee (G-BA) is a central decision-making body that issues binding directives to ensure the quality of both inpatient and outpatient health care services within the German Statutory Health Insurance system. Quality measurement on the basis of quality indicators has proceeded furthest in the field of external quality assurance (QA) of inpatient services. Originally designed for quality development in a "protected environment" through learning from better practices, it has been faced with new expectations since competitive elements have been introduced into the health care system. The economisation of medicine is de facto the driving force of the development of QA measures. In terms of health policy, the 2013 coalition agreement includes "a renaissance of the concept of quality competition". In particular, this is meant to strengthen the decision-making options of insured persons by creating more transparency into the quality of not only inpatient but also outpatient care and, if necessary, to support the possibility of selective agreements with individual health insurance funds. The campaign planned to improve the quality of hospitals also provides for a quality-oriented advancement of hospital planning and funding; and the Federal Joint Committee, supported by the new Institute for Quality Assurance and Transparency in the Healthcare System in accordance with Section 137a of Book V of the Social Code (SGB V) in the GKV-FQWG version will be assigned new tasks within this context, too. On the whole, the measures already agreed upon in the Act to Improve the Financial Structure and Quality of the Statutory Health Insurance System (GKV-FQWG) and-as far as can now be anticipated-the proceedings of the working group set up between the German government and the German federal states indicate that there is a high need to improve the methods and tools of external quality assurance available, starting with questions about the validity of the quality indicators used and their relevance to patient care. Special issues and tasks require the development of new methods and tools. The need for paying more attention to the patient perspective will pose a particular challenge to future quality measurement. Additional information about the QA documentation of health care providers and the basis of social data that should be used preferentially can be gained from patient surveys. Despite the high political expectations (for example, concerning the development of online charts comparing the quality of inpatient care delivery), the Federal Joint Committee should not overlook the necessity of embedding quality measurement and public reporting into a comprehensive quality framework which can be used to promote continuous quality improvement through a structured feedback of the results to health care providers. In addition, we need a consistent patient orientation and a systematic evaluation of the QA measures employed. By networking more closely with evidence-based medicine and health services research, quality assurance may give rise to a systematic quality research from which genuine quality and care objectives can be derived and which, as an integral part of a "learning care", supports a patient-oriented advancement of care structures.

Klazinga, N., et al. (2011). "Health services research related to performance indicators and benchmarking in Europe." J Health Serv Res Policy **16 Suppl 2**: 38-47.

OBJECTIVE: Measuring quality of care through performance indicators and subsequently using these to compare, learn, and improve (benchmarking) has become a central component of health care policy. This paper aims to identify the main themes of health services research in this area and focuses on opportunities for improving the evidence underpinning performance indicators. METHODS: A literature survey was carried out to identify research activities and main research themes in Europe in the years 2000-09. Identified literature was categorized into sub-topics and for each topic the main methodological issues were identified and discussed. Experts validated the findings and explored the potential for related further European research. RESULTS: The distribution of research on performance and benchmarking across EU member states varies in time, scope and settings with a large amount of

studies focusing on hospitals. Eight specific fields of research were identified (research on concepts and performance frameworks; performance indicators and benchmarking using mortality data; performance indicators and benchmarking related to cancer care; performance indicators and benchmarking on care delivered in hospitals; patient safety indicators; performance indicators in primary care; patient experience; research on the practice of benchmarking and performance improvement). Expert discussions confirmed that research on performance indicators and benchmarking should focus on the development of indicators, as well as their use. The research should involve the potential users and incorporate scientific approaches from biomedicine and epidemiology as well as the social sciences. Further progress is hampered by data availability. Issues which need to be addressed include the use of unique patient identifiers (UPIs) to facilitate linkages between separate databases; standardized measurement of the experiences of patients and others; and deepening collaboration between Eurostat, the World Health Organization (WHO), and the Organization for Economic Co-operation and Development (OECD) to facilitate the availability of internationally comparable performance information. CONCLUSIONS: This study suggests a number of themes for future research. These include testing and improving: the validity and reliability of performance indicators, especially related to avoidable mortality and other outcome indicators; the effectiveness and efficiency of embedding performance indicators in the various governance, monitoring and management models, and their effect on health systems, services and professionals; and the effectiveness and efficiency of linking performance indicators to other national and international strategies and policies such as accreditation and certification, practice guidelines, audits, quality systems, patient safety strategies, national standards on volume and/or quality, public reporting, pay-for-performance and patient/consumer involvement. The field would benefit from strengthening the clearinghouse function for research findings, training of researchers and appropriate scientific publication media. Results should be systematically shared with policy-makers and managers, and networking stimulated between the growing number of regional and national institutes involved in quality measurement and reporting.

Kliger, A. S. (2016). "Quality Measures for Dialysis: Time for a Balanced Scorecard." Clin J Am Soc Nephrol **11**(2): 363-368.

Recent federal legislation establishes a merit-based incentive payment system for physicians, with a scorecard for each professional. The Centers for Medicare and Medicaid Services evaluate quality of care with clinical performance measures and have used these metrics for public reporting and payment to dialysis facilities. Similar metrics may be used for the future merit-based incentive payment system. In nephrology, most clinical performance measures measure processes and intermediate outcomes of care. These metrics were developed from population studies of best practice and do not identify opportunities for individualizing care on the basis of patient characteristics and individual goals of treatment. The In-Center Hemodialysis (ICH) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey examines patients' perception of care and has entered the arena to evaluate quality of care. A balanced scorecard of quality performance should include three elements: population-based best clinical practice, patient perceptions, and individually crafted patient goals of care.

Knols, R. H., et al. (2016). "Exergames for Patients in Acute Care Settings: Systematic Review of the Reporting of Methodological Quality, FITT Components, and Program Intervention Details." Games Health J **5**(3): 224-235.

OBJECTIVE: This study was designed to summarize (1) the evidence from studies investigating the use of exergames in acute care settings, (2) the methodological quality of these studies, (3) the reporting of frequency, intensity, time, and type (FITT) of exergaming components and adherence, and (4) reporting of intervention details enabling study replication. MATERIALS AND METHODS: Medline-Ovid, EMBASE, CINAHL, PsychInfo, and the Cochrane Library were consulted. Two authors independently selected and systematically reviewed the included reports. Study quality was scored for each study. RESULTS: Of the nine reports representing five randomized clinical trials, one controlled clinical trial, and three single-group studies, the methodological quality was rather low, and the majority of the reports appeared to have a high risk of bias. Altogether, 365 patients were included in the selected articles. Energy expenditure, 6-Minute Walking Test, Timed Up and Go Test, Modified Berg Balance Scale, level of enjoyment, Transitional Dyspnea Index, upper limb activity, cognitive performance, and length of hospital stay favored exergaming. Three studies considered 70 percent or more of methodological quality items. Two studies reported all four FITT components. No studies reported adherence. Three studies each included descriptions of six intervention details. CONCLUSIONS: The included studies suggest that

patients in acute care settings may benefit from exergaming. The relationship between exergaming and patient outcomes requires, however, further exploration. Future adequately powered studies with low risk of bias and with acute care populations that are followed over extended time periods should be performed to substantiate or refute the advantageous effect of exergaming in acute care settings. Future studies should pay attention to the description of FITT components and adherence to the intervention. Attention to include details of the used exergaming intervention is important for replication purposes.

Kraska, R. A., et al. (2016). "Impact of public reporting on the quality of hospital care in Germany: A controlled before-after analysis based on secondary data." Health Policy **120**(7): 770-779.

BACKGROUND: Since 2005 all German hospitals are obliged to publish structured quality reports (QR). International studies suggest that mandatory reporting motivates hospitals to improve the quality of care. We examine whether such an effect can be demonstrated for hospitals in Germany and whether differences exist between for-profit and non-profit hospitals. METHOD: The study was designed as a controlled pre-post intervention study, whereby the intervention consisted in the first notification of the obligation to publish values for clinical quality indicators (QI). The data basis consisted of those QI reported in identical manner from 2006 to 2012 and multivariable statistical analyses were performed. QI from the same clinical area but without reporting obligation in 2006, served as control group. RESULTS: Six QI were included in the intervention group and demonstrated significant quality improvement. The major part of improvements occurred immediately after the intervention. 31 QI were included in the control group, with about 60% showing improvement trends. In comparison, the biggest proportional improvements were registered for publicly reported QI. No significant differences in relation to profit orientation were found. CONCLUSION: Results indicate a positive effect of public reporting on hospital care, independent of a hospital's profit orientation. Improvements in the quality of care were registered for all observed QI over time, but public reporting stimulated an accelerated QI improvement.

Kristoffersen, D. T., et al. (2015). "Survival curves to support quality improvement in hospitals with excess 30-day mortality after acute myocardial infarction, cerebral stroke and hip fracture: a before-after study." BMJ Open **5**(3): e006741.

OBJECTIVES: To evaluate survival curves (Kaplan-Meier) as a means of identifying areas in the clinical pathway amenable to quality improvement. DESIGN: Observational before-after study. SETTING: In Norway, annual public reporting of nationwide 30-day in-and-out-of-hospital mortality (30D) for three medical conditions started in 2011: first time acute myocardial infarction (AMI), stroke and hip fracture; reported for 2009. 12 of 61 hospitals had statistically significant lower/higher mortality compared with the hospital mean. PARTICIPANTS: Three hospitals with significantly higher mortality requested detailed analyses for quality improvement purposes: Telemark Hospital Trust Skien (AMI and stroke), Ostfold Hospital Trust Fredrikstad (stroke), Innlandet Hospital Trust Gjovik (hip fracture). OUTCOME MEASURES: Survival curves, crude and risk-adjusted 30D before (2008-2009) and after (2012-2013). INTERVENTIONS: Unadjusted survival curves for the outlier hospitals were compared to curves based on pooled data from the other hospitals for the 30-day period 2008-2009. For patients admitted with AMI (Skien), stroke (Fredrikstad) and hip fracture (Gjovik), the curves suggested increased mortality from the initial part of the clinical pathway. For stroke (Skien), increased mortality appeared after about 8 days. The curve profiles were thought to reflect suboptimal care in various phases in the clinical pathway. This informed improvement efforts. RESULTS: For 2008-2009, hospital-specific curves differed from other hospitals: borderline significant for AMI (p=0.064), highly significant (p</=0.005) for the remainder. After intervention, no difference was found (p>0.188). Before-after comparison of the curves within each hospital revealed a significant change for Fredrikstad (p=0.006). For the three hospitals, crude 30D declined and they were non-outliers for risk-adjusted 30D for 2013. CONCLUSIONS: Survival curves as a supplement to 30D may be useful for identifying suboptimal care in the clinical pathway, and thus informing design of quality improvement projects.

Kumpunen, S., et al. (2014). Public reporting in health and long-term care to facilitate provider choice. Copenhague OMS Bureau régional de l'Europe**:** 48 , tabl., graph., fig.
http://www.euro.who.int/__data/assets/pdf_file/0020/263540/Public-reporting-in-health-and-long-term-care-to-facilitate-provider-choice-Eng.pdf

Promoting and enabling choice in publicly-funded health and long-term care services has gained popularity in many countries over recent decades, as it can empower individuals and bring about improved care and outcomes as providers compete for business. But for choice (and competition) of care provider to live up to its potential, people need good comparative information about care providers to make informed decisions. In the policy summary authors review the literature on the measurement and reporting of quality information, provide insights to support future investment in public reporting systems, and summarize strategies aiming to increase the use of reporting by patients and users.

Lagu, T., et al. (2013). "A mixed-methods analysis of patient reviews of hospital care in England: implications for public reporting of health care quality data in the United States." Jt Comm J Qual Patient Saf **39**(1): 7-15.

BACKGROUND: In the United States patients have limited opportunities to read and write narrative reviews about hospitals. In contrast, the National Health Service (NHS) in England encourages patients to provide feedback to hospitals on their quality-reporting website, NHS Choices. The scope and content of the narrative feedback was studied. METHODS: All NHS hospitals with more than 10 reviews posted on NHS Choices were included in a cross-sectional mixed-methods (qualitative and quantitative) analysis of patients' reviews of 20 randomly selected hospitals. RESULTS: The final sample consisted of 264 hospitals and 2,640 patient responses to structured questions. All 200 reviews from the 20 hospitals randomly selected were subjected to further quantitative and qualitative analysis. Comments about clinicians and staff were common (179 [90%]) and overwhelmingly positive, with 149 (83%) favorable to workers. In 124 (62%) of the 200 reviews, patients commented on technical aspects of hospital care, including quality of care, injuries, errors, and incorrect medical record or discharge documentation. Perceived medical errors were described in 51 (26%) hospital reviews. Comments about the hospital facility appeared in half (52%) of reviews, describing hospital cleanliness, food, parking, and amenities. Hospitals replied to 56% of the patient reviews. DISCUSSION: NHS Choices represents the first government-run initiative that enables any patient to provide narrative feedback about hospital care. Reviews appear to have similar domains to those covered in existing satisfaction surveys but also include detailed feedback that would be unlikely to be revealed by such surveys. Online narrative reviews can therefore provide useful and complementary information to consumers (patients) and hospitals, particularly when combined with systematically collected patient experience data.

Lagu, T. et Lindenauer, P. K. (2010). "Putting the public back in public reporting of health care quality." Jama **304**(15): 1711-1712.

Lamb, G. C., et al. (2013). "Publicly reported quality-of-care measures influenced Wisconsin physician groups to improve performance." Health Aff (Millwood) **32**(3): 536-543.

Public reporting of how physicians and hospitals perform on certain quality of care measures is increasingly common, but little is known about whether such disclosures have an impact on the quality of care delivered to patients. We analyzed fourteen publicly reported quality of ambulatory care measures from 2004 to 2009 for the Wisconsin Collaborative for Healthcare Quality, a voluntary consortium of physician groups. We also fielded a survey of the collaborative's members and analyzed Medicare billing data to independently compare members' performance to that of providers in the rest of Wisconsin, neighboring states, and the rest of the United States. We found that physician groups in the collaborative improved their performance during the study period on many measures, such as cholesterol control and breast cancer screening. Physician groups reported on the survey that publicly reported performance data motivated them to act on some, but not all, of the quality measures. Our study suggests that large group practices will engage in quality improvement efforts in response to public reporting, especially when comparative performance is displayed, as it was in this case on the collaborative's website.

Lawson, E. H., et al. (2015). "Comparison between clinical registry and medicare claims data on the classification of hospital quality of surgical care." Ann Surg **261**(2): 290-296.

OBJECTIVE: To compare the classification of hospital statistical outlier status as better or worse performance than expected for postoperative complications using Medicare claims versus clinical registry data. BACKGROUND: Controversy remains as to the most favorable data source for measuring postoperative complications for pay-for-performance and public reporting polices. METHODS: Patient-level records (2005-2008) were linked between the American College of Surgeons National Surgical

Quality Improvement Program (ACS-NSQIP) and Medicare inpatient claims. Hospital statistical outlier status for better or worse performance than expected was assessed using each data source for superficial surgical site infection (SSI), deep/organ-space SSI, any SSI, urinary tract infection, pneumonia, sepsis, deep venous thrombosis, pulmonary embolism, venous thromboembolism, and myocardial infarction by developing hierarchical multivariable logistic regression models. Kappa statistics and correlation coefficients assessed agreement between the data sources. RESULTS: A total of 192 hospitals with 110,987 surgical patients were included. Agreement on hospital rank for complication rates between Medicare claims and ACS-NSQIP was poor-to-moderate (weighted kappa: 0.18-0.48). Of hospitals identified as statistical outliers for better or worse performance by Medicare claims, 26% were also identified as outliers by ACS-NSQIP. Of outliers identified by ACS-NSQIP, 16% were also identified as outliers by Medicare claims. Agreement between the data sources on hospital outlier status classification was uniformly poor (weighted kappa: -0.02-0.34). CONCLUSIONS: Despite using the same statistical methodology with each data source, classification of hospital outlier status as better or worse performance than expected for postoperative complications differed substantially between ACS-NSQIP and Medicare claims.

Lin, G. A., et al. (2010). "Impact of changes in clinical practice guidelines on assessment of quality of care." Med Care **48**(8): 733-738.

