AHA Policy Statement

Nonfinancial Incentives for Quality
A Policy Statement From the American Heart Association

Vincent Bufalino, MD, FAHA; Eric D. Peterson, MD, MPH, FAHA;
Harlan M. Krumholz, MD, FAHA; Gregory L. Burke, MD, MS, FAHA;
Kenneth A. LaBresh, MD, FAHA; Daniel W. Jones, MD, FAHA; David P. Faxon, MD, FAHA;
Adolfo M. Valadez, MD, MPH; Penelope Solis, JD; J. Sanford Schwartz, MD

The American Heart Association (AHA) and its division, the American Stroke Association, are dedicated to improving the quality of care available to patients who have or are at risk of acquiring cardiovascular diseases, including stroke. Heart disease, stroke, and other cardiovascular diseases remain the No. 1 killer in the United States and a leading cause of permanent disability. Approximately 71 million Americans have some form of these diseases. In 2006, cardiovascular diseases will cost this nation an estimated $403 billion in medical expenses and lost productivity. The AHA is committed to reducing cardiovascular disease by improving the quality of care in the United States, ensuring that this care is patient-centered and of the highest quality and that it ultimately improves patient outcomes.

Background

Earlier this year, the AHA published the statement Payment for Quality: Guiding Principles and Recommendations in response to increased interest by healthcare professionals, policy makers, purchasers, and consumers to use financial incentive programs to realign payment for health care and improve the quality of care delivered. Financial incentives involve the direct linkage of financial remuneration with clinical performance, an approach that has been termed “pay for performance,” “pay for value,” or “pay for quality.” Yet, much remains unknown about the effectiveness of the use of financial incentives as a payment strategy and the overall benefit conferred to patients. For this reason, the AHA decided to craft 4 principles to guide the structure and metrics used in pay-for-quality programs and identified at least 6 areas that required additional research to serve as criteria that should be considered when designing and evaluating pay-for-quality programs.

This second policy statement focuses on the use of nonfinancial incentives alone or in tandem with pay-for-quality programs. Nonfinancial incentives (NFIs) may include but are not limited to provider profiling in the form of public reporting, technical assistance for quality improvement activities, reduced administrative requirements, and recognition awards. NFIs can be integrated into either mandatory or voluntary programs. For purposes of illustration, a number of examples of NFI programs are described below.

Two prominent examples of public reporting programs are the New York Cardiac Surgery Reporting System and the Centers for Medicare and Medicaid Services “Hospital Compare” Web site. Initiated in 1989, the New York Cardiac Surgery Reporting System is the nation’s longest-standing effort to measure and report outcomes data for cardiac surgery. The system collects data on all coronary bypass operations, valve operations, and heart transplants and also collects data on patient demographics, such as admission, discharge, and surgical procedure dates; preoperative risk factors; and discharge status. One recent study found that public reporting of outcomes data did appear to be associated with a reduction in mortality rates for coronary artery bypass graft surgery.

In addition to state-driven efforts to require mandatory reporting, national efforts exist to make quality data available to the public. Currently, the Centers for Medicare and Medicaid Services publishes data on quality measures related to acute myocardial infarction, heart failure, pneumonia, and prevention of surgical infection. Data gathered on these measures are made available to the public via the “Hospital Compare” Web site as a means to inform consumers on the quality of care rendered by hospitals to patients being treated...
for one of the above conditions. Publishing these quality data also serves as a means by which to reward those hospitals that provide high-quality care.

Although a number of mandatory programs exist that are intended to influence quality of care, there are also a number of voluntary programs that serve as nonfinancial incentives. The Health and Stroke Physician Recognition Program, one of the voluntary recognition programs implemented through the National Committee for Quality Assurance, assesses physician performance on the basis of accepted clinical guidelines.8 Another example of a recognition program is the AHA/American Stroke Association’s Get With the Guidelines program,7 which recognizes hospitals with an award for achieving at least an 85% compliance rate for a set of performance measures for 3 conditions (coronary artery disease, heart failure, and stroke) and sustaining that improvement over time. Additionally, a number of government recognition programs exist that serve as nonfinancial incentives. Established in 1988, the Malcolm Baldrige National Quality Award recognizes those who have developed and successfully implemented a strategic plan for quality improvement.8 Similarly, the Medicare Quality Improvement Organizations can honor quality improvement efforts undertaken by hospitals.

Although both financial and nonfinancial incentives require valid measurement systems to discriminate performance among the groups undergoing evaluation, the primary distinction is in what is done with the information. While nonfinancial incentives may escape the scrutiny that is given to financial incentives because their impact is less direct, these efforts to improve health care must also be undertaken with caution; otherwise, programs that use NFIs will have an adverse effect on the healthcare system.

NFIs are potentially powerful interventions that should be guided by principles that emphasize the promotion of excellent patient care and encourage the development of enabling structures within the healthcare system that enhance its safety, effectiveness, efficiency, equity, timeliness, and patient-centeredness. The properties of any NFI system should be directed toward providing nonpecuniary rewards for actions that promote improvements in patient care and outcome; therefore, emphasis should be placed on the encouragement of system change and accountability.

