



November 2007

## VA's Performance Measurement Makeover

by Michael J. Kussman, M.D., M.S., MACP, Under Secretary for Health, Veterans Health Administration

### Contents

|  |   |
|--|---|
| Director's Letter  | 2 |
| Response to Commentary                                     | 3 |
| Research Highlights  |   |
| • Providing Optimal Care Is Complex—And So Is Measuring It | 4 |
| • Building a Better VA Performance Measurement System      | 5 |
| • Performance Measurement: Technical Aspects               | 6 |
| VA's Performance Management Work Group                     | 7 |

Former New York Yankees' catcher Yogi Berra, famous for his amusing observations about life, once reputedly said, "You've got to be careful if you don't know where you're going—because you might not get there." As nonsensical as Yogi's comment may seem, it underscores an important point about providing veterans with the best possible health care: in order to know where we are going, we first need to know where we are.

That's what makes VA's performance management system so important. The system helps us understand our successes, identify gaps in our care or management processes, and build improvements to enable us to provide veterans with "the best care anywhere."

### Turning Point for Measurement System

Although the current performance measurement system has served VA well, we are at a turning point. The Executive Career Field (ECF) plan for 2008 is the beginning of a new use of performance measurement. In 1995, when measures became a formalized part of the ECF plan by which all Senior Executives in the Veterans Health Administration are evaluated, all VA performance measures were simultaneously part of the ECF plan. Measures flowed through a Performance Management Work Group where vote counts determined their fate. Those votes were sometimes swayed by views of the ideal number of measures, not just the intrinsic properties of the new measure which was up for consideration.

Of VA's four missions: patient care, education, research, and emergency management, I believe that patient care is by far the most important. Therefore, it is critical we assess our performance in delivering patient care by

collecting data on broad and comprehensive measures covering the core areas of care we provide. We have turned a key corner in measurement with the development, this year, of both a comprehensive set of Health Systems Indicators and an ECF plan that is a subset of Health Systems Indicators. The Health Systems Indicators are a library of measures that cover, with breadth and depth, the care that we provide to our veterans. We are liberated from the "too few, too many" dilemma that existed when all performance measures were included in the ECF plan. Now we can ask the only performance question that really matters: How are we doing in taking care of our veterans?

Patients' perceptions, as measured by the Survey of Healthcare Experiences of Patients, allow us to add a rich patient-centered dimension to what we learn about the care we provide and also allow us to shape that care to meet the needs of patients. Both dimensions, measuring clinical care and asking our patients about their care, are critical.

In some cases, there are disconnects (such as the fact that patients' perceptions of the clinical quality of care delivered does not correlate with the clinical quality we measure). However, we learn and improve by addressing both key components—as well as the factors that lead to the lack of connection between the two.

The 2008 ECF plan will address a more select and limited set of measures. It will include a new category that we refer to as transformational measures, an expanded set of measures that reflect the efficiency of the care we provide, and core competencies that we deem essential for our senior executives. We know our staff, clinicians and non-clinicians alike,

## Director's Letter



Fiscal year 2007 has been a year of many accomplishments for HSR&D. Highlights include recognition of the innovative work done by HSR&D investigators through a number of prestigious awards. Dr. Rudy Moos received the 2006 Dan Anderson Research Award; Dr. Doug Owens earned the VA Under Secretary for Health Award; Drs. Rachael Werner, Louise Walter, and Paul Haidet received distinguished awards at the Society of General Internal Medicine Annual Meeting; Dr. Joseph Hanlon was honored by the American Geriatrics Society; and Dr. Kevin Volpp received the new investigator award at the AcademyHealth Annual Research Meeting, just to name a few.