BACKGROUND: Measures for pay-for-performance and public reporting programs may be based on clinical practice guidelines. The impact of guideline changes over time-and whether evolving clinical evidence can render measures based on prior guidelines misleading-is not known. OBJECTIVE: To assess the impact of using different percutaneous coronary intervention (PCI) guidelines when evaluating whether PCI was indicated. RESEARCH DESIGN: PCIs from the National Cardiovascular Data Registry's CathPCI registry performed in 2003-2004 were categorized into indication classes (Class I, IIa, IIb, III), using 2001 American College of Cardiology/American Heart Association guidelines for PCI, the guidelines available at the time of the procedures. The same procedures were recategorized using 2005 guidelines, which reflect the best evidence available to clinicians at the time of PCI. Procedures unable to be categorized were labeled as "Not Certain." SUBJECTS: Patients undergoing PCI for stable or unstable angina in 394 hospitals. MEASURES: Number of procedures changing classification categories using 2001 versus 2005 guidelines. RESULTS: A total of 345,779 PCIs were evaluated. Applying 2001 guidelines, 47.9% had Class I indications; 33.3% Class IIa; 5.9% Class IIb; 3.7% Class III; and 9.2% Not Certain. Applying 2005 guidelines to the same procedures, 25.1% had Class I indications; 57.5% Class IIa; 5.5% Class IIb; 3.7% Class III; and 8.3% Not Certain; 41.1% of procedures changed the classification overall. CONCLUSIONS: The changes in guidelines resulted in a marked shift in whether PCIs done in 2003-2004 were considered indicated. Guideline-based performance measures should be carefully evaluated before implementation to avoid incorrect assessments of quality of care.

Lindenauer, P. (2009). "Public reporting and pay-for-performance programs in perioperative medicine: are they meeting their goals?" Cleve Clin J Med **76 Suppl 4**: S3-8.

Public reporting and pay-for-performance reimbursement are two strategies designed to stimulate hospital quality improvement. Information about the quality of hospital care (including surgical volumes and staffing, process-based measures, and mortality and other outcomes) is compiled on various Web sites, giving the public means to compare providers. While public reporting has been shown to foster quality-improvement activities by hospitals, its effects on clinical outcomes are less certain. Likewise, consumers' awareness and use of publicly available hospital and provider quality data have been low but appear to be increasing.

Lindenauer, P. (2010). Transparency to improve the value of hospital care. In : The Healthcare Imperative: Lowering Costs and Improving Outcomes:. Institute of Medicine.

Lindenauer, P. K., et al. (2014). "Attitudes of hospital leaders toward publicly reported measures of health care quality." JAMA Intern Med **174**(12): 1904-1911.

IMPORTANCE: Public reporting of quality is considered a key strategy for stimulating improvement efforts at US hospitals; however, little is known about the attitudes of hospital leaders toward existing quality measures. OBJECTIVES: To describe US hospital leaders' attitudes toward hospital quality

measures found on the Centers for Medicare & Medicaid Services' Hospital Compare website, assess use of these measures for quality improvement, and examine the association between leaders' attitudes and hospital quality performance. DESIGN, SETTING, AND PARTICIPANTS: We mailed a 21-item questionnaire from January 1 through September 31, 2012, to senior hospital leaders from a stratified random sample of 630 US hospitals, including equal numbers with better-than-expected, as-expected, and worse-than-expected performance on mortality and readmission measures. MAIN OUTCOMES AND MEASURES: We assessed levels of agreement with statements concerning quality measures, examined use of measures for improvement activities, and analyzed the association between leaders' attitudes and hospital performance. RESULTS: Of 630 hospitals surveyed, 380 (60.3%) responded. For each of the mortality, readmission, process, and patient experience measures, more than 70% of hospitals agreed with the statement that "public reporting stimulates quality improvement activity at my institution"; agreement for measures of cost and volume was 65.2% and 53.3%, respectively. A similar pattern was observed for the statement that "our hospital is able to influence performance on this measure"; agreement for processes of care and patient experience measures was 96.4% and 94.2%, respectively. A total of 89.7% of hospitals agreed that the hospital's reputation was influenced by patient experience measures; agreement was 77.4% for mortality, 69.9% for readmission, 76.3% for process measures, 66.1% for cost measures, and 54.0% for volume measures. A total of 87.1% of hospitals reported incorporating performance on publicly reported measures into their hospital's annual goals, whereas 90.2% reported regularly reviewing the results with the hospital's board of trustees and 94.3% with senior clinical and administrative leaders. When compared with chief executive officers and chief medical officers, respondents who identified themselves as chief quality officers or vice presidents of quality were less likely to agree that public reporting stimulates quality improvement and that measured differences are large enough to differentiate among hospitals. CONCLUSIONS AND RELEVANCE: Hospital leaders indicated that the measures reported on the Hospital Compare website exert strong influence over local planning and improvement efforts. However, they expressed concerns about the clinical meaningfulness, unintended consequences, and methods of public reporting.

Lindenauer, P. K., et al. (2007). "Public reporting and pay for performance in hospital quality improvement." N Engl J Med **356**(5): 486-496.

BACKGROUND: Public reporting and pay for performance are intended to accelerate improvements in hospital care, yet little is known about the benefits of these methods of providing incentives for improving care. METHODS: We measured changes in adherence to 10 individual and 4 composite measures of quality over a period of 2 years at 613 hospitals that voluntarily reported information about the quality of care through a national public-reporting initiative, including 207 facilities that simultaneously participated in a pay-for-performance demonstration project funded by the Centers for Medicare and Medicaid Services; we then compared the pay-for-performance hospitals with the 406 hospitals with public reporting only (control hospitals). We used multivariable modeling to estimate the improvement attributable to financial incentives after adjusting for baseline performance and other hospital characteristics. RESULTS: As compared with the control group, pay-for-performance hospitals showed greater improvement in all composite measures of quality, including measures of care for heart failure, acute myocardial infarction, and pneumonia and a composite of 10 measures. Baseline performance was inversely associated with improvement; in pay-for-performance hospitals, the improvement in the composite of all 10 measures was 16.1% for hospitals in the lowest quintile of baseline performance and 1.9% for those in the highest quintile ($P<0.001$). After adjustments were made for differences in baseline performance and other hospital characteristics, pay for performance was associated with improvements ranging from 2.6 to 4.1% over the 2-year period. CONCLUSIONS: Hospitals engaged in both public reporting and pay for performance achieved modestly greater improvements in quality than did hospitals engaged only in public reporting. Additional research is required to determine whether different incentives would stimulate more improvement and whether the benefits of these programs outweigh their costs.

Loftus, T., et al. (2015). "The Impact of Documentation Training on Performance Reporting." Cureus **7**(7): e283.

With the advent of public reporting of clinical performance for physicians, the need for accurate documentation is essential. This study tested the hypothesis that a short tutorial on five key documentation tips for a group of colorectal surgeons could significantly improve their reported clinical performance. Data was collected on a total of 626 consecutive inpatients before and after the

introduction of a short tutorial focusing on five key documentation tips to a group of colorectal surgeons. Quality metrics were compared between the two time periods. Significant improvements were observed for complications (p = 0.001), morbidity (p = 0.046), ileus (p = 0.027), and digestive system complications (p < 0.01). There was no difference in mortality (p = 0.569) or readmissions (p = 0.920). A short tutorial focusing on five key documentation tips is associated with improvement in the reported clinical performance of colorectal surgeons.

Lower, H. L., et al. (2015). "The quality of denominator data in surgical site infection surveillance versus administrative data in Norway 2005-2010." BMC Infect Dis **15**: 549.

BACKGROUND: High quality of surveillance systems for surgical site infections (SSIs) is the key to their usefulness. The Norwegian Surveillance System for Antibiotic Consumption and Healthcare-Associated Infections (NOIS) was introduced by regulation in 2005, and is based largely on automated extraction of data from underlying systems in the hospitals. METHODS: This study investigates the quality of NOIS-SSI's denominator data by evaluating completeness, representativeness and accuracy compared with de-identified administrative data for 2005-2010. Comparisons were made by region, hospital type and size, age and sex for 4 surgical procedures. RESULTS: The completeness of NOIS improved from 29.2 % in 2005 to 79.8 % in 2010. NOIS-SSI became representative over time for most procedures by hospital size and type, but not by region. It was representative by age and sex for all years and procedures. Accuracy was good for all years and procedures by all explanatory variables. CONCLUSIONS: A flexible and incremental implementation strategy has encouraged the development of computer-based surveillance systems in the hospitals which gives good accuracy, but the same strategy has adversely affected the completeness and representativeness of the denominator data. For the purpose of evaluating risk factors and implementing prevention and precautionary measures in the individual hospitals, representativeness seems sufficient, but for benchmarking and/or public reporting it is not good enough.

Luft, H. S. (2012). "Advancing public reporting through a new 'aggregator' to standardize data collection on providers' cost and quality." Health Aff (Millwood) **31**(3): 619-626.

Advocates for consumer-friendly public reporting on the performance of health care providers anticipate that, at some point, well-vetted and standardized measures will be widely available to help patients choose clinicians who provide the best care. However, achieving that goal would require assembling standardized data from many sources. Such an effort would raise concerns, including privacy considerations about having a single massive data repository; questions of how such an effort would be funded; and potential misuse of the data. This paper proposes creating a public-private data aggregator that would receive patient and provider data from payers that are deidentified in such a way as to remain useful for consumer-reporting and research purposes. The aggregator could be funded through fees charged to commercial users. Meanwhile, registered researchers putting their methods and findings in the public domain could access the data aggregator for free.

Lyratzopoulos, G., et al. (2011). "How can health care organizations be reliably compared?: Lessons from a national survey of patient experience." Med Care **49**(8): 724-733.

BACKGROUND: Patient experience is increasingly used to assess organizational performance, for example in public reporting or pay-for-performance schemes. Conventional approaches using 95% confidence intervals are commonly used to determine required survey samples or to report performance but these may result in unreliable organizational comparisons. METHODS: We analyzed data from 2.2 million patients who responded to the English 2009 General Practice Patient Survey, which included 45 patient experience questions nested within 6 different care domains (access, continuity of care, communication, anticipatory care planning, out-of-hours care, and overall care satisfaction). For each question, unadjusted and case-mix adjusted (for age, sex, and ethnicity) organization-level reliability, and intraclass correlation coefficients were calculated. RESULTS: Mean responses per organization ranged from 23 to 256 for questions evaluating primary care practices, and from 1454 to 2758 for questions evaluating out-of-hours care organizations. Adjusted and unadjusted reliability values were similar. Twenty-six questions had excellent reliability (>/=0.90). Seven nurse communication questions had very good reliability (>/=0.85), but 3 anticipatory care planning questions had lower reliability (<0.70). Reliability was typically <0.70 for questions with <100 mean responses per practice, usually indicating questions which only a subset of patients were eligible to answer. Nine questions had both excellent reliability and high

intraclass correlation coefficients (>/=0.10) indicating both reliable measurement and substantial performance variability. CONCLUSIONS: High reliability is a necessary property of indicators used to compare health care organizations. Using the English General Practice Patient Survey as a case study, we show how reliability and intraclass correlation coefficients can be used to select measures to support robust organizational comparisons, and to design surveys that will both provide high-quality measurement and optimize survey costs.

Makary, M. A., et al. (2013). "Variation in surgical site infection monitoring and reporting by state." J Healthc Qual **35**(2): 41-46.

OBJECTIVE: Surgical site infections (SSIs) are common, costly, and often preventable. There are no national requirements for measuring or reporting hospital SSI rates and state-level monitoring occurs with little coordination between states. We designed a study to describe the current status of SSI reporting in the United States. METHODS: We reviewed SSI monitoring and reporting legislation in all 50 states in September 2010. Data collected included whether SSI monitoring and reporting legislation exists, if public reporting is required, how the data are accessible, and for which procedures SSI data are reported. RESULTS: Twenty-one (42%) states have legislation for SSI monitoring and reporting. All 21 of these states require public release of findings. Of the states with legislation, eight (38%) currently have SSI data available publicly. A range of two to seven procedures were reported for SSI measurement by individual states. Eighteen (86%) states use state agency websites to make their data publicly available. CONCLUSION: There is wide variation in state monitoring and reporting of SSI rates. Standardized reporting may be needed so that consumers can make informed health choices based on quality metrics.

Mansky, T. et Nimptsch, U. (2014). "[Hospital quality measurement-what matters?]." Z Evid Fortbild Qual Gesundhwes **108**(8-9): 487-494.

In Germany, the aims of hospital quality measurement have evolved from intra-professional quality assurance via organisational quality improvement to public reporting. Recently, quality-based purchasing is also discussed as a political option. These developments lead to new requirements for quality measurement which have gained little attention so far. Quality indicators have to become more comprehensive, more outcome-related, and more tamper-resistant. Furthermore statistical limitations of quality measurement related to low case numbers may impair quality assessment and therefore have to be considered in political discussions. In many cases the use of administrative data allows for the measurement of meaningful endpoints and is less prone to manipulation than separate data collections. Also, it allows for the extension of quality measurements to other medical conditions without causing additional effort. Bearing costs and benefits in mind, the use of administrative data might be the only way to establish nationwide long-term outcome measurements. Using administrative data also enables the advancement of provider-independent quality measurement. This may cause political controversies. Irrespective of future political regulations, new outcome-related quality measurements already have been shown to contribute to improving hospital care, if used in internal quality management systems.

Marshall, M. N., et al. (2004). "How do we maximize the impact of the public reporting of quality of care?" Int J Qual Health Care **16 Suppl 1**: i57-63.

BACKGROUND: Many developed countries are beginning to see the public reporting of comparative information about the quality of health care as an important way of improving accountability, stimulating quality improvement and empowering members of the public. The production and dissemination of quality reports is particularly high on the policy agenda in the US and the UK, and there is now a considerable amount of experience and evidence from these countries to guide the process. Over the last decade there has been a lively debate about the balance between the advantages and problems of public reporting, but most commentators now believe it is time to cease asking whether we should disseminate information and start asking how it can be done most effectively. PURPOSE: To recommend ways of helping policy makers and practitioners to maximize the impact of quality reports and minimize the unintended consequences. Recommended strategies. We make recommendations about the importance of understanding the macro- and micro--environment within which public reporting takes place, of actively addressing the unintended consequences of public reporting, of incentivizing the response to the data and of engaging the public and media. The effectiveness of the different strategies, on their own or in combination, is likely to be determined by the environment within which reporting

takes place. CONCLUSIONS: It is not desirable to look for a common 'fix' applicable to all organizations or transferable across all international boundaries. However, in this paper we describe lessons that we think are common to all countries attempting to produce and disseminate health care quality reports.

Marshall, M. N., et al. (2003). "Public reporting on quality in the United States and the United Kingdom." Health Aff (Millwood) **22**(3): 134-148.

The public reporting of comparative information about health care quality is becoming an accepted way of improving accountability and quality. Quality report cards have been prominent in the United States for more than a decade and are a central feature of British health system reform. In this paper we examine the common challenges and differences in implementation of the policy in the two countries. We use this information to explore some key questions relating to the content, target audience, and use of published information. We end by making specific recommendations for maximizing the effectiveness of public reporting.

Marshall, M. N., et al. (2000). "The public release of performance data: what do we expect to gain? A review of the evidence." Jama **283**(14): 1866-1874.

CONTEXT: Information about the performance of hospitals, health professionals, and health care organizations has been made public in the United States for more than a decade. The expected gains of public disclosure have not been made clear, and both the benefits and potential risks have received minimal empirical investigation. OBJECTIVE: To summarize the empirical evidence concerning public disclosure of performance data, relate the results to the potential gains, and identify areas requiring further research. DATA SOURCES: A literature search was conducted on MEDLINE and EMBASE databases for articles published between January 1986 and October 1999 in peer-reviewed journals. Review of citations, public documents, and expert advice was conducted to identify studies not found in the electronic databases. STUDY SELECTION: Descriptive, observational, or experimental evaluations of US reporting systems were selected for inclusion. DATA EXTRACTION: Included studies were organized based on use of public data by consumers, purchasers, physicians, and hospitals; impact on quality of care outcomes; and costs. DATA SYNTHESIS: Seven US reporting systems have been the subject of published empirical evaluations. Descriptive and observational methods predominate. Consumers and purchasers rarely search out the information and do not understand or trust it; it has a small, although increasing, impact on their decision making. Physicians are skeptical about such data and only a small proportion makes use of it. Hospitals appear to be most responsive to the data. In a limited number of studies, the publication of performance data has been associated with an improvement in health outcomes. CONCLUSIONS: There are several potential gains from the public disclosure of performance data, but use of the information by provider organizations for quality improvement may be the most productive area for further research.