Any intervention that seeks to change the performance of the healthcare system should be evaluated. In addition to ensuring that an NFI program is based on the best interests of the patient, such an evaluation needs to incorporate rigorous systems to ensure that the goal of the program translates into an actual measurable benefit for people. Moreover, there is a need to ensure that more favorable outcomes occur from changing practice.

NFIs that are developed should meet certain criteria to ensure that these interventions reflect the current state of the science and that the metrics used in these programs are appropriate to discriminate provider performance. NFIs should also serve to improve the healthcare system across the 6 dimensions noted by the 2001 Institute of Medicine report, Crossing the Quality Chasm, namely, by making it more safe, effective, patient-centered, timely, efficient, and equitable.9 In the absence of scientific evidence supporting the long-term effectiveness of these programs, the AHA developed the present statement to provide guidance on the criteria that should be used when NFIs are designed and evaluated. In developing this statement, the AHA used the recommendations delineated in both the Crossing the Quality Chasm report and the 2005 Institute of Medicine report, Performance Measurement: Accelerating Improvement.10

**Principles**

1. **Promote health care that is safe, effective, patient-centered, timely, efficient, and equitable.** NFIs should be designed, implemented, and evaluated to ensure the alignment of NFIs with delivery of high-quality care in the best interests of patients. For alignment with NFIs, quality-of-care measures should be evaluated and updated in a timely manner. Programs should be reevaluated periodically and should be responsive to changes in the evidence-based research, including consensus-based treatment guidelines. NFIs should be aligned to support systems-focused reforms in healthcare delivery. These programs should encourage coordination of care across specialties, providers, and facilities. NFIs for implementation and maintenance of health information technology should be explored. At the same time, NFI programs should address the burden of documentation on the healthcare delivery system.

2. **Employ rigorous methodological approaches for measurement of quality.** Quality-of-care measures should be standardized, evidence-based, and risk-adjusted. Rigorous methods should be used for measurement of quality, such as definition of data standards and provisions for consistency of measures. To the extent possible, quality measures should be based on clinical information, and these measures should be tested and validated to ensure that they are appropriate measures. If administrative data are used, these measures should be tested and validated against high-quality clinically derived data. Use of the highest-quality methodological approaches will minimize the likelihood of misinterpretation of quality. The alignment of incentives with these measures should be transparent. The AHA is committed to the science,11–14 data standards,15,16 performance measures,17,18 and methodological standards for developing these incentives.19–22

3. **Include evaluation mechanisms.** NFIs should include evaluation components to determine whether program goals are achieved or whether inadvertent adverse consequences result. Monitoring is needed to build an evidence base for outcomes of NFI programs. Evaluation is also necessary to ensure that NFI programs do not increase disparities in health care and do not have unintended consequences either at the patient or provider level.

4. **Provide financial and technical assistance to providers who need help establishing performance measures and infrastructure for improvement.** In addition to data collecting and reporting, providers may require additional financial and technical assistance in implementing quality improvement strategies, and these resources must be made available for these programs to improve the quality of patient care.

5. **Encourage local innovation in quality improvement and in the pursuit of national goals.** Local communities should be encouraged to identify and pursue priorities locally for...
quality improvement, as long as these efforts align with national goals for improving healthcare quality. Performance measurement, improvement, and reporting activities engaged in by public and private payers, accreditation and certification entities, and the federal, state, and local government should align with national goals and measures.

**Research Needs**

The AHA encourages further research into the realignment of NFIs to improve quality of care. Additional evidence may indicate how NFI programs could guide quality improvements in health systems and patient outcomes. Much research is still needed to understand the benefits and risks of NFI programs. Examples of potential research needs include but are not limited to the following:

1. Analyses of the effectiveness of alternative forms of NFIs on provider performance and patient decision making;
2. Identification and evaluation of new evidence-based performance measures to broaden our assessment of provider quality (eg, emerging therapies, safety metrics, and care equity);
3. Longitudinal evaluations of the impact of NFI programs on patient outcomes, particularly with respect to racial and ethnic disparities in health outcomes;
4. Evaluation of the optimal information services necessary to record patient outcomes and feedback time; and
5. Exploration of methodological issues, such as how various risk-adjustment techniques or means of creating a composite measure affect provider performance ratings.

This statement will be revised and updated as additional data on the effectiveness of NFIs become available.

---

**References**


KEY WORDS: AHA Scientific Statements cardiovascular diseases patients
Nonfinancial Incentives for Quality: A Policy Statement From the American Heart Association
Vincent Bufalino, Eric D. Peterson, Harlan M. Krumholz, Gregory L. Burke, Kenneth A. LaBresh, Daniel W. Jones, David P. Faxon, Adolfo M. Valadez and Penelope Solis

_Circulation._ 2007;115:398-401; originally published online December 18, 2006; doi: 10.1161/CIRCULATIONAHA.106.180202

_Circulation_ is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2006 American Heart Association, Inc. All rights reserved.
Print ISSN: 0009-7322. Online ISSN: 1524-4539

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circ.ahajournals.org/content/115/3/398

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in _Circulation_ can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to _Circulation_ is online at:
http://circ.ahajournals.org//subscriptions/