This year also brought enhanced training and learning opportunities. Our Resource Centers have developed and implemented 67 cyber seminars to train investigators in health economics and data and information systems. Both managers and researchers benefited from the results of the new Evidence-Based Synthesis Pilot Project, with several synthesis reports now available on the HSR&D website (visit [www.hsrd.research.va.gov/publications/esp/](http://www.hsrd.research.va.gov/publications/esp/)). Most importantly, the investigator initiated research and career development programs continue to thrive. HSR&D reviewed 112 research proposals at our recent Scientific Merit Review Board meeting, and we expect to fund 27 of them. In addition, we hope to fund nine career development awards of the 31 reviewed.

It has been a challenging year, particularly as we worked to improve data security, confidentiality, and privacy protection. Personally, in my first year as Director of HSR&D, I have learned more about the organization from the Central Office perspective. Moreover, I have gained an immense appreciation for the hard work and dedication of our investigators and of the HSR&D staff in both Central Office and the field, who work diligently to improve the health and care of our veterans. I look forward to working with all of you in fiscal year 2008!

*Seth A. Eisen, M.D., M.Sc.  
Director, HSR&D*

want to do the right thing for our veterans. We do not believe that a measure *must* be in the ECF plan in order for us to improve our care. But we do know that presence in the plan is a powerful driver. This led to the development of Mission Critical Measures (measures designated as “must achieve” for this system of care) as part of the ECF plan.

Many new items are part of our new measurement system. The breadth and depth of our measures, and continual monitoring of them through a library of Health System Indicators, allow us to maintain continual readiness. If we see a key measure trending in the wrong direction, we act immediately:

first through alerts to the field; then by adding the measure back to the plan; and, finally, by developing quality improvement initiatives around the measure. Transformational measures provide us with stretch goals in key areas where we have opportunities for improvement.

### An External Benchmarking Opportunity

This year, we have formalized the concept of external comparisons. While we desire to provide great care because of our deep and passionate commitment to achieving excellence, the perception of VHA's quality is important to our very existence. In the past, one of the

challenges to external perceptions of quality was the charge by detractors that VA both developed our own measures and compared ourselves to ourselves—resulting in a lack of credibility. The statute that established the National Quality Forum (NQF) required federal entities such as ours to use NQF-endorsed measures. An August 2006 Executive Order further mandated use of measures developed by external entities, such as the Ambulatory Quality Alliance and the National Committee for Quality Assurance (NCQA).

This year, the quality measures in the ECF plan will be those of the Healthcare Effectiveness Data and Information Set (HEDIS), and ORYX measures that have been developed and given face validity as a result of the work of multiple bodies, including the NCQA, the American Medical Association, the Joint Commission, the Centers for Medicare and Medicaid Services, and the final arbiter, the NQF. Therefore, it will no longer be possible to challenge that we do well on measures only when we can create them ourselves. We gladly accept the challenge of comparing ourselves on measures that have been externally developed and widely used. This also gives VHA a valuable external benchmarking opportunity, and we do well when given that opportunity.

These measures and all measures are population-based. None are intended to guide treatments of individual patients. Making sure that this message is clear for clinicians is the ongoing challenge of measurement, not just for the VA, but for all who develop and use health care performance measures. No VA measures will be dropped; instead they will remain in the library of Health Systems Indicators so that our clinicians continue to receive a refined and granular look at the care they provide to patients.

As our knowledge about how to measure clinical performance expands, and our library of measures grows, we also face the challenge of narrowing our focus to areas of critical importance, and the ability to shift that focus in response to new knowledge and events. As Yogi also supposedly said, “You can observe a lot by watching.”

## Response to Commentary

# The Role of Health Services Research in Performance Measurement

Paul W. Shekelle, M.D., Ph.D., VA Greater Los Angeles Healthcare System

Health services researchers in VA have the benefit of working within a health care organization that is engaged in one of the boldest, large scale initiatives regarding performance measurement. Dr. Kussman's article explains what the next generation of that performance measurement system will be, and how it relates to the Executive Career Field plan. This new initiative offers many exciting opportunities for health services researchers interested in quality measurement and improvement.