Mazor, K. M., et al. (2009). "Communicating hospital infection data to the public: a study of consumer responses and preferences." Am J Med Qual **24**(2): 108-115.

There is growing interest in public reporting of health care performance data relating to healthcare-associated infections (HAIs). This study evaluated different approaches for reporting hospital-level comparative data on HAIs and the extent to which such data might influence hospital choice. Eight versions of a report were developed, varying whether data were consistent across indicators, whether data were presented in text or graphs, and whether confidence intervals were included. A report and a questionnaire were mailed to a randomly selected sample of local residents. Findings provide no evidence that consistency of indicators, data presentation, report format, or inclusion of confidence intervals significantly impacted consumers' understanding. More educated consumers reported greater understanding of the reports. Responses suggested that public reporting of comparative data on HAIs could influence hospital choice, but other factors including prior experience, reputation, physicians' recommendations, and insurance coverage are also influential. Most consumers understand information on HAIs when it is presented in a short, simple report, and most correctly select the best or worst hospital. Consumers may be influenced by such data, but other factors are likely to be as or more important.

McConnell, K. J., et al. (2016). "Modern Management Practices and Hospital Admissions." Health Econ **25**(4): 470-485.

We investigate whether the modern management practices and publicly reported performance measures are associated with choice of hospital for patients with acute myocardial infarction (AMI). We define and measure management practices at approximately half of US cardiac care units using a novel survey approach. A patient's choice of a hospital is modeled as a function of the hospital's performance on publicly reported quality measures and the quality of its management. The estimates, based on a grouped conditional logit specification, reveal that higher management scores and better performance on publicly reported quality measures are positively associated with hospital choice. Management practices appear to have a direct correlation with admissions for AMI--potentially through reputational effects--and indirect association, through better performance on publicly reported measures. Overall, a one standard deviation change in management practice scores is associated with an 8% increase in AMI admissions.

McCrum, M. L., et al. (2013). "Mortality for publicly reported conditions and overall hospital mortality rates." JAMA Intern Med **173**(14): 1351-1357.

IMPORTANCE: Federal efforts about public reporting and quality improvement programs for hospitals have focused primarily on a small number of medical conditions. Whether performance on these conditions accurately predicts the quality of broader hospital care is unknown. OBJECTIVE: To determine whether mortality rates for publicly reported medical conditions are correlated with hospitals' overall performance. METHODS: Using national Medicare data, we compared hospital performance at 2322 US acute care hospitals on 30-day risk-adjusted mortality, aggregated across the 3 publicly reported conditions (acute myocardial infarction, congestive heart failure, and pneumonia), with performance on a composite risk-adjusted mortality rate across 9 other common medical conditions, a composite mortality rate across 10 surgical conditions, and both composites combined. We also examined the relationship between alternative surrogates of quality (hospital size and teaching status) and performance on these composite outcomes. RESULTS: Our sample included 6,670,859 hospitalizations for Medicare fee-for-service beneficiaries from 2008 through 2009. Hospitals in the top quartile of performance on publicly reported conditions had a 3.6% lower absolute risk-adjusted mortality rate on the combined medical-surgical composite than those in the bottom quartile (9.4% vs 13.0%; P < .001). These top performers on publicly reported conditions had 5 times greater odds of being in the top quartile on the overall combined composite risk-adjusted mortality rate (odds ratio [OR], 5.3; 95% CI, 4.3-6.5). Mortality rates for the index condition were predictive of medical (OR, 8.4; 95% CI, 6.8-10.3) and surgical (2.7; 2.2-3.3) performance when these groups were considered separately. In comparison, large size (OR, 1.9; 95% CI, 1.5-2.4) and teaching status (2.4; 1.8-3.2) showed weaker relationships with overall hospital mortality rates. CONCLUSIONS AND RELEVANCE: Hospital performance on publicly reported conditions can potentially be used as a signal of overall hospital mortality rates.

McDonald, K. M., et al. (2013). "Evaluating the state of quality-improvement science through evidence synthesis: insights from the closing the quality gap series." Perm J **17**(4): 52-61.

CONTEXT: The Closing the Quality Gap series from the Agency for Healthcare Research and Quality summarizes evidence for eight high-priority health care topics: outcomes used in disability research, bundled payment programs, public reporting initiatives, health care disparities, palliative care, the patient-centered medical home, prevention of health care-associated infections, and medication adherence. OBJECTIVE: To distill evidence from this series and provide insight into the "state of the science" of quality improvement (QI). METHODS: We provided common guidance for topic development and qualitatively synthesized evidence from the series topic reports to identify cross-topic themes, challenges, and evidence gaps as related to QI practice and science. RESULTS: Among topics that examined effectiveness of QI interventions, we found improvement in some outcomes but not others. Implementation context and potential harms from QI activities were not widely evaluated or reported, although market factors appeared important for incentive-based QI strategies. Patient-focused and systems-focused strategies were generally more effective than clinician-focused strategies, although the latter approach improved clinician adherence to infection prevention strategies. Audit and feedback appeared better for targeting professionals and organizations, but not patients. Topic reviewers observed heterogeneity in outcomes used for QI evaluations, weaknesses in study design, and incomplete

reporting. CONCLUSIONS: Synthesizing evidence across topics provided insight into the state of the QI field for practitioners and researchers. To facilitate future evidence synthesis, consensus is needed around a smaller set of outcomes for use in QI evaluations and a framework and lexicon to describe QI interventions more broadly, in alignment with needs of decision makers responsible for improving quality.

McMurtry, R. Y. (2005). "Public reporting makes accountability possible." Healthc Pap **6**(2): 57-61.

This paper reviews the meta-analysis of Brown, Bhimani and MacLeod and finds it an important contribution to the literature on performance reporting (PR) in healthcare. Of 1,053 papers identified in their search, only 62 met their criteria for inclusion in the review. The authors used a Knowledge, Attitudes and Behaviour (KAB) model for their analysis. Of the 63 papers reviewed, most related to individual consumers and groups of providers, fewer related to groups of consumers and individual providers. The principal findings were that there is a shortfall in the literature on PR to 2004 and limited evidence that PR is having any impact on KAB of consumers or providers. They appropriately conclude that there is a need for the development of a conceptual model and thereby the requirement that the goal of placing PR "within a context that focuses attention and that supports action" may be achieved. In general, the conclusions are defensible and, given the lack of impact of PR they have demonstrated, their work should stimulate response and action within healthcare systems. Finally, this paper concludes by proposing six characteristics of successful PR--clear definition of context and goals, objective and verifiable indicators, transparent and useable information, equitability in scope, engaging the continuum of care, and integrating measures of cost-utility.

Medves, J., et al. (2010). "Systematic review of practice guideline dissemination and implementation strategies for healthcare teams and team-based practice." Int J Evid Based Healthc **8**(2): 79-89.

AIM: To synthesis the literature relevant to guideline dissemination and implementation strategies for healthcare teams and team-based practice. METHODS: Systematic approach utilising Joanna Briggs Institute methods. Two reviewers screened all articles and where there was disagreement, a third reviewer determined inclusion. RESULTS: Initial search revealed 12,083 of which 88 met the inclusion criteria. Ten dissemination and implementation strategies identified with distribution of educational materials the most common. Studies were assessed for patient or practitioner outcomes and changes in practice, knowledge and economic outcomes. A descriptive analysis revealed multiple approaches using teams of healthcare providers were reported to have statistically significant results in knowledge, practice and/or outcomes for 72.7% of the studies. CONCLUSION: Team-based care using practice guidelines locally adapted can affect positively patient and provider outcomes.

Meltzer, D. O. et Chung, J. W. (2014). "The population value of quality indicator reporting: a framework for prioritizing health care performance measures." Health Aff.(Millwood.) **33**(1): 132-139. PM:24395945

The Agency for Healthcare Research and Quality (AHRQ) National Healthcare Quality and Disparities Reports contain more than 250 quality indicators, such as whether a patient with a suspected heart attack received an aspirin. The Department of Health and Human Services National Quality Measures Clearinghouse identifies more than 2,100 such indicators. Because resources for making quality improvements are limited, there is a need to prioritize among these indicators. We propose an approach to assess how reporting specific quality indicators would change care to improve the length and quality of life of the US population. Using thirteen AHRQ quality indicators with readily available data on the benefits of indicator reporting, we found that seven of them account for 93 percent of total benefits, while the remaining six account for only 7 percent of total benefits. Use of a framework such as this could focus resources on indicators having the greatest expected impact on population health

Merkow, R. P., et al. (2014). "Relationship between cancer center accreditation and performance on publicly reported quality measures." Ann Surg **259**(6): 1091-1097.

OBJECTIVE: To evaluate differences in hospital structural quality characteristics and assess the association between national publicly reported quality indicators and cancer center accreditation status. BACKGROUND: Cancer center accreditation and public reporting are 2 approaches available to help guide patients with cancer to high-quality hospitals. It is unknown whether hospital performance on

these measures differs by cancer accreditation. METHODS: Data from Medicare's Hospital Compare and the American Hospital Association were merged. Hospitals were categorized into 3 mutually exclusive groups: National Cancer Institute-Designated Cancer Centers (NCI-CCs), Commission on Cancer (CoC) centers, and "nonaccredited" hospitals. Performance was assessed on the basis of structural, processes-of-care, patient-reported experiences, costs, and outcomes. RESULTS: A total of 3563 hospitals (56 NCI-CCs, 1112 CoC centers, and 2395 nonaccredited hospitals) were eligible for analysis. Cancer centers (NCI-CCs and CoC centers) were more likely larger, higher volume teaching hospitals with additional services and specialists than nonaccredited hospitals (P < 0.001). Cancer centers performed better on 3 of 4 process measures, 8 of 10 patient-reported experience measures, and Medicare spending per beneficiary than nonaccredited hospitals. NCI-CCs performed worse than both CoC centers and nonaccredited hospitals on 8 of 10 outcome measures. Similarly, CoC centers performed worse than nonaccredited hospitals on 5 measures. For example, 35% of NCI-CCs, 13.5% of CoC centers, and 3.5% of nonaccredited hospitals were poor performers for serious complications. CONCLUSIONS: Accredited cancer centers performed better on most process and patient experience measures but showed worse performance on most outcome measures. These discordant findings emphasize the need to focus on oncology-specific measurement strategies.

Mockford, C., et al. (2012). "The impact of patient and public involvement on UK NHS health care: a systematic review." Int J Qual Health Care **24**(1): 28-38.

PURPOSE: Patient and public involvement (PPI) has become an integral part of health care with its emphasis on including and empowering individuals and communities in the shaping of health and social care services. The aims of this study were to identify the impact of PPI on UK National Health Service (NHS) healthcare services and to identify the economic cost. It also examined how PPI is being defined, theorized and conceptualized, and how the impact of PPI is captured or measured. DATA SOURCES: Seventeen key online databases and websites were searched, e.g. Medline and the King's Fund. STUDY SELECTION: UK studies from 1997 to 2009 which included service user involvement in NHS healthcare services. Date extraction Key themes were identified and a narrative analysis was undertaken. RESULTS OF DATA SYNTHESIS: The review indicates that PPI has a range of impacts on healthcare services. There is little evidence of any economic analysis of the costs involved. A key limitation of the PPI evidence base is the poor quality of reporting impact. Few studies define PPI, there is little theoretical underpinning or conceptualization reported, there is an absence of robust measurement of impact and descriptive evidence lacked detail. CONCLUSION: There is a need for significant development of the PPI evidence base particularly around guidance for the reporting of user activity and impact. The evidence base needs to be significantly strengthened to ensure the full impact of involving service users in NHS healthcare services is fully understood.

Mor, V. (2005). "Improving the quality of long-term care with better information." Milbank Q **83**(3): 333-364.

Publicly reporting information stimulates providers' efforts to improve the quality of health care. The availability of mandated, uniform clinical data in all nursing homes and home health agencies has facilitated the public reporting of comparative quality data. This article reviews the conceptual and technical challenges of applying information about the quality of long-term care providers and the evidence for the impact of information-based quality improvement. Quality "tools" have been used despite questions about the validity of the measures and their use in selecting providers or offering them bonus payments. Although the industry now realizes the importance of quality, research still is needed on how consumers use this information to select providers and monitor their performance and whether these efforts actually improve the outcomes of care.

Morsi, E., et al. (2012). "Primary care physicians' use of publicly reported quality data in hospital referral decisions." J Hosp Med **7**(5): 370-375.

BACKGROUND: Despite government investment in public reporting of hospital quality data, patients still rely on recommendations from their primary care physicians (PCPs). Little is known about how physicians make hospital referrals. OBJECTIVE: To characterize factors that influence PCPs' hospital referral choices. DESIGN: Web-based physician survey. PARTICIPANTS: PCPs affiliated with 3 Massachusetts hospitals. MAIN MEASURES: Physician demographics, familiarity with public reporting, and opinions about which factors would influence hospital referral decisions for an elderly patient with pneumonia. RESULTS: Of

194 PCPs who received invitations, 92 (47%) responded. Although 93% maintained admitting privileges, only 20% admitted patients. The following were considered "very" important in referral decisions: "familiarity with the hospital" (70%), "patient preference" (62%), and "admitting arrangements with a hospitalist group" (62%). "Publicly available quality measures" were "not at all" important to 42%. Only 61% were aware of hospital quality reporting; 16% were familiar with Hospital Compare, a Centers for Medicare and Medicaid Services (CMS) Web site. No physicians reported ever using quality information to make a referral decision or discussing it with patients. No physician factors were associated with awareness of publicly reported data. PCPs identified the following factors as being "very" important in determining the quality of pneumonia care: antibiotics within 6 hours of arrival (66%), appropriate initial antibiotic (63%), and blood cultures performed prior to the administration of antibiotics (51%). CONCLUSIONS: Although PCPs most valued the information available through Hospital Compare, only 16% were aware of it, and none used publicly reported quality data in referral decisions. Medicare and high-performing hospitals should consider marketing Hospital Compare to PCPs.

Mukamel, D. B., et al. (2010). "Measuring quality for public reporting of health provider quality: making it meaningful to patients." Am J Public Health **100**(2): 264-269.

Public quality reports of hospitals, health plans, and physicians are being used to promote efficiency and quality in the health care system. Shrinkage estimators have been proposed as superior measures of quality to be used in these reports because they offer more conservative and stable quality ranking of providers than traditional, nonshrinkage estimators. Adopting the perspective of a patient faced with choosing a local provider on the basis of publicly provided information, we examine the advantages and disadvantages of shrinkage and nonshrinkage estimators and contrast the information made available by them. We demonstrate that 2 properties of shrinkage estimators make them less useful than nonshrinkage estimators for patients making choices in their area of residence.

Najjar, P., et al. (2015). "A multidisciplinary three-phase approach to improve the clinical utility of patient safety indicators." Qual Manag Health Care **24**(2): 62-68.

PURPOSE: The AHRQ Patient Safety Indicators (PSIs) are used for calculation of risk-adjusted postoperative rates for adverse events. The payers and quality consortiums are increasingly requiring public reporting of hospital performance on these metrics. We discuss processes designed to improve the accuracy and clinical utility of PSI reporting in practice. METHODS: The study was conducted at a 793-bed tertiary care academic medical center where PSI processes have been aggressively implemented to track patient safety events at discharge. A three-phased approach to improving administrative data quality was implemented. The initiative consisted of clinical review of all PSIs, documentation improvement, and provider outreach including active querying for patient safety events. RESULTS: This multidisciplinary effort to develop a streamlined process for PSI calculation reduced the reporting of miscoded PSIs and increased the clinical utility of PSI monitoring. Over 4 quarters, 4 of 41 (10%) PSI-11 and 9 of 138 (7%) PSI-15 errors were identified on review of clinical documentation and appropriate adjustments were made. CONCLUSION: A multidisciplinary, phased approach leveraging existing billing infrastructure for robust metric coding, ongoing clinical review, and frontline provider outreach is a novel and effective way to reduce the reporting of false-positive outcomes and improve the clinical utility of PSIs.

Natale, J. E., et al. (2011). "Benchmarking, public reporting, and pay-for-performance: a mixed-methods survey of California pediatric intensive care unit medical directors." Pediatr Crit Care Med **12**(6): e225-232.

OBJECTIVES: We sought to assess the attitudes of pediatric intensive care unit medical directors in California regarding the need for, the validity of, and the potential impact of benchmarking, public reporting, and pay-for-performance on pediatric critical care. DESIGN: Cross-sectional survey. SETTING: Pediatric intensive care units in California. SUBJECTS: Medical directors of pediatric intensive care units. INTERVENTIONS: None. MEASUREMENTS AND MAIN RESULTS: Self-administered questionnaire and a semi-structured phone interview from 16 pediatric intensive care unit medical directors. All data were anonymized before review. Standard methods for identifying and agreeing on themes in transcribed interviews were applied. Seventy-three percent of California pediatric intensive care unit medical directors agree that benchmarking improves patient outcomes but are undecided whether public reporting and pay-for-performance improve healthcare quality. They are wary of the validity of data used

to generate these performance measures and are discouraged by the time and costs required to collect data for standard performance outcomes (severity-adjusted pediatric intensive care unit mortality). Leadership opinions appear potentially "dynamic" in multiple domains and across each of the measures assessed. CONCLUSIONS: Pediatric intensive care unit medical directors sometimes express contradictory opinions about the merits of shared benchmarking efforts and express concerns across a range of logistic, methodological, and policy issues. These findings raise fundamental questions about how to create clinical performance standards that facilitate quality improvement in the face of a seriously divided constituency. Further, we propose that pediatric intensive care unit medical directors play more active roles in the development, implementation, and communication of shared state-wide data collection.

Nelson, E. C., et al. (2005). "Publicly reporting comprehensive quality and cost data: a health care system's transparency initiative." Jt Comm J Qual Patient Saf **31**(10): 573-584.

BACKGROUND: Transparency in health care, including the public reporting of health care results, is an expanding and unstoppable phenomenon. Health care systems have an opportunity to: (1) be proactive and accountable for the care they provide, (2) help patients learn more about their condition as a supplement to understanding the performance measures, and (3) use public reporting to foster process of care and outcome improvement initiatives. An overview is provided of the first 22 months of a transparency initiative at Dartmouth-Hitchcock Medical Center (DHMC). LAUNCHING THE TRANSPARENCY INITIATIVE: An interdisciplinary operations group works with the various clinical programs--both providers and patients--to identify what quality and cost measures are most desired by patients and what measures are the focus of the clinical program's internal measurement and reporting processes. The measures are presented on the DHMC Web site, with access to additional resources, such as clinical decision aids. DISCUSSION: A variety of factors are important to the transparency initiative--senior leaders' perceptions, risk management issues, resources required for the design and maintenance of the initiative, and developing both methodological protocols and technical systems.

Nicklin, W., et al. (2005). "Performance reporting: alignment with accreditation." Healthc Pap **6**(2): 50-56.

This paper reviews the strong relationship of performance measurement and reporting with the Canadian Council on Health Services Accreditation (CCHSA) accreditation program and consistency with the direction of ongoing development. The CCHSA authors discuss the issue of public reporting of the accreditation results, the impact of public reporting on accreditation, aligning accreditation with the public reporting requirements, the measurement framework, quality improvement results and reporting and the linkage of accreditation with accountability. As public reporting gains momentum, the accreditation program must align to enable this while protecting the fundamental integrity and value of the program. Participating in the accreditation program clearly demonstrates the organization's commitment to accountability.

Nimptsch, U., et al. (2016). "[Impact of quality measurement, transparency and peer review on in-hospital mortality - retrospective before-after study with 63 hospitals]." Z Evid Fortbild Qual Gesundhwes **115-116**: 10-23.

BACKGROUND: In 2008 the 'Initiative Qualitatsmedizin' (initiative for quality in medical care, IQM) was established as a voluntary non-profit association of hospital providers of all kinds of ownership. Currently, about 350 hospitals from Germany and Switzerland participate in IQM. Member hospitals are committed to a quality strategy based on measuring outcome indicators using administrative data, peer review procedures to improve medical quality, and transparency by public reporting. This study aims to investigate whether voluntary implementation of this approach is associated with improvements in medical outcome. METHODS: Within a retrospective before-after study 63 hospitals, which started to participate in IQM between 2009 and 2011, were monitored. In-hospital mortality in these hospitals was studied for 14 selected inpatient services in comparison to the German national average. The analyses examine whether in-hospital mortality declined after participation of the studied hospitals in IQM, independently of secular trends or deviations in case mix when compared to the national average, and whether such findings were associated with initial hospital performance or peer review procedures. RESULTS: Declining in-hospital mortality was observed in hospitals with initially subpar performance. These declines were statistically significant for treatment of myocardial infarction, heart failure, pneumonia, and septicemia. Similar, but statistically non-significant trends were observed for nine further treatments. Following peer-review procedures significant declines in in-hospital mortality were observed

for treatments of myocardial infarction, heart failure, and pneumonia. Mortality declines after peer reviews regarding stroke, hip fracture and colorectal resection were not significant, and after peer reviews regarding mechanically ventilated patients no changes were observed. CONCLUSION: The results point to a positive impact of the quality approach applied by IQM on clinical outcomes. A more targeted selection of hospitals to be peer-reviewed might further enhance the impact of this approach.

O'Neill, E. et Humphreys, H. (2009). "Use of surveillance data for prevention of healthcare-associated infection: risk adjustment and reporting dilemmas." Curr Opin Infect Dis **22**(4): 359-363.

PURPOSE OF REVIEW: Healthcare-associated or nosocomial infection (HCAI) is of increasing importance to healthcare providers and the public. Surveillance is crucial but must be adjusted for risk, especially when used for interhospital comparisons or for public reporting. RECENT FINDINGS: Surveillance data are increasingly adjusted for risk factors for HCAI if meaningful comparisons are made between institutions or across national boundaries. Postdischarge surveillance is important in detecting those infections that may not present to the institution in which the original procedure occurred. Caution is urged when comparing data from two sources, for example, an active surveillance program and administrative datasets. The public reporting of HCAI rates can assist in improving the quality of healthcare, but to date there is little evidence that this is happening. In the United States, a number of states have introduced mandatory reporting of HCAIs, but there is considerable variation in what data are released, how these are reported and the rigor of the validation of the dataset. SUMMARY: The consumerization of healthcare requires a response from healthcare providers to engage with the public on how, when and what risk-adjusted surveillance data to release. Information campaigns are required to ensure the public understand any publicly released data and its limitations.

Parast, L., et al. (2015). "Challenges in assessing the process-outcome link in practice." J Gen Intern Med **30**(3): 359-364.

The expanded use of clinical process-of-care measures to assess the quality of health care in the context of public reporting and pay-for-performance applications has led to a desire to demonstrate the value of such efforts in terms of improved patient outcomes. The inability to observe associations between improved delivery of clinical processes and improved clinical outcomes in practice has raised concerns about the value of holding providers accountable for delivery of clinical processes of care. Analyses that attempt to investigate this relationship are fraught with many challenges, including selection of an appropriate outcome, the proximity of the outcome to the receipt of the clinical process, limited power to detect an effect, small expected effect sizes in practice, potential bias due to unmeasured confounding factors, and difficulties due to changes in measure specification over time. To avoid potentially misleading conclusions about an observed or lack of observed association between a clinical process of care and an outcome in the context of observational studies, individuals conducting and interpreting such studies should carefully consider, evaluate, and acknowledge these types of challenges.

Paris, V. et Polton, D. (2005). Development of a methodology for collection and analysis of data on efficiency and effectiveness in health care provision. Rapport Irdes. Paris IRDES**:** 143.
http://forum.europa.eu.int/irc/DownLoad/kfeuAUJCmXGRui5-HDPDBYExBIKZOH3t3p4Sm0Fc6BADOpGuFl2e7fdGIlxwQGaBFj50JU/SHA%20Efficiency%20%26%20Effectiveness%20January%202005.pdf - http://forum.europa.eu.int/Public/irc/dsis/health/library => Reports and ongoing developments => Health care

This report presents a proposal for a set of indicators on health system performance to be developed from the system of health accounts (SHA) and other relevant data in European countries. The proposed indicators relate to four dimensions of health system performance : sustainability, efficiency, effectiveness and access including equity. The choice of dimensions, and their related indicators, has been guided by European Union policy objectives for health and health care, and a review of recent and ongoing work on measuring health system performance by academic researchers, national governments and international organisations. This work carried out to produce this report has been done within two Eurostat grant-funded projects : Development of a methodology for collection and analysis data on efficiency and effectiveness in health care provision and system of health accounts in the EU, definition of a minimum data set and of additional information needed to analyse and evaluate SHA.

Park, J. et Werner, R. M. (2011). "Changes in the relationship between nursing home financial performance and quality of care under public reporting." Health Econ **20**(7): 783-801.

The relationship between financial performance and quality of care in nursing homes is not well defined and prior work has been mixed. The recent focus on improving the quality of nursing homes through market-based incentives such as public reporting may have changed this relationship, as public reporting provides nursing homes with increased incentives to engage in quality-based competition. If quality improvement activities require substantial production costs, nursing home profitability may become a more important predictor of quality under public reporting. This study explores the relationship between financial performance and quality of care and test whether this relationship changes under public reporting. Using a 10-year (fiscal years 1997-2006) panel data set of 9444 skilled nursing facilities in the US, this study employs a facility fixed-effects with and without instrumental variables approach to test the effect of finances on quality improvement and correct for potential endogeneity. The results show that better financial performance, as reflected by the 1-year lagged total profit margin, is modestly associated with higher quality but only after public reporting is initiated. These findings have important policy implications as federal and state governments use market-based incentives to increase demand for high-quality care and induce providers to compete based on quality.

Parsons, A., et al. (2012). "Validity of electronic health record-derived quality measurement for performance monitoring." J Am Med Inform Assoc **19**(4): 604-609.

BACKGROUND: Since 2007, New York City's primary care information project has assisted over 3000 providers to adopt and use a prevention-oriented electronic health record (EHR). Participating practices were taught to re-adjust their workflows to use the EHR built-in population health monitoring tools, including automated quality measures, patient registries and a clinical decision support system. Practices received a comprehensive suite of technical assistance, which included quality improvement, EHR customization and configuration, privacy and security training, and revenue cycle optimization. These services were aimed at helping providers understand how to use their EHR to track and improve the quality of care delivered to patients. MATERIALS AND METHODS: Retrospective electronic chart reviews of 4081 patient records across 57 practices were analyzed to determine the validity of EHR-derived quality measures and documented preventive services. RESULTS: Results from this study show that workflow and documentation habits have a profound impact on EHR-derived quality measures. Compared with the manual review of electronic charts, EHR-derived measures can undercount practice performance, with a disproportionately negative impact on the number of patients captured as receiving a clinical preventive service or meeting a recommended treatment goal. CONCLUSION: This study provides a cautionary note in using EHR-derived measurement for public reporting of provider performance or use for payment.

Pencheon, D. (2008). The Good Indicators Guide: Understanding how to use and choose indicators, Coventry : NHS Institute for Innovation and Improvement.
http://www.apho.org.uk/resource/item.aspx?RID=44584

This guide is intended to be a short, practical resource for anyone in any health system who is responsible for using indicators to monitor and improve performance, systems or outcomes.

Peters, E., et al. (2007). "Less is more in presenting quality information to consumers." Med Care Res Rev **64**(2): 169-190.

Much effort has been put into improving measures of health care quality. Although early research suggested that consumers made little use of quality reports, most reports were based on nonstandardized measures and were not user friendly. Information presentation approaches, however, will have a significant influence on what information is attended and used. The present research examines whether information presentation methods differentially influence consumers who differ in numeric skills. Results of three studies support the idea that "less is more" when presenting consumers with comparative performance information to make hospital choices. Results were particularly strong for those lower in numeracy, who had higher comprehension and made better choices when the information-presentation format was designed to ease the cognitive burden and highlight the meaning of important information. These findings have important implications for the sponsors of comparative quality reports designed to inform consumer decision making in health care.

Petticrew, M., et al. (1999). "Quality-assessed reviews of health care interventions and the database of abstracts of reviews of effectiveness (DARE). NHS CRD Review, Dissemination, and Information Teams." Int J Technol Assess Health Care **15**(4): 671-678.

OBJECTIVES: Database of Abstracts of Reviews of Effectiveness (DARE) (http:@www.york.ac.uk/inst/crd/) at the NHS Centre for Reviews and Dissemination provides a unique international resource of structured summaries of quality-assessed reviews of health care interventions. These reviews have been identified from searches of electronic databases and by hand-searching journals. This paper describes and summarizes the DARE database, including the topic areas covered and the review methods used. METHODS: The first 480 structured abstracts on the DARE database were summarized. Data were extracted from each database field and coded for analysis. RESULTS: Most of the systematic reviews investigated the effectiveness of treatments: 54% investigated the effectiveness of medical therapies, and 10% assessed surgical interventions. Around two-thirds used meta-analytic methods to combine primary studies. The quality of the reviews was variable, with just over half of the reviews (52%, n = 251) having systematically assessed the validity of the included primary studies. Narrative reviews were more likely than meta-analyses to reach negative conclusions (42% vs. 25%, p = .0001). The 21 reviews that reported drug company funding were more likely to reach positive conclusions (81% vs. 66%, p = .15). CONCLUSION: The DARE database is a valuable source of quality-assessed systematic reviews, and is free and easily accessible. It provides a valuable online resource to help in filtering out poorer quality reviews when assessing the effectiveness of health technologies.

Pham, H. H., et al. (2006). "The impact of quality-reporting programs on hospital operations." Health Aff (Millwood) **25**(5): 1412-1422.

We used data from the 2005-06 Community Tracking Study site visits to examine the impact of quality reporting on hospitals' data collection and review processes, feedback and accountability mechanisms, quality improvement activities, and resource allocation. Individual hospitals participate in multiple, varied reporting programs with distinct effects on hospital operations. Reporting programs play complementary roles in encouraging quality improvement but are poorly coordinated and command sizable resources, in large part because of inadequate information technology. Policy should be directed at encouraging formal assessments of how individual and combinations of programs affect quality outcomes, and the development of adaptable information systems.

Prince, P. et Willett, P. (2014). "The mental health and addictions quality initiative: collaboration in public reporting and quality improvement." Healthc Manage Forum **27**(1): 25-29.

Provincial and national initiatives to measure healthcare performance have primarily focused on general hospital care, with little or no attention paid to developing indicators appropriate for specialized mental health services. Officially launched in 2011, a key objective of the Mental Health and Addictions Quality Initiative is to improve the quality of care through collaboration and transparency. Standardized mental health and addictions indicators reflective of hospital accountability and accessible to the public were developed and are currently compared among 15 hospitals.

Pussegoda, K., et al. (2017). "Systematic review adherence to methodological or reporting quality." Syst Rev **6**(1): 131.
https://doi.org/10.1186/s13643-017-0527-2

Guidelines for assessing methodological and reporting quality of systematic reviews (SRs) were developed to contribute to implementing evidence-based health care and the reduction of research waste. As SRs assessing a cohort of SRs is becoming more prevalent in the literature and with the increased uptake of SR evidence for decision-making, methodological quality and standard of reporting of SRs is of interest. The objective of this study is to evaluate SR adherence to the Quality of Reporting of Meta-analyses (QUOROM) and PRISMA reporting guidelines and the A Measurement Tool to Assess Systematic Reviews (AMSTAR) and Overview Quality Assessment Questionnaire (OQAQ) quality assessment tools as evaluated in methodological overviews.

Rechel, B., et al. (2016). "Public reporting on quality, waiting times and patient experience in 11 high-income countries." Health Policy **120**(4): 377-383.

This article maps current approaches to public reporting on waiting times, patient experience and aggregate measures of quality and safety in 11 high-income countries (Australia, Canada, England, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland and the United States). Using a questionnaire-based survey of key national informants, we found that the data most commonly made available to the public are on waiting times for hospital treatment, being reported for major hospitals in seven countries. Information on patient experience at hospital level is also made available in many countries, but it is not generally available in respect of primary care services. Only one of the 11 countries (England) publishes composite measures of overall quality and safety of care that allow the ranking of providers of hospital care. Similarly, the publication of information on outcomes of individual physicians remains rare. We conclude that public reporting of aggregate measures of quality and safety, as well as of outcomes of individual physicians, remain relatively uncommon. This is likely to be due to both unresolved methodological and ethical problems and concerns that public reporting may lead to unintended consequences.

Reiter, A., et al. (2011). "Selection of hospital quality indicators for public disclosure in Germany." Z Evid Fortbild Qual Gesundhwes **105**(1): 44-48.