## Refining Individual Measures

First, there is the traditional role of health services research in understanding and refining the individual measures themselves. How reliable is measurement? How accurately does the measure assess what is considered "quality" for this condition? Is it useful for distinguishing between providers? We know, for example, from work done by Eve Kerr and colleagues that existing External Peer Review Process (EPRP) measures correlate significantly but modestly with two other ways of assessing quality—using a larger and more comprehensive set of process measures, and the implicit review of medical records by peers.<sup>1</sup>

The finding by Kerr et al. suggests that each of these measurement systems pro-

vides a valid assessment of quality but each is also only a part of the picture. What are the implications of this finding? How can the measurement be improved? Health services research has a long history of doing this kind of "basic science" on the properties of quality measures. As new measures get proposed for inclusion in VA's measurement set, and as we learn more about what processes influence patient outcomes, there is—literally—an endless stream of this kind of work that needs doing.

## Performance Measurement as Intervention

I would like to suggest that health services researchers get more involved in another kind of research, which looks at performance measurement as an intervention. An intervention that is complex, which includes many components, such as the process that sets what the measurement criteria are, activities to achieve buy-in by people in the field, mechanisms for providing feedback, benchmarking, the use of a modest financial incentive to stimulate performance, etc. As an intervention, VA's performance measurement is likely influenced by many factors—at the VISN level, at the facility level, even perhaps at the individual level. And with 21 VISNs and hundreds of facilities, these factors are going to have a natural degree of variation throughout VA.

What kinds of components in this multi-component intervention, and what organizational characteristics, are associated with varying "success"? Can we identify specific organizational features and characteristics of individual intervention components that lead to greater "success"? Does performance measurement produce unintended consequences, and how can these be minimized? Do some measures or implementation methods work better than others to promote improvement and minimize unintended consequences? Research to date has only begun to generate the needed insights regarding how best to implement large policy interventions such as performance measurement and feedback.

The needed research is much messier than many researchers like—it is rarely feasible to study these policies experimentally, meaning that inference is going to have to come from observational studies. In most circumstances, it is not even possible to study policy implementation in a controlled fashion. I think it unlikely that policymakers would accept on a regular basis the implementation of performance measurement components on some facilities and not others. But just because it is more difficult does not mean we should shy away from the task. Indeed, VA health services researchers should strive to be at the leading edge of developing the methods by which generalizable knowledge can result from the study of real world policy initiatives.

There are already resources within VA to help us. The VA's QUERI program has been generating useful lessons about the difficulties in studying the implementation of complex interventions. *Implementation Science*, co-edited by Brian Mittman of the HSR&D Center at Sepulveda, publishes research in this field (visit [www.implementationscience.com](http://www.implementationscience.com)). We have an exciting task in front of us. It's going to be a challenge. But it is also going to offer great rewards, in terms of understanding how better to improve the delivery of care by VA, and by extension, other health systems.

## References

1. Kerr E, et al. Quality by Any Other Name: A Comparison of Three Profiling Systems for Assessing Health Care Quality, *Health Services Research*, in press.

### Mark your calendars!

HSR&D's National Meeting is scheduled for February 13-15, 2008 at the Marriott Waterfront in Baltimore, Md. *Implementation across the Nation: From Bedside and Clinic to Community and Home* is the theme for the 2008 meeting. This theme was selected to emphasize HSR&D's commitment to examining best practices in implementing state of the art health care for veterans. Together with workshops, oral presentations, and poster sessions, meeting highlights include a keynote address by Dr. Carolyn Clancy, Director of AHRQ, presentation of the Under Secretary's Award for Outstanding Achievement in Health Services Research, and a presentation by a young veteran injured in combat in Afghanistan. Visit [www.hsr.d.research.va.gov/meetings/2008/](http://www.hsr.d.research.va.gov/meetings/2008/) for more infor-

## Research Highlights

# Providing Optimal Care Is Complex— And So Is Measuring It

Rodney A. Hayward, M.D., HSR&D Center for Practice Management and Outcomes Research, VA Ann Arbor Healthcare System

Performance measurement is a powerful policy tool for promoting efficient high-quality care. However, it is often underestimated just how harmful performance measures can be when they are poorly constructed.<sup>1-3</sup> Perhaps the hardest lesson is that developing performance measures that promote optimal care usually requires clinically detailed data and complex measures, and that simplistic or naïve “good care” measures can have strong perverse incentives.