OBJECTIVES: This paper introduces the QUALIFY instrument as an indicator assessment method used to select quality indicators suitable for public disclosure in Germany. METHODS: Fifty-five hospital quality indicators previously approved in routine use were systematically tested for suitability in public disclosure. A multi-disciplinary expert team including patient representatives used the QUALIFY instrument to assess the methodological quality of these indicators in detailed respect to their purpose. The team applied 14 of the 20 QUALIFY criteria to each indicator, the minimum acceptance level for public reporting was determined in advance. RESULTS: Thirty one indicators from eleven clinical conditions fulfilled all fourteen methodological criteria required for national reporting. They include eleven outcome and twenty process indicators. CONCLUSIONS: QUALIFY proved to be a useful tool for selecting quality indicators suitable for public disclosure and thus contributes substantially to proper information on German hospital quality. It ensures high transparency in a very sensitive context to all stakeholders.

Renzi, C., et al. (2014). "Does public reporting improve the quality of hospital care for acute myocardial infarction? Results from a regional outcome evaluation program in Italy." Int J Qual Health Care **26**(3): 223-230.

OBJECTIVE: To evaluate whether public reporting of performance data was associated with a change over time in quality indicators for acute myocardial infarction (AMI) in Italian hospitals. DESIGN: Pre-post evaluation of AMI indicators in the Lazio region, before and after disclosure of the Regional Outcome Evaluation Program, and a comparative evaluation versus other Italian regions not participating in the program. SETTING/DATA SOURCES: Nationwide Hospital Information System and vital status records. PARTICIPANTS: 24 800 patients treated for AMI in Lazio and 39 350 in the other regions. INTERVENTION: Public reporting of the Regional Outcome Evaluation Program in the Lazio region. MAIN OUTCOME MEASURE: Risk-adjusted indicators for AMI. RESULTS: The proportion of ST-segment elevation myocardial infarction (STEMI) patients treated with percutaneous coronary interventions (PCI) within 48 h in Lazio changed from 31.3 to 48.7%, before and after public reporting, respectively (relative increase 56%; P < 0.001). In the other regions, the proportion increased from 51.5 to 58.4% (relative increase 13%; P < 0.001). Overall 30-day mortality and 30-day mortality for patients treated with PCI did not improve during the study period. The 30-day mortality for STEMI patients not treated with PCI in Lazio was significantly higher in 2009 (29.0%) versus 2006/07 (24.0%) (P = .002). CONCLUSIONS: Public reporting may have contributed to increasing the proportion of STEMI patients treated with timely PCI. The mortality outcomes should be interpreted with caution. Changes in AMI diagnostic and coding systems should also be considered. Risk-adjusted quality indicators represent a fundamental instrument for monitoring and potentially enhancing quality of care.

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Renzi, C., et al. (2012). "Reporting of quality indicators and improvement in hospital performance: the p.re.val.e. Regional outcome evaluation program." Health Serv Res **47**(5): 1880-1901.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3513610/pdf/hesr0047-1880.pdf

OBJECTIVE: To evaluate whether reporting of hospital performance was associated with a change in quality indicators in Italian hospitals. DATA SOURCES/STUDY SETTING: Nationwide Hospital Information System for 2006-2009. STUDY DESIGN: We performed a pre-post evaluation in Lazio (before and after disclosure of the Regional Outcome Evaluation Program P.Re.Val.E.) and a comparative evaluation versus Italian regions without comparable programs. We analyzed risk-adjusted proportions of percutaneous coronary intervention (PCI), hip fractures operated on within 48 hours, and cesarean deliveries. DATA COLLECTION/EXTRACTION METHODS: Using standardized ICD-9-CM coding algorithms, we selected 381,053 acute myocardial infarction patients, 250,712 hip fractures, and 1,736,970 women who had given birth. PRINCIPAL FINDINGS: In Lazio PCI within 48 hours changed from 22.49 to 29.43 percent following reporting of the P.Re.Val.E results (relative increase, 31 percent; p < .001). In the other regions this proportion increased from 22.48 to 27.09 percent during the same time period (relative increase, 21 percent; p < .001). Hip fractures operated on within 48 hours increased from 11.73 to 15.78 percent (relative increase, 34 percent; p < .001) in Lazio, and not in other regions (29.36 to 28.57 percent). Cesarean deliveries did not decrease in Lazio (34.57-35.30 percent), and only slightly decreased in the other regions (30.49-28.11 percent). CONCLUSIONS: Reporting of performance data may have a positive but limited impact on quality improvement. The evaluation of quality indicators remains paramount for public accountability

Riga, M., et al. (2015). "MERIS (Medical Error Reporting Information System) as an innovative patient safety intervention: a health policy perspective." Health Policy **119**(4): 539-548.

The economic crisis in Greece poses the necessity to resolve problems concerning both the spiralling cost and the quality assurance in the health system. The detection and the analysis of patient adverse events and medical errors are considered crucial elements of this course. The implementation of MERIS embodies a mandatory module, which adopts the trigger tool methodology for measuring adverse events and medical errors an intensive care unit [ICU] environment, and a voluntary one with web-based public reporting methodology. A pilot implementation of MERIS running in a public hospital identified 35 adverse events, with approx. 12 additional hospital days and an extra healthcare cost of euro12,000 per adverse event or of about euro312,000 per annum for ICU costs only. At the same time, the voluntary module unveiled 510 reports on adverse events submitted by citizens or patients. MERIS has been evaluated as a comprehensive and effective system; it succeeded in detecting the main factors that cause adverse events and discloses severe omissions of the Greek health system. MERIS may be incorporated and run efficiently nationally, adapted to the needs and peculiarities of each hospital or clinic.

Rinke, M. L., et al. (2015). "State-Mandated Hospital Infection Reporting Is Not Associated With Decreased Pediatric Health Care-Associated Infections." J Patient Saf **11**(3): 123-134.

OBJECTIVES: State governments increasingly mandate public reporting of central line-associated blood stream infections (CLABSIs). This study tests if hospitals located in states with state-mandated, facility-identified, pediatric-specific public CLABSI reporting have lower rates of CLABSIs as defined by the Agency for Healthcare Research and Quality's Pediatric Quality Indicator 12 (PDI12). METHODS: Utilizing the Kids' Inpatient Databases from 2000 to 2009, we compared changes in PDI12 rates across three groups of states: states with public CLABSI reporting begun by 2006, states with public reporting begun by 2009 and never-reporting states. In the baseline period (2000-2003), no states mandated public CLABSI reporting. A multivariable, hospital-level random intercept, logistic regression was performed comparing changes in PDI12 rates in states with public reporting to changes in PDI12 rates in never-reporting states. RESULTS: 4,705,857 discharge records were eligible for PDI12. PDI12 rates significantly decreased in all reporting groups, comparing baseline to the post-public reporting period (2009): Never Reporters 88% decrease (95% CI, 86%-89%), Reporting Begun by 2006 90% decrease (95% CI, 83%-94%), and Reporting Begun by 2009 74% decrease (95% CI, 72%-76%). The Never Reporting Group had comparable decreases in PDI12 rates to the Reporting Begun by 2006 group (P = 0.4) and significantly larger decreases in PDI12 rates compared to the Reporting Begun by 2009 group (P < 0.001), despite having no states with public reporting. CONCLUSIONS: Public CLABSI reporting alone appears to be insufficient to affect administrative data-based measures of pediatric CLABSI rates or children may be inadequately targeted in current public reporting efforts.

Robinowitz, D. L. et Dudley, R. A. (2006). "Public reporting of provider performance: can its impact be made greater?" Annu Rev Public Health **27**: 517-536.

Public reporting of provider performance is becoming increasingly commonplace. In this chapter, we first review studies of prior public reports (or report cards) that show real but small impact on provider attempts to improve quality, on consumers' impressions of providers, and even on consumer selection of providers. Among other factors, two potential explanations for the low level of impact are that, in most early reports, the large majority of providers have been labeled "average" and consumers may have had difficulty understanding the statistical assessments. In response, some current report card producers are using or considering a variety of methods to increase the number of distinctions among providers and the ease of comprehension of the labels used. Therefore, we also consider the advantages and disadvantages of several novel approaches to analyzing and reporting provider performance.

Robinson, J. C., et al. (2009). "Measurement of and reward for efficiency In California's pay-for-performance program." Health Aff (Millwood) **28**(5): 1438-1447.

Pay-for-performance (P4P) programs are expanding their purview from quality to include efficiency, and many consider the episode of care as the appropriate unit of measurement. Two years' experience by the California P4P program, however, reveals that the requisite claims data often are incomplete or poorly coded and that even large physician groups have too few patients experiencing most types of episodes to permit statistically valid measurement for public reporting and incentive payment. The California P4P program is shifting its efficiency focus to metrics not reliant on episode measurement while shifting episode measurement to supporting bundled payment for acute surgical and medical interventions.

Rodrigues, R., et al. (2014). "The public gets what the public wants: experiences of public reporting in long-term care in Europe." Health Policy **116**(1): 84-94.

INTRODUCTION: Public reporting of quality in long-term care is advocated on the basis of allowing providers to improve their performance by benchmarking and supporting users to choose the best providers. Both mechanisms are intended to drive improvements in quality. However, there is relatively scarce comparative research on the experiences and impact of public reporting on quality in long-term care in Europe. METHODS: Using information gathered from key informants by means of a structured questionnaire and country profiles, this paper discusses experiences with public reporting mechanisms in seven European countries and available information on their impact on quality in long-term care. RESULTS: Countries surveyed included a variety of public reporting schemes, ranging from pilot programmes to statutory mechanisms. Public reporting mechanisms more often focus on institutional care. Inspections carried out as part of a legal quality assurance framework are the main source of information gathering, supplemented by provider self-assessments in the context of internal quality management and user satisfaction surveys. Information on quality goes well beyond structural indicators

to also include indicators on quality of life of users. Information is displayed using numerical scores (percentages), but also measures such as ratings (similar to school grades) and ticks and crosses. Only one country corrects for case-mix. The internet is the preferred medium of displaying information. DISCUSSION: There was little evidence to show whether public reporting has a significant impact on driving users' choices of provider. Studies reported low awareness of quality indicators among potential end users and information was not always displayed in a convenient format, e.g. through complicated numerical scores. There is scarce evidence of public reporting directly causing improved quality, although the relative youth and the pilot characteristics of some of the schemes covered here could also have contributed to downplay their impact. The establishment of public reporting mechanisms did however contribute to shaping the discussion on quality measurement in several of the countries surveyed. CONCLUSIONS: The findings presented in this paper highlight the need to consider some factors in the discussion of the impact of public reporting in long-term care, namely, the organisation of care markets, frequently characterised by limited competition; the circumstances under which user choice takes place, often made under conditions of duress; and the leadership conditions needed to bring about improvements in quality in different care settings.

Rodriguez, H. P., et al. (2012). "The reliability of medical group performance measurement in a single insurer's pay for performance program." Med Care **50**(2): 117-123.

BACKGROUND: Most public reporting and pay for performance (P4P) programs in the United States continue to be organized and implemented by single insurers. Adequate medical group-level reliability on clinical care process measures is possible in multistakeholder initiatives because patient samples can be pooled across payers. However, the extent to which reliable measurement is achievable in single insurer P4P initiatives remains unclear. METHODS: This study uses 7 years (2001 to 2007) of patient-level clinical care process data from an insurer in Washington State involving 20 medical groups. Eight clinical care process measures were analyzed. We compared the medical group-level reliability and resulting sample size requirements for each of the 8 measures using unadjusted and adjusted binary mixed models. The relation of baseline intraclass correlation coefficients (ICCs) and medical group performance change over time was examined for each clinical care process measure. RESULTS: Only 45% of all medical group measurements (group-years for all observations) had sufficient sample sizes to achieve reliable estimates of group performance. Measures with the largest deficiencies in patient samples per group included appropriate asthma treatment and low-density lipoprotein screening for patients with coronary artery disease. There was an inconsistent relationship between the size of baseline ICCs and medical group performance improvement over time. CONCLUSIONS: Unreliable performance measurement is an important consequence of the prevailing organization and implementation of public reporting and P4P programs in the US. Multi-payer collaborations may be an important vehicle for ensuring reliable medical group performance measurement and comparisons on clinical care process measures.

Rosenthal, M. B., et al. (2004). "Paying for quality: providers' incentives for quality improvement." Health Aff (Millwood) **23**(2): 127-141.

Paying health care providers to meet quality goals is an idea with widespread appeal, given the common perception that quality of care in the United States remains unacceptably low despite a decade of benchmarking and public reporting. There has been little critical analysis of the design of the current generation of quality incentive programs. In this paper we examine public reports of paying for quality over the past five years and assess each of the identified programs in terms of key design features, including the market share of payers, the structure of the reward system, the amount of revenue at stake, and the targeted domains of health care quality.

Rotar, A. M., et al. (2016). "Reporting and use of the OECD Health Care Quality Indicators at national and regional level in 15 countries." International Journal for Quality in Health Care **28**(3): 398-404. http://intqhc.oxfordjournals.org/content/intqhc/28/3/398.full.pdf

Quality problem or issue OECD member states are involved since 2003 in a project coordinated by the OECD on Health Care Quality Indicators (HCQI). All OECD countries are biennially requested by the OECD to deliver national data on the quality indicators for international benchmarking purposes.Initial assessment Currently, there is no knowledge whether the OECD HCQI information is used by the countries themselves for healthcare system accountability and improvement purposes.Choice of solution

The objective of the study is to explore the reporting and use of OECD HCQI in OECD member-states.Implementation Data were collected through a questionnaire sent to all OECD member-states containing factual questions on the reporting on all OECD HCQ-indicators. Responses were received between June and December 2014. In this timeframe, two reminders were sent to the participants. The work progress was presented during HCQI Meetings in November 2014 and May 2015.Evaluation Fifteen countries reported to have a total of 163 reports in which one or more HCQIs were reported. One hundred and sixteen were national and 47 were regional reports. Forty-nine reports had a general system focus, 80 were disease specific, 10 referred to a specific type of care setting, 22 were thematic and 2 were a combination of two (disease specific for a particular type of care and thematic for a specific type of care). Most reports were from Canada: 49. All 15 countries use one or more OECD indicators.Lessons learned The OECD quality indicators have acquired a clear place in national and regional monitoring activities. Some indicators are reported more often than others. These differences partly reflect differences between healthcare systems. Whereas some indicators have become very common, such as cancer care indicators, others, such as mental healthcare and patient experience indicators are relatively new and require some more time to be adopted more widely.

Rothberg, M. B., et al. (2009). "Public reporting of hospital quality: recommendations to benefit patients and hospitals." J Hosp Med **4**(9): 541-545.

Public reporting of hospital performance holds tremendous promise for improving the care provided by hospitals. To date, however, consumers have failed to embrace public reporting, despite considerable efforts to promote it. We review a number of reasons that public reporting has failed to live up to expectations, and we make 10 recommendations to improve the value of public reporting for both patients and hospitals. We also review 3 leading performance reporting programs to evaluate how well they adhere to these recommendations.

Ryan, A. M., et al. (2012). "Medicare's public reporting initiative on hospital quality had modest or no impact on mortality from three key conditions." Health Aff (Millwood) **31**(3): 585-592.

Hospital Compare, Medicare's public reporting initiative, began reporting measures of hospital quality for almost all US acute care hospitals in 2005. The impact of this public reporting initiative on patient mortality is unknown. We used Medicare claims data from the period 2000-08 to estimate the effect of Hospital Compare on thirty-day mortality for heart attack, heart failure, and pneumonia. Our analysis indicates that the fact that hospitals had to report quality data under Hospital Compare led to no reductions in mortality beyond existing trends for heart attack and pneumonia and led to a modest reduction in mortality for heart failure. We conclude that Medicare's public reporting initiative for hospitals has had a minimal impact on patient mortality.

Safavi, K. C., et al. (2014). "Variation in surgical quality measure adherence within hospital referral regions: do publicly reported surgical quality measures distinguish among hospitals that patients are likely to compare?" Health Serv Res **49**(4): 1108-1120.

OBJECTIVE: To determine whether surgical quality measures that Medicare publicly reports provide a basis for patients to choose a hospital from within their geographic region. DATA SOURCE: The Department of Health and Human Services' public reporting website, http://www.medicare.gov/hospitalcompare. STUDY DESIGN: We identified hospitals (n = 2,953) reporting adherence rates to the quality measures intended to reduce surgical site infections (Surgical Care Improvement Project, 1-3) in 2012. We defined regions within which patients were likely to compare hospitals using the hospital referral regions (HRRs) from the Dartmouth Atlas of Health Care Project. We described distributions of reported SCIP adherence within each HRR, including medians, interquartile ranges (IQRs), skewness, and outliers. PRINCIPAL FINDINGS: Ninety-seven percent of HRRs had median SCIP-1 scores >/=95 percent. In 93 percent of HRRs, half of the hospitals in the HRR were within 5 percent of the median hospital's score. In 62 percent of HRRs, hospitals were skewed toward the higher rates (negative skewness). Seven percent of HRRs demonstrated positive skewness. Only 1 percent had a positive outlier. SCIP-2 and SCIP-3 demonstrated similar distributions. CONCLUSIONS: Publicly reported quality measures for surgical site infection prevention do not distinguish the majority of hospitals that patients are likely to choose from when selecting a surgical provider. More studies are needed to improve public reporting's ability to positively impact patient decision making.

Sander, U., et al. (2015). "Information presentation features and comprehensibility of hospital report cards: design analysis and online survey among users." J Med Internet Res **17**(3): e68.

BACKGROUND: Improving the transparency of information about the quality of health care providers is one way to improve health care quality. It is assumed that Internet information steers patients toward better-performing health care providers and will motivate providers to improve quality. However, the effect of public reporting on hospital quality is still small. One of the reasons is that users find it difficult to understand the formats in which information is presented. OBJECTIVE: We analyzed the presentation of risk-adjusted mortality rate (RAMR) for coronary angiography in the 10 most commonly used German public report cards to analyze the impact of information presentation features on their comprehensibility. We wanted to determine which information presentation features were utilized, were preferred by users, led to better comprehension, and had similar effects to those reported in evidence-based recommendations described in the literature. METHODS: The study consisted of 5 steps: (1) identification of best-practice evidence about the presentation of information on hospital report cards; (2) selection of a single risk-adjusted quality indicator; (3) selection of a sample of designs adopted by German public report cards; (4) identification of the information presentation elements used in public reporting initiatives in Germany; and (5) an online panel completed an online questionnaire that was conducted to determine if respondents were able to identify the hospital with the lowest RAMR and if respondents' hospital choices were associated with particular information design elements. RESULTS: Evidence-based recommendations were made relating to the following information presentation features relevant to report cards: evaluative table with symbols, tables without symbols, bar charts, bar charts without symbols, bar charts with symbols, symbols, evaluative word labels, highlighting, order of providers, high values to indicate good performance, explicit statements of whether high or low values indicate good performance, and incomplete data ("N/A" as a value). When investigating the RAMR in a sample of 10 hospitals' report cards, 7 of these information presentation features were identified. Of these, 5 information presentation features improved comprehensibility in a manner reported previously in literature. CONCLUSIONS: To our knowledge, this is the first study to systematically analyze the most commonly used public reporting card designs used in Germany. Best-practice evidence identified in international literature was in agreement with 5 findings about German report card designs: (1) avoid tables without symbols, (2) include bar charts with symbols, (3) state explicitly whether high or low values indicate good performance or provide a "good quality" range, (4) avoid incomplete data (N/A given as a value), and (5) rank hospitals by performance. However, these findings are preliminary and should be subject of further evaluation. The implementation of 4 of these recommendations should not present insurmountable obstacles. However, ranking hospitals by performance may present substantial difficulties.

Schapira, M. M., et al. (2016). "The Nursing Home Compare Report Card: Perceptions of Residents and Caregivers Regarding Quality Ratings and Nursing Home Choice." Health Serv Res **51 Suppl 2**: 1212-1228.

OBJECTIVE: To evaluate the perceived usefulness of publicly reported nursing home quality indicators. STUDY SETTING: Primary data were collected from October 2013 to August 2014 among a convenience sample of persons (or family member) recently admitted or anticipating admission to a nursing home within 75 miles of the city of Philadelphia. STUDY DESIGN: Structured interviews were conducted to assess the salience of data on the Medicare Nursing Home Compare website, including star ratings, clinical quality measures, and benchmarking of individual nursing home quality with state and national data. DATA COLLECTION: Interviews were transcribed verbatim, independently coded by two reviewers, and agreement determined. A thematic analysis of transcripts was undertaken. PRINCIPAL FINDINGS: Thirty-five interviews were completed. Eighty-three percent (n = 29) were caregivers and 17 percent (n = 6) were residents. Star ratings, clinical quality measures, and benchmarking information were salient to decision making, with preferred formats varying across participants. Participants desired additional information on the source of quality data. Confusion was evident regarding the relationship between domain-specific and overall star quality ratings. CONCLUSIONS: The Nursing Home Compare website provides salient content and formats for consumers. Increased awareness of this resource and clarity regarding the definition of measures could further support informed decision making regarding nursing home choice.

Scherer, M., et al. (2013). "[The Quality indicator project of the German college of general practice and family medicine (DEGAM): development of indicators based on the guidelines dementia, neck pain and sore throat]." Z Evid Fortbild Qual Gesundhwes **107**(1): 74-86.

> A debate on the application of quality indicators (QIs) arose among the members of the German College of General Practitioners and Family Physicians (DEGAM) when two QI systems for ambulatory care (QISA and AQUIK) were published in a short time interval. A research question that emanated from this discussion was whether appropriate QI might be developed based on German general practice guidelines. In spring 2010, the DEGAM guideline committee (SLK) decided to conduct a project on guideline-based development of QIs using the DEGAM guidelines for dementia, neck pain and sore throat. All members of the SLK were invited to participate in the development process which comprised three face-to-face meetings and four paper-pencil ratings. Finally, 17 QIs for the three guidelines on dementia (n=8), neck pain (n=7) and sore throat (n=2) emerged. These QIs received different ratings in the dimensions relevance, practicability, and appropriateness for public reporting as well as for pay for performance. In this project, guideline authors themselves developed QIs based on German general practice guidelines for the first time ever. Not before practice administration systems facilitate the availability of data in the context of clinical documentation, the practicability of the new QIs can be proven in real every-day practice.

Schlesinger, M., et al. (2015). "Using Patient-Reported Information to Improve Clinical Practice." Health Serv Res **50 Suppl 2**: 2116-2154.

> OBJECTIVE: To assess what is known about the relationship between patient experience measures and incentives designed to improve care, and to identify how public policy and medical practices can promote patient-valued outcomes in health systems with strong financial incentives. DATA SOURCES/STUDY SETTING: Existing literature (gray and peer-reviewed) on measuring patient experience and patient-reported outcomes, identified from Medline and Cochrane databases; evaluations of pay-for-performance programs in the United States, Europe, and the Commonwealth countries. STUDY DESIGN/DATA COLLECTION: We analyzed (1) studies of pay-for-performance, to identify those including metrics for patient experience, and (2) studies of patient experience and of patient-reported outcomes to identify evidence of influence on clinical practice, whether through public reporting or private reporting to clinicians. PRINCIPAL FINDINGS: First, we identify four forms of "patient-reported information" (PRI), each with distinctive roles shaping clinical practice: (1) patient-reported outcomes measuring self-assessed physical and mental well-being, (2) surveys of patient experience with clinicians and staff, (3) narrative accounts describing encounters with clinicians in patients' own words, and (4) complaints/grievances signaling patients' distress when treatment or outcomes fall short of expectations. Because these forms vary in crucial ways, each must be distinctively measured, deployed, and linked with financial incentives. Second, although the literature linking incentives to patients experience is limited, implementing pay-for-performance systems appears to threaten certain patient-valued aspects of health care. But incentives can be made compatible with the outcomes patients value if: (a) a sufficient portion of incentives is tied to patient-reported outcomes and experiences, (b) incentivized forms of PRI are complemented by other forms of patient feedback, and (c) health care organizations assist clinicians to interpret and respond to PRI. Finally, we identify roles for the public and private sectors in financing PRI and orchestrating an appropriate balance among its four forms. CONCLUSIONS: Unless public policies are attentive to patients' perspectives, stronger financial incentives for clinicians can threaten aspects of care that patients most value. Certain policy parameters are already clear, but additional research is required to clarify how best to collect patient narratives in varied settings, how to report narratives to consumers in conjunction with quantified metrics, and how to promote a "culture of learning" at the practice level that incorporates patient feedback.

Schmitt, J., et al. (2014). "[Recommendations for quality indicators in German S3 guidelines: a critical appraisal]." Gesundheitswesen **76**(12): 819-826.

> BACKGROUND: Assessment of the quality of medical care plays an increasingly important role in the German healthcare system. Requirements for quality indicators include validity, reliability, responsiveness, interpretability and feasibility. Because of the high impact of guidelines, quality indicators that are recommended in such guidelines are of special relevance. METHODS: We conducted a systematic review of all German S3 guidelines (actual as of November 30(th), 2013) to investigate the proportion of

guidelines recommending quality indicators, which categories to classify quality indicators were used, and whether quality indicators in German S3 guidelines were developed following evidence-based methods. RESULTS: In 34 from 87 S3 guidelines (39%) a total of 394 quality indicators were defined. The vast majority of the recommended quality indicators focused on process quality. Outcome indicators were only recommended in 9 S3 guidelines (10%). None of the guidelines analysed reported the properties of the recommended quality indicators. CONCLUSION: Despite the increasing relevance of quality assessment for all stakeholders in the German healthcare system only approximately 40% of the S3 guidelines define indicators to measure the quality of care. Recommendations to assess outcome indicators are only provided in 10% of S3 guidelines. The process of the development and recommendation of quality indicators is heterogeneous and frequently not transparently reported. The current practice for the recommendation and validation of quality indicators in German S3 guidelines does not meet the requirements of evidence-based healthcare.

Scott, I. A. et Ward, M. (2006). "Public reporting of hospital outcomes based on administrative data: risks and opportunities." Med J Aust **184**(11): 571-575.

In the wake of findings from the Bundaberg Hospital and Forster inquiries in Queensland, periodic public release of hospital performance reports has been recommended. A process for developing and releasing such reports is being established by Queensland Health, overseen by an independent expert panel. This recommendation presupposes that public reports based on routinely collected administrative data are accurate; that the public can access, correctly interpret and act upon report contents; that reports motivate hospital clinicians and managers to improve quality of care; and that there are no unintended adverse effects of public reporting. Available research suggests that primary data sources are often inaccurate and incomplete, that reports have low predictive value in detecting "outlier" hospitals, and that users experience difficulty in accessing and interpreting reports and tend to distrust their findings.

Shahian, D. M., et al. (2015). "The Society of Thoracic Surgeons voluntary public reporting initiative: the first 4 years." Ann Surg **262**(3): 526-535; discussion 533-525.

OBJECTIVES: To evaluate participant characteristics and outcomes during the first 4 years of the Society of Thoracic Surgeons (STS) public reporting program. BACKGROUND: This is the first detailed analysis of a national, voluntary, cardiac surgery public reporting program using STS clinical registry data and National Quality Forum-endorsed performance measures. METHODS: The distributions of risk-adjusted mortality rates, multidimensional composite performance scores, star ratings, and volumes for public reporting versus nonreporting sites were studied during 9 consecutive semiannual reporting periods (2010-2014). RESULTS: Among 8929 unique observations (approximately 1000 STS participant centers, 9 reporting periods), 916 sites (10.3%) were classified low performing, 6801 (76.2%) were average, and 1212 (13.6%) were high performing. STS public reporting participation varied from 22.2% to 46.3% over the 9 reporting periods. Risk-adjusted, patient-level mortality rates for isolated coronary artery bypass grafting were consistently lower in public reporting versus nonreporting sites (P value range: <0.001-0.0077). Reporting centers had higher composite performance scores and star ratings (23.2% high performing and 4.5% low performing vs 7.6% high performing and 13.8% low performing for nonreporting sites). STS public reporting sites had higher mean annualized coronary artery bypass grafting volumes than nonreporting sites (169 vs 145, P < 0.0001); high-performing programs had higher mean coronary artery bypass grafting volumes (n = 241) than average (n = 139) or low-performing (n = 153) sites. Risk factor prevalence (except reoperation) and expected mortality rates were generally stable during the study period. CONCLUSIONS: STS programs that voluntarily participate in public reporting have significantly higher volumes and performance. No evidence of risk aversion was found.

Sharon, J. et Matthew, H. (2016). "A Decade Lost: Primary Healthcare Performance Reporting across Canada under the Action Plan for Health System Renewal." Healthcare Policy **11**(4): 95-110.
http://www.longwoods.com/product/24593

<p>In 2004, Canada's First Ministers committed to reforms that would shape the future of the Canadian healthcare landscape. These agreements included commitments to improved performance reporting within the primary healthcare system. The aim of this paper was to review the state of primary healthcare performance reporting after the public reporting mandate agreed to a decade ago in the Action Plan for Health System Renewal of 2003 expired. A grey literature search was performed to identify reports

released by the governmental and independent reporting bodies across Canada. No province, or the federal government, met their performance reporting obligations from the 2004 accords. Although the indicators required to report on in the 2004 Accord no longer reflect the priorities of patients, policy makers and physicians, provinces are also failing to report on these priorities. Canada needs better primary healthcare performance reporting to enable accountability and improvement within and across provinces. Despite the national mandate to improve public health system reporting, an opportunity to learn from the diverse primary healthcare reforms, underway across Canada for the past decade, has already been lost.</p>

Shekelle, P. G., et al. (2008). Does public release of performance results improve quality of care? A systematic review. Londres Health Foundation**:** 46 , fig., tabl. ann.
http://www.health.org.uk/publications/research_reports/performance_results.html

It is now acknowledged that the NHS should be reporting on outcomes. What remains less well understood is just what should be measured, how performance should be reported and what effect it may have. In the context of the NHS Next Stage Review, with its emphasis on quality measurement and increased reporting on outcomes, there is a need to review the best evidence about the impact of public reporting on improving performance in healthcare. This report from The Health Foundation reviews the international evidence on this issue. It tests current theory that the public release of performance data can increase the accountably of healthcare providers and motivate organisational quality improvement activities. The report tackles this by looking at the impact of reporting on selection and change. It explores whether public release prompts improvements in effectiveness, patient safety and patient centredness. The report offers robust evidence in an active area of policy. Despite major improvements in healthcare, quality gaps persist. The report backs the current direction of policy by showing that transparent systematic, data-driven performance measurement and feedback have a key role in quality improvement. The study offers suggestions for implementation, finding that public release of outcome data can stimulate change at the level of the hospital. However, it has little effect on consumer selection of provider.

Sherlaw-Johnson, C., et al. (2016). Using data to identify good-quality care for older people. Londres The Nuffield Trust**:** 30 , fig., tabl.
http://www.nuffieldtrust.org.uk/publications/using-data-identify-good-quality-care-older-people

This report describes the results of a pilot analysis of the effectiveness of using routine health care data to determine areas that have made quality improvements in the care of frail and older people over time. It focuses on a few indicators that were mainly derived from acute emergency hospital use and applies statistical analyses to them at the local authority area level. It concludes that there is scope to use these methods and approaches not only to track past change, but also as part of real-time monitoring of ongoing interventions.

Sinaiko, A. D., et al. (2012). "How report cards on physicians, physician groups, and hospitals can have greater impact on consumer choices." Health Aff (Millwood) **31**(3): 602-611.

Public report cards with quality and cost information on physicians, physician groups, and hospital providers have proliferated in recent years. However, many of these report cards are difficult for consumers to interpret and have had little impact on the provider choices consumers are making. To gain a more focused understanding of why these reports cards have not been more successful and what improvements could be made, we interviewed experts and surveyed registrants at the March 2011 AHRQ National Summit on Public Reporting for Consumers in Health Care. We found broad agreement that public reporting has been disconnected from consumer decisions about providers because of weaknesses in report card content, design, and accessibility. Policy makers have an opportunity to change the landscape of public reporting by taking advantage of advances in measurement, data collection, and information technology to deliver a more consumer-centered report card. Overcoming the constraint of limited public funding, and achieving the acceptance of providers, is critical to realizing future success.

Smith, B., et al. (2015). "What consumers want to know about quality when choosing a hospice provider." Am J Hosp Palliat Care **32**(4): 393-400.