This push for simple measures is strongest in the community where the resources and will to invest in electronic medical records and chart-based review have been lacking.<sup>3</sup> However, since there is considerable political pressure for the VA to adopt those measures used in the community (so as to allow benchmarking), the recent push for all-or-none “good care” measures is of considerable concern (e.g., A1c < 7 percent, blood pressure < 130/80, LDL < 100mg/dl, etc). Such measures are likely to be very imprecise measures of efficient high-quality care, and are also prone to perverse incentives, such as promoting treatment irrespective of how small the potential benefit and how great the patient burden or risks.<sup>1-3</sup>

## Diabetes Measures

Take annual diabetes eye exams for example. Although well-timed photocoagulation for early diabetic retinopathy is one of the most beneficial treatments in all of medicine, research conducted by VA HSR&D suggests that almost all visual impairment that is preventable by early detection will be captured by: 1) screening those with no known eye disease every two to three years,

and 2) close individualized surveillance (every 4 to 12 months) after early retinopathy has been detected.<sup>4</sup> Therefore, annual exams are not of high importance for the vast majority of low-risk patients, and are too infrequent for the highest risk patients who will account for most preventable complications. As a result, the conventional performance measure (annual examinations for diabetic patients), which provides a strong incentive to focus resources on getting everyone into clinic every 13 months, provides no incentive to develop an effective system to optimize care.

In fact, a health system that schedules exams every 10 to 11 months and devotes its scarce administrative resources to trying to get anyone who misses this appointment into the clinic as soon as possible, is likely to improve its performance rating while doing almost nothing to improve outcomes. In contrast, a health system that uses its administrative resources to aggressively reschedule those needing close follow up (because of known retinopathy) and to have low-risk patients seen at least every two years (those whose last retinal exam was normal on their last visit), may make its performance rating much worse while substantially improving patient outcomes.

It should not be surprising therefore that when we tried to develop an effective system to improve eye screening and follow-up for diabetic patients, that the prevailing annual eye exam performance measure was one of the biggest barriers to implementing the more effective system. Although many may criticize clinic leaders for not doing the “right” thing, these clinics and providers have huge demands on their time and

attention. As has happened with so many important quality improvement initiatives that we’ve consulted on in the past 10 years, the clinicians and administrators eventually said, “If the problem you want us to address is really that important, then get the performance measure changed. We are struggling to meet dozens of demands and we just do not have the time and personnel to electively take on more things.”

## Measuring “Good Care”

It is rare that “good care” can be measured simply. Although the new NCQA diabetes measures of A1c < 7 percent and BP < 130/80 may seem straightforward enough, they actually provide strong incentives for speculative, costly, and potentially dangerous polypharmacy. In addition, these are unadjusted outcome measures that are likely to be inaccurate. For example, the A1c measure more strongly rewards adding or increasing the dose of a glitazone, which has high costs and limited data on long-term safety, in someone with an A1c of 7.5 percent than it does for doing so in someone with an A1c of 8.5 percent, even though a risk of an A1c of 7.5 percent is trivial compared to the risk of an A1c of 8.5 percent.

Similarly, although adding up to three to four medications at moderate doses in pursuit of good blood pressure control in a high CV-risk patient has been shown to be highly beneficial, the benefits of pursuing the 130/80 targets using more than three to four medications is pure speculation. Furthermore, there is ample reason to be concerned about harmful effects from polypharmacy or excessively lowering diastolic blood pressure.