Despite the availability of endorsed quality measures and widespread usage of hospice, hospice quality data are rarely available to consumers. Moreover, little is known about how consumers prioritize extant measures. This study drew on focus group and survey data collected in 5 metropolitan areas. The study found that consumers reported the hospice quality indicators we tested were easy to understand. Participants placed top priority on measures related to pain and symptom management. Relative to consumers with hospice experience, consumers without previous experience tended to place less value on spiritual support for patients and caregivers, emotional support for caregivers, and after-hours availability. The National Quality Forum-approved measures resonate well with consumers. Consumers also appear to be ready for access to data on the quality of hospice providers.

Smith, M. A., et al. (2012). "Public reporting helped drive quality improvement in outpatient diabetes care among Wisconsin physician groups." Health Aff (Millwood) **31**(3): 570-577.

Public reporting on the quality of ambulatory health care is growing, but knowledge of how physician groups respond to such reporting has not kept pace. We examined responses to public reporting on the quality of diabetes care in 409 primary care clinics within seventeen large, multispecialty physician groups. We determined that a focus on publicly reported metrics, along with participation in large or externally sponsored projects, increased a clinic's implementation of diabetes improvement interventions. Clinics were also more likely to implement interventions in more recent years. Public reporting helped drive both early implementation of a single intervention and ongoing implementation of multiple simultaneous interventions. To fully engage physician groups, accountability metrics should be structured to capture incremental improvements in quality, thereby rewarding both early and ongoing improvement activities.

Snowden, A. M., et al. (2012). "Addressing health care disparities using public reporting." Am J Med Qual **27**(4): 275-281.

The literature highlights that disparities in health care performance exist. Publicly reporting data about disparities at an actionable level is needed. The Minnesota Health Care Disparities Report is designed to publicly report medical group health care performance rates for patients enrolled in state/federally funded programs. In addition, differences between patients enrolled in state-funded public programs and those in private or Medicare programs at statewide and medical group levels are presented. The endeavor is a cooperative one between Minnesota Community Measurement, an independent nonprofit community organization, and the Minnesota Department of Human Services, the state Medicaid agency. Public reporting makes transparent the gaps in the delivery of health care between patients enrolled in these programs at a medical group level and can facilitate quality improvement locally, where accountability lies and actions to address disparities can occur.

Specchia, M. L., et al. (2012). "Peer pressure and public reporting within healthcare setting: improving accountability and health care quality in hospitals." Ig Sanita Pubbl **68**(6): 771-780.

In the last few years, the need of public reporting of health outcomes has acquired a great importance. The public release of performance results could be a tool for improving health care quality and many attempts have been made in order to introduce public reporting programs within the health care context at different levels. It would be necessary to promote the introduction of a standardized set of outcome and performance measures in order to improve quality of health care services and to make health care providers aware of the importance of transparency and accountability.

Speicher, P. J., et al. (2014). "Wound classification reporting in HPB surgery: can a single word change public perception of institutional performance?" HPB (Oxford) **16**(12): 1068-1073.

INTRODUCTION: The drive to improve outcomes and the inevitability of mandated public reporting necessitate uniform documentation and accurate databases. The reporting of wound classification in patients undergoing hepato-pancreatico-biliary (HPB) surgery and the impact of inconsistencies on quality metrics were investigated. METHODS: The 2005-2011 National Surgical Quality Improvement Program (NSQIP) participant use file was interrogated to identify patients undergoing HPB resections. The effect of wound classification on post-operative surgical site infection (SSI) rates was determined

through logistic regression. The impact of variations in wound classification reporting on perceived outcomes was modelled by simulating observed-to-expected (O/E) ratios for SSI. RESULTS: In total, 27,376 patients were identified with significant heterogeneity in wound classification. In spite of clear guidelines prompting at least 'clean-contaminated' designation for HPB resections, 8% of all cases were coded as 'clean'. Contaminated [adjusted odds ratio (AOR): 1.39, P = 0.001] and dirty (AOR: 1.42, P = 0.02] cases were associated with higher odds of SSI, whereas clean-contaminated were not (P = 0.99). O/E ratios were highly sensitive to modest changes in wound classification. CONCLUSIONS: Perceived performance is affected by heterogeneous reporting of wound classification. As institutions work to improve outcomes and prepare for public reporting, it is imperative that all adhere to consistent reporting practices to provide accurate and reproducible outcomes.

Spivack, S. B., et al. (2014). "Hospital cardiovascular outcome measures in federal pay-for-reporting and pay-for-performance programs: a brief overview of current efforts." Circ Cardiovasc Qual Outcomes **7**(5): 627-633.

Stausberg, J., et al. (2015). "Measuring Data Quality: A Review of the Literature between 2005 and 2013." Stud Health Technol Inform **210**: 712-716.

A literature review was done within a revision of a guideline concerned with data quality management in registries and cohort studies. The review focused on quality indicators, feedback, and source data verification. Thirty-nine relevant articles were selected in a stepwise selection process. The majority of the papers dealt with indicators. The papers presented concepts or data analyses. The leading indicators were related to case or data completeness, correctness, and accuracy. In the future, data pools as well as research reports from quantitative studies should be obligatory supplemented by information about their data quality, ideally picking up some indicators presented in this review.

SteelFisher, G. K. (2005). "International innovations in health care: quality improvements in the United Kingdom." Issue Brief (Commonw Fund)(833): 1-16.

Starting in 1997, the United Kingdom has introduced a series of interdependent legislative and regulatory reforms to improve access, treatment, and administration in the National Health Service (NHS)--attracting worldwide attention in the process. The NHS quality agenda involves a centrally coordinated program, defined quality targets, public reporting, enhanced incentives for stakeholders, improved information technology, and increased financial support. These efforts so far seem to be improving care in a country that suffered from a long list of serious health care problems.

Sunderkamp, S., et al. (2014). "[Analysis of public quality reports for home care and long-term care with respect to their usefulness for the customer]." Pflege **27**(5): 325-336.

BACKGROUND: Public quality reports, based on new legislative regulations of 2008, were supposed to offer potential customers the possibility to make a well-informed choice of a care provider. AIM: This empirical study on marks for long-term care is based on the public quality reports of the Medical Service of the Health Insurance Companies (MDK), of 11 884 home care services and 10 310 nursing homes, which corresponds to a comprehensive survey of almost all care providers in Germany. METHOD: Descriptive statistical methods and discussion of the results concerning the customer benefit. RESULTS: The analysis of transparency reports reveals a limited value for customers, which is particularly caused by very good quality results with low scattering. In addition, a high amount of missing data - especially in the area of home care providers - leads to a growing influence of service criteria on the final grade. Though deficits in nursing might be compensated by good marks in service criteria, it rarely occurs. At present, a more detailed look at risk criteria hardly improves the customer benefit. CONCLUSION: The marks for nursing need to be improved to increase their informative value for the customer.
Publisher: Hintergrund: Seit dem Pflege-Weiterentwicklungsgesetz von 2008 und der Entwicklung der Pflegetransparenzvereinbarungen sollen Verbraucher die Moglichkeit erhalten, auf Basis einer flachendeckenden Qualitatsbeurteilung von ambulanten Pflegediensten und stationaren Pflegeeinrichtungen eine informierte Wahl ihres Pflegeanbieters vorzunehmen. Ziel: Diese Studie pruft die Pflegenoten auf Basis einer empirischen Analyse der veroffentlichten MDK-Qualitatsberichte von 11 884 ambulanten Pflegediensten und 10 310 Pflegeheimen, was einer erstmaligen Vollerhebung aller bundesdeutschen Pflegeanbieter gleichkommt. Methoden: Auswertungen der deskriptiven Statistik und Diskussion der Ergebnisse in Hinblick auf die Nutzlichkeit der Noten fur den Verbraucher. Ergebnisse: Die

Auswertungen zeigen eine begrenzte Aussagekraft der Pflegenoten fur den Verbraucher. Ursachlich dafur sind insbesondere die durchschnittlich sehr guten Noten bei geringer Streuung und die grossen Lucken in der Bewertung der einzelnen Kriterien, vor allem im ambulanten Bereich. Sie verstarken den Einfluss pflegeferner Kriterien auf die Gesamtnote und begunstigen den Ausgleich von Pflegemangeln durch guten Service. Dies kommt aber sehr selten vor. Eine starkere Bewertung von Risikokriterien wurde die Aussagekraft derzeit kaum erhohen. Schlussfolgerungen: Die Konzeption der Pflegenoten bedarf einer grundlichen Optimierung, um die Nutzlichkeit fur den Verbraucher zu erhohen.

Taber, D. J., et al. (2014). "The concept of a composite perioperative quality index in kidney transplantation." J Am Coll Surg **218**(4): 588-597.

BACKGROUND: Public reporting of patient and graft outcomes in a national registry and close Centers for Medicare and Medicaid Services oversight has resulted in transplantation being a highly regulated surgical discipline. Despite this, transplantation surgery lacks comprehensive tracking and reporting of perioperative quality measures. Therefore, the aim of this study was to determine the association between a kidney transplantation centers' perioperative quality benchmarking and graft and patient outcomes. STUDY DESIGN: This was an analysis of 2011 aggregate data compiled from 2 national datasets that track outcomes from member hospitals and transplantation centers. The transplantation centers included in this study were composed of accredited US kidney transplantation centers that report data through the national registry and are associate members of the University HealthSystem Consortium. RESULTS: A total of 16,811 kidney transplantations were performed at 236 centers in the United States in 2011, of which 10,241 (61%) from 93 centers were included in the analysis. Of the 6 perioperative quality indicators, 3 benchmarked metrics were significantly associated with a kidney transplantation center's underperformance: mean ICU length of stay (C-statistic 0.731; p = 0.002), 30-day readmissions (C-statistic 0.697; p = 0.012) and in-hospital complications (C-statistic 0.785; p = 0.001). The composite quality index strongly correlated with inadequate center performance (C-statistic 0.854; p < 0.001, R(2) = 0.349). The centers in the lowest quartile of the quality index performed 2,400 kidney transplantations in 2011, which led to 2,640 more hospital days, 4,560 more ICU days, 120 more postoperative complications, and 144 more patients with 30-day readmissions, when compared with centers in the 3 higher-quality quartiles. CONCLUSIONS: An objective index of a transplantation center's quality of perioperative care is significantly associated with patient and graft survival.

Tomasone, J. R., et al. (2015). "Effectiveness of guideline dissemination and implementation strategies on health care professionals' behaviour and patient outcomes in the cancer care context: a systematic review protocol." Syst Rev **4**: 113.

BACKGROUND: Health care professionals (HCPs) are able to make effective decisions regarding patient care through the use of systematically developed clinical practice guidelines (CPGs). These recommendations are especially important in a cancer health care context as patients are exposed to a multitude of interdisciplinary HCPs offering high-quality care throughout diagnosis, treatment, survivorship and palliative care. Although a large number of CPGs targeted towards cancer are widely disseminated, it is unknown whether implementation strategies targeting the use of these guidelines are effective in effecting HCP behaviour and patient outcomes in the cancer care context. The purpose of this systematic review will be to determine the effectiveness of different CPG dissemination and implementation interventions on HCPs' behaviour and patient outcomes in the cancer health care context. METHODS/DESIGN: Five electronic databases (CINAHL, the Cochrane Controlled Trials Register, MEDLINE via Ovid, EMBASE via Ovid and PsycINFO via Ovid) will be searched to include all studies examining the dissemination and/or implementation of CPGs in a cancer care setting targeting all HCPs. CPG implementation strategies will be included if the CPGs were systematically developed (e.g. literature review/evidence-informed, expert panel, evidence appraisal). The studies will be limited to randomized controlled trials, controlled clinical trials and quasi-experimental (interrupted time series, controlled before-and-after designs) studies. Two independent reviewers will assess articles for eligibility, data extraction and quality appraisal. DISCUSSION: The aim of this review is to inform cancer care health care professionals and policymakers about evidence-based implementation strategies that will allow for effective use of CPGs. SYSTEMATIC REVIEW REGISTRATION: PROSPERO CRD42015019331.

Toomey, S. L., et al. (2015). "The Development of a Pediatric Inpatient Experience of Care Measure: Child HCAHPS." Pediatrics **136**(2): 360-369.

The Centers for Medicare and Medicaid Services (CMS) uses Adult Hospital Consumer Assessment of Healthcare Providers and Systems (Adult HCAHPS) scores for public reporting and pay-for-performance for most US hospitals, but no publicly available standardized survey of inpatient experience of care exists for pediatrics. To fill the gap, CMS and the Agency for Healthcare Research and Quality commissioned the development of a pediatric version (Child HCAHPS), a survey of parents/guardians of pediatric patients (<18 years old) who were recently hospitalized. This article describes the development of Child HCAHPS, which included an extensive review of the literature and quality measures, expert interviews, focus groups, cognitive testing, pilot testing of the draft survey, a national field test with 69 hospitals in 34 states, psychometric analysis, and end-user testing of the final survey. We conducted extensive validity and reliability testing to determine which items would be included in the final survey instrument and develop composite measures. We analyzed national field test data of 17,727 surveys collected in November 2012 to January 2014 from parents of recently hospitalized children. The final Child HCAHPS instrument has 62 items, including 39 patient experience items, 10 screeners, 12 demographic/descriptive items, and 1 open-ended item. The 39 experience items are categorized based on testing into 18 composite and single-item measures. Our composite and single-item measures demonstrated good to excellent hospital-level reliability at 300 responses per hospital. Child HCAHPS was developed to be a publicly available standardized survey of pediatric inpatient experience of care. It can be used to benchmark pediatric inpatient experience across hospitals and assist in efforts to improve the quality of inpatient care.

Totten, A. M., et al. (2012). "Closing the quality gap: revisiting the state of the science (vol. 5: public reporting as a quality improvement strategy)." Evid Rep Technol Assess (Full Rep)(208.5): 1-645.

OBJECTIVES: The goal of this review was to evaluate the effectiveness of public reporting of health care quality information as a quality improvement strategy. We sought to determine if public reporting results in improvements in health care delivery and patient outcomes. We also considered whether public reporting affects the behavior of patients or of health care providers. Finally we assessed whether the characteristics of the public reports and the context affect the impact of public reports. DATA SOURCES: Articles available between 1980 and 2011 were identified through searches of the following bibliographical databases: MEDLINE(R), Embase, EconLit, PsychINFO, Business Source Premier, CINAHL, PAIS, Cochrane Database of Systematic Reviews, EPOC Register of Studies, DARE, NHS EED, HEED, NYAM Grey Literature Report database, and other sources (experts, reference lists, and gray literature). REVIEW METHODS: We screened citations based on inclusion and exclusion criteria developed based on our definition of public reporting. We initially did not exclude any studies based on study design. Of the 11,809 citations identified through title and abstract triage, we screened and reviewed 1,632 articles. A total of 97 quantitative and 101 qualitative studies were included, abstracted, entered into tables, and evaluated. The heterogeneity of outcomes as well as methods prohibited formal quantitative synthesis. Systematic reviews were used to identify studies, but their conclusions were not incorporated into this review. RESULTS: For most of the outcomes, the strength of the evidence available to assess the impact of public reporting was moderate. This was due in part to the methodological challenges researchers face in designing and conducting research on the impact of population-level interventions. Public reporting is associated with improvement in health care performance measures such as those included in Nursing Home Compare. Almost all identified studies found no evidence or only weak evidence that public reporting affects the selection of health care providers by patients or their representatives. Studies of health care providers' response to public reports suggest they engage in activities to improve quality when performance data are made public. Characteristics of public reports and the context, which are likely to be important when considering the diffusion of quality improvement activities, were rarely studied or even described. CONCLUSIONS: The heterogeneity of the outcomes and the moderate strength of evidence for most outcomes make it difficult to draw definitive conclusions. However, some observations were supported by existing research. Public reporting is more likely to be associated with changes in health care provider behaviors than with selection of health services providers by patients or families. Quality measures that are publicly reported improve over time. Although the potential for harms is frequently cited by commentators and critics of public reporting, the amount of research on harms is limited and most studies do not confirm the potential harm.

Utzon, J. et Kaergaard, J. (2009). "[Publication of healthcare quality data to citizens--status and perspectives]." Ugeskr Laeger **171**(20): 1670-1674.

Public quality reports are intended to stimulate active consumer participation by enabling consumers to make informed choices about their healthcare providers. Despite all efforts, public reporting has been shown not to be effective in stimulating consumers to choose their healthcare provider based on performance information in Denmark and other countries. Numerous barriers are identified. In an effort to move towards an effective public reporting system in Denmark, the present article discusses how quality information can be made accessible and meaningful to wider groups of consumers.

Van D.en Berg, M. J., et al. (2014). "The Dutch health care performance report: seven years of health care performance assessment in the Netherlands." Health Research Policy and Systems **12**(1): 7. http://www.health-policy-systems.com/content/12/1/1/abstract

In 2006, the first edition of a monitoring tool for the performance of the Dutch health care system was released:the Dutch Health Care Performance Report (DHCPR). The Netherlands was among the first countries in the world developing such a comprehensive tool for reporting performance on quality, access, and affordability of health care. The tool contains 125 performance indicators; the choice for specific indicators resulted from a dialogue between researchers and policy makers. In the 'policy cycle', the DHCPR can rationally be placed between evaluation (accountability) and agenda-setting (for strategic decision making). In this paper, we reflect on important lessons learned after seven years of health care system performance assessment. These lessons entail the importance of a good conceptual framework for health system performance assessment, the importance of repeated measurement, the strength of combining multiple perspectives (e.g., patient, professional, objective, subjective) on the same issue, the importance of a central role for the patients' perspective in performance assessment, how to deal with the absence of data in relevant domains, the value of international benchmarking and the continuous exchange between researchers and policy makers.

Van Der Weyden, M. B. (1995). "Politics and publishing: the Quality in Australian Health Care Study." Med J Aust **163**(9): 453-454.

Veillard, J. H., et al. (2013). "The PATH project in eight European countries: an evaluation." Int J Health Care Qual Assur **26**(8): 703-713.

PURPOSE: This paper's aim is to evaluate the perceived impact and the enabling factors and barriers experienced by hospital staff participating in an international hospital performance measurement project focused on internal quality improvement. DESIGN/METHODOLOGY/APPROACH: Semi-structured interviews involving international hospital performance measurement project coordinators, including 140 hospitals from eight European countries (Belgium, Estonia, France, Germany, Hungary, Poland, Slovakia and Slovenia). Inductively analyzing the interview transcripts was carried out using the grounded theory approach. FINDINGS: Even when public reporting is absent, the project was perceived as having stimulated performance measurement and quality improvement initiatives in participating hospitals. Attention should be paid to leadership/ownership, context, content (project intrinsic features) and processes supporting elements. RESEARCH LIMITATIONS/IMPLICATIONS: Generalizing the findings is limited by the study's small sample size. Possible implications for the WHO European Regional Office and for participating hospitals would be to assess hospital preparedness to participate in the PATH project, depending on context, process and structural elements; and enhance performance and practice benchmarking through suggested approaches. ORIGINALITY/VALUE: This research gathered rich and unique material related to an international performance measurement project. It derived actionable findings.

Voerman, G. E., et al. (2013). "A systematic approach towards the development of a set of quality indicators for public reporting in community-based maternity care." Midwifery **29**(4): 316-324.

OBJECTIVE: to demonstrate the process and outcome of a systematic approach towards the development of a set of quality indicators for public reporting on quality of community-based maternity care. DESIGN AND SETTING: a four-stepped approach was adopted. Firstly, we defined key elements of community-based maternity care, by performing a systematic search on care guidelines/ standards. Secondly, the literature was searched for existing indicators for maternity care, which were subsequently categorised according to the key elements and systematically selected on suitability of public presentation. The

emerging set of indicators suitable for public reporting was presented to five health-care professionals using a Delphi technique (step 3). Based on the comments of the professionals, the set was adjusted and subsequently presented to the health-care consumers (a sample of pregnant women) in step four to test its validity, after which the final set was composed. PARTICIPANTS: health-care professionals in the field of maternity care and pregnant women. FINDINGS: key elements of community-based maternity care were extracted from eight guidelines and care standards. We then extracted 10 documents with 223 indicators in total, from which 19 indicators covering the key elements were included in the first set and presented to experts. Based on their comments three indicators were deleted and four indicators were added to the set or slightly rephrased. These were subsequently judged by 13 pregnant women. Seventy-five per cent of the indicators were judged positively by them; no indicator was judged negatively. The set of indicators was thus left unchanged after this final step. KEY CONCLUSIONS AND IMPLICATIONS FOR CLINICAL PRACTICE: the systematic approach adopted in this study resulted in an indicator set that was considered valid by both maternity care professionals and pregnant women, and is likely to satisfy the essential requirements on clinimetric properties. The next step will be to pilot test the indicator set on feasibility in daily clinical practice and to refine the set when necessary. In the future, maternity care professionals may use the set to present the quality of care they provide and to define issues of improvement. Pregnant women may use the information to make a founded choice between maternity care professionals, which ultimately should result in improved safety and quality of maternity care as well as patient satisfaction. Although we focused on the Dutch, community-based maternity care system, the approach used may be extrapolated to other care processes and health-care systems. Extrapolation of the results itself (i.e. the indicator set) may need to be limited to systems with an emphasis on community-based maternity care.

Vukovic, V., et al. (2017). "Does public reporting influence quality, patient and provider's perspective, market share and disparities? A review." European Journal of Public Health **27**(6): 972-978.
http://dx.doi.org/10.1093/eurpub/ckx145

BackgroundPublic reporting (PR) of healthcare (HC) provider's quality was proposed as a public health instrument for providing transparency and accountability in HC. Our aim was to assess the impact of PR on five main domains: quality improvement; patient choice, service utilization and market share; provider's perspective; patient experience; and unintended consequences. MethodsPubMed, Scopus, ISI WOS, and EconLit databases were searched to identify studies investigating relationships between PR and five main domains, published up to April 1, 2016. ResultsSixty-two papers published between 1988 and 2015 were included. Nineteen studies investigated quality improvement, 19 studies explored the unintended consequences of PR, 10 explored the effects on market share, 10 on patients' choice, 7 evaluated the provider's perspective, 4 economic outcome, 4 service utilization, 2 purchasers' use of PR and 2 studies explored patient experiences. The effect of PR was diverse throughout the studies—mostly positive on: patient experience (100%), quality improvement (63%), patient choice, service utilization and market share (46%); mixed on provider's perspective and economic outcome (27%) and mainly negative on unintended consequences (68%). ConclusionsOur research covering different outcomes and settings reported that PR is associated with changes in HC provider's behavior and can influence market share. Unintended consequences are a concern of PR and should be taken into account when allocating HC resources. The experiences collected in this paper could give a snapshot about the impact of PR on a HC user's perception of the providers' quality of care, helping them to make empowered choices.

Wasfy, J. H. et Yeh, R. W. (2016). "Future of the PCI Readmission Metric." Circ Cardiovasc Qual Outcomes **9**(2): 186-189.

Between 2013 and 2014, the Centers for Medicare and Medicaid Services and the National Cardiovascular Data Registry publically reported risk-adjusted 30-day readmission rates after percutaneous coronary intervention (PCI) as a pilot project. A key strength of this public reporting effort included risk adjustment with clinical rather than administrative data. Furthermore, because readmission after PCI is common, expensive, and preventable, this metric has substantial potential to improve quality and value in American cardiology care. Despite this, concerns about the metric exist. For example, few PCI readmissions are caused by procedural complications, limiting the extent to which improved procedural technique can reduce readmissions. Also, similar to other readmission measures, PCI readmission is associated with socioeconomic status and race. Accordingly, the metric may unfairly penalize hospitals that care for underserved patients. Perhaps in the context of these limitations, Centers

for Medicare and Medicaid Services has not yet included PCI readmission among metrics that determine Medicare financial penalties. Nevertheless, provider organizations may still wish to focus on this metric to improve value for cardiology patients. PCI readmission is associated with low-risk chest discomfort and patient anxiety. Therefore, patient education, improved triage mechanisms, and improved care coordination offer opportunities to minimize PCI readmissions. Because PCI readmission is common and costly, reducing PCI readmission offers provider organizations a compelling target to improve the quality of care, and also performance in contracts involve shared financial risk.

Weeramanthri, T. (1996). "The Quality in Australian Health Care Study (QAHCS)--a review." Health Inf Manag **26**(2): 94-96.

The author reviews the politics, publicity, methods and findings of the Quality in Australian Health Care Study, which was released to a blaze of media attention in 1995. The study is a significant contribution to the growing literature on the identification and categorisation of preventable adverse events, using expert retrospective review of medical records, and a mix of explicit and implicit criteria. However, its potential impact has been lessened by the way its findings were released.

Werner, R., et al. (2010). "Public reporting drove quality gains at nursing homes." Health Aff (Millwood) **29**(9): 1706-1713.

Public reporting of the quality of care delivered in hospitals and nursing homes is thought to foster improvements in care. When information is available, consumers may choose high-quality providers. That choice, in turn, may stimulate providers to improve quality as a way to attract a larger share of the market. However, these assumptions have gone largely untested. We examined short-stay care provided at 8,137 nursing homes after the Nursing Home Compare public reporting requirements went into effect in 2002. We found that quality improved both because consumers chose higher-quality nursing homes and because providers improved the care they delivered. These findings support the continued use of public reporting to improve quality.

Werner, R. M. et Asch, D. A. (2005). "The unintended consequences of publicly reporting quality information." Jama **293**(10): 1239-1244.

Health care report cards publicly report information about physician, hospital, and health plan quality in an attempt to improve that quality. Reporting quality information publicly is presumed to motivate quality improvement through 2 main mechanisms. First, public quality information allows patients, referring physicians, and health care purchasers to preferentially select high-quality physicians. Second, public report cards may motivate physicians to compete on quality and, by providing feedback and by identifying areas for quality improvement initiatives, help physicians to do so. Despite these plausible mechanisms of quality improvement, the value of publicly reporting quality information is largely undemonstrated and public reporting may have unintended and negative consequences on health care. These unintended consequences include causing physicians to avoid sick patients in an attempt to improve their quality ranking, encouraging physicians to achieve "target rates" for health care interventions even when it may be inappropriate among some patients, and discounting patient preferences and clinical judgment. Public reporting of quality information promotes a spirit of openness that may be valuable for enhancing trust of the health professions, but its ability to improve health remains undemonstrated, and public reporting may inadvertently reduce, rather than improve, quality. Given these limitations, it may be necessary to reassess the role of public quality reporting in quality improvement.

Werner, R. M. et Bradlow, E. T. (2010). "Public reporting on hospital process improvements is linked to better patient outcomes." Health Aff (Millwood) **29**(7): 1319-1324.

The Centers for Medicare and Medicaid Services publicly reports so-called process performance at all U.S. hospitals, such as whether certain recommended treatments are given to specific types of patients. We examined whether hospital performance on key process indicators improved during the three years since this reporting began. We also studied whether or not these changes improved patient outcomes or yielded other quality improvements, such as reduced hospital readmission rates. We found that, from 2004 to 2006, hospital process performance improved and was associated with better patient and quality

outcomes. Most notably, for acute myocardial infarction, performance improvements were associated with declines in mortality rates, lengths-of-stay, and readmission rates. Although we cannot conclude that public reporting caused the improvement in processes or outcomes, these results are encouraging, since improving process performance may improve quality more broadly.

Werner, R. M., et al. (2009). "Impact of public reporting on unreported quality of care." Health Serv Res **44**(2 Pt 1): 379-398.

OBJECTIVE: The impact of quality improvement incentives on nontargeted care is unknown and some have expressed concern that such incentives may be harmful to nontargeted areas of care. Our objective is to examine the effect of publicly reporting quality information on unreported quality of care. DATA SOURCES/STUDY SETTING: The nursing home Minimum Data Set from 1999 to 2005 on all postacute care admissions. STUDY DESIGN: We studied 13,683 skilled nursing facilities and examined how unreported aspects of clinical care changed in response to changes in reported care after public reporting was initiated by the Centers for Medicare and Medicaid Services on their website, Nursing Home Compare, in 2002. PRINCIPAL FINDINGS: We find that overall both unreported and reported care improved following the launch of public reporting. Improvements in unreported care were particularly large among facilities with high scores or that significantly improved on reported measures, whereas low-scoring facilities experienced no change or worsening of their unreported quality of care. CONCLUSIONS: Public reporting in the setting of postacute care had mixed effects on areas without public reporting, improving in high-ranking facilities, but worsening in low-ranking facilities. While the benefits of public reporting may extend beyond areas that are being directly measured, these initiatives may also widen the gap between high- and low-quality facilities.

Werner, R. M., et al. (2009). "Impact of public reporting on quality of postacute care." Health Serv Res **44**(4): 1169-1187.

OBJECTIVE: Evidence supporting the use of public reporting of quality information to improve health care quality is mixed. While public reporting may improve reported quality, its effect on quality of care more broadly is uncertain. This study tests whether public reporting in the setting of nursing homes resulted in improvement of reported and broader but unreported quality of postacute care. DATA SOURCES/STUDY SETTING: 1999-2005 nursing home Minimum Data Set and inpatient Medicare claims. STUDY DESIGN: We examined changes in postacute care quality in U.S. nursing homes in response to the initiation of public reporting on the Centers for Medicare and Medicaid Services website, Nursing Home Compare. We used small nursing homes that were not subject to public reporting as a contemporaneous control and also controlled for patient selection into nursing homes. Postacute care quality was measured using three publicly reported clinical quality measures and 30-day potentially preventable rehospitalization rates, an unreported measure of quality. PRINCIPAL FINDINGS: Reported quality of postacute care improved after the initiation of public reporting for two of the three reported quality measures used in Nursing Home Compare. However, rates of potentially preventable rehospitalization did not significantly improve and, in some cases, worsened. CONCLUSIONS: Public reporting of nursing home quality was associated with an improvement in most postacute care performance measures but not in the broader measure of rehospitalization.

Ressources électroniques

SITES INSTITUTIONNELS

En France

Site de la HAS

- Projet COMPAQH
- CLARTE – PSI (Indicateurs de sécutité des soins hospitaliers)
- IPAQSS-IQSS (Indicateurs de la qualité des soins dans les établissements de santé)

- Voir aussi : Open data HAS
- Indicateurs PSI (Patient safety Indicators)

Site du Ministèe chargé de la santé

- Les indicateurs de la qaulité des soins dans les établissements de santé

Site de l'Anap

Tableau de bord de la performance dans le secteur médico-social : Guide des indicateurs de l'Anap

A l'étranger

Site de l'OCDE

- Projet sur les indicateurs comparés de qualité des soins
- Review of National Health Care Quality (rapport 2017 « Caring for quality in Health") avec des documents pas pays
- PaRIS – Patient Reported Indicators Survey

Site de l'OMS

- Management de la qualité des soins

Site du Nice (Royaume-Uni)

- Quality and Outcomes Framework Indicators (QOF)

Site de l'AHRQ Quality indicators (Etats-Unis)

- Patient safety indicators

Site du KCE (Belgique)

- http://kce.fgov.be/fr/content/focus-sur-les-indicateurs-de-qualit%C3%A9

BASES DE DONNEES

Cochrane Library

Fondée en 1995 en Grande-Bretagne sous le nom de Cochrane Database of Systematic Reviews (CDSR), elle a été renommée Cochrane Library et est constituée de plusieurs bases. Pubmed donne accès aux versions courtes des Cochrane Database Systematic Reviews (champ Journal ou TA, taper Cochrane database Sys Rev [ta]). Cette base met à la disposition des revues systématiques de la littérature, réactualisées régulièrement. Ces revues sont réalisées par la Cochrane collaboration, réseau international de correspondants chargés d'analyser systématiquement les essais contrôlés randomisés de diverses spécialités médicales. Elle contient de nombreuses revues de la littérature sur les domaines aussi divers que la grossesse, la stérilité, la schizophrénie ou les atteintes

cérébrales. On accède aux résumés des synthèses des groupes de travail de la Cochrane avec les objectifs, la stratégie de recherche, l'analyse de données et les conclusions des reviewers.

Bases d'évaluation de l'University of York

Ce site met à disposition trois bases de données d'evidence based medicine :

- Database of Abstracts of Review of Effectiveness (DARE) : fondée en 1994 par le Centre for Reviews and Dissemination.
- NHS Economic Evaluation Database (NHS EED) : fondée par les Departments of Health of England and Wales.
- Health Technology Assessment (HTA) Database : fondée par le Centre for Reviews and Dissemination. et l'Inhata.

Ces bases permettent d'accéder à des résumés d'aide à la décision médicale, à des analyses critiques de synthèses publiées dans la littérature médicale sur les thérapeutiques, les médicaments et les technologies médicales. Les caractéristiques des études sont fournies ainsi que les banques de données utilisées (Embase, Medline), le nombre d'études sélectionnées, les résultats de la synthèse, la conclusion des auteurs, les commentaires des reviewers.