Trying to measure a complex clinical scenario using simplistic performance measures and wishful thinking is increasingly promoted by disease advocates and industry-sponsored experts in the community. NCQA’s new “good control” diabetes measures and its resistance to revising its eye care measure despite the strong advice

*continued on page 8*

## Research Highlights

# Building a Better VA Performance Measurement System

Steven M. Asch, M.D., M.P.H., HSR&D Center for the Study of Healthcare Provider Behavior, VA Greater Los Angeles Healthcare System

Why measure quality of care? The answer to this question might seem obvious, but in thinking about how we can build a better quality measurement system, we must first clarify the purpose of this sometimes labor intensive activity. The most obvious answer is that measuring performance is an essential step in guiding quality improvement. But no measurement set is comprehensive, and there is always a danger that tracking performance for selected indicators will lead to improvement in those limited areas at the expense of equally important areas not targeted by the performance measurement system. So, a second purpose to any quality measurement system must also be to represent the broader and underlying quality provided in areas beyond the system. With luck, a quality measurement system will lead to improvement in those areas as well.

## The Evidence for Performance Measurement

The VHA performance measurement system is among the most widely implemented in the world. Managers receive regular reports as to how their regions or facilities are doing on selected measures of essential processes of care and intermediate outcomes. They pass these incentives down to line providers. What is the evidence that performance measurement has improved care? While it is difficult to disentangle the effects of performance measurement from other components of VHA reorganization that began in the 1990s, it is clear that VHA performance on the tracked items has surpassed competing systems. For example,

Jha et al. compared the VHA to Medicare and found better performance for 12 of 13 measures. But was this teaching to the test? How much of the improvement was confined to the tracked areas?

**“To paraphrase Kevin Costner in *Field of Dreams*, this is evidence that if you build it (the performance measurement system, that is), they will come.”**

A few years ago, Eve Kerr, Beth McGlynn, myself, and others investigated this question using a very broad range of quality indicators included in RAND’s QATools measurement set. We confirmed that the VHA outperformed a community sample overall on basic process measures. In the tracked areas, the difference was marked. VHA patients received 66 percent of recommended care as compared to 43 percent, a 23 point advantage. In unrelated measures of quality, the VHA also did slightly better, but the difference was much smaller, on the order of 5 percent. To paraphrase Kevin Costner in *Field of Dreams*, this is evidence that if you build it (the performance measurement system, that is), they will come.

## Building a Better Measurement Set

So far, it seems that performance measurement is bearing fruit in its primary purpose of guiding quality improvement to measured areas, but not for the secondary purpose of engineering more widespread improve-

ment. Interestingly, however, we found that the VHA performed better on measures that were related, but not the same as, the targeted areas. A related measure might be an aspect of diabetes that was not in the performance set, or an immunization that was not directly tracked like influenza vaccination. The VHA advantage here was real, 12 percent. We hypothesize that this is due to a chain reaction effect in the minds of the providers, who now think about diabetes care more because of performance measurement, but do so more holistically than the performance measurement set would require. Likewise, clinic managers have adjusted their thinking by building systems to make it easier to vaccinate for influenza and thus ease other vaccinations as well. So, if you build it, they will come, and they might stay at your neighbor’s house, too.

**“...we cannot afford to ignore important broad areas of care, because if we do, we may fail to spark quality improvement in related areas.”**

What are the implications for building a better performance measurement set? First, we cannot afford to ignore important broad areas of care, because if we do, we may fail to spark quality improvement in related areas. For example, the VHA performance measurement system had ignored acute care in the past, and this is now being remedied. Second, we should empirically test how well leading indicator systems represent broader concepts of quality of care to help us choose leading indicators more wisely. The VHA system is widely admired, and considerations such as these will keep it at the forefront.

## Research Highlights

# Performance Measurement: Technical Aspects

Timothy P. Hofer, M.D., Ms.C., HSR&D Center for Practice Management and Outcomes Research, VA Ann Arbor Healthcare System

This article will briefly review some general concepts related to the technical aspects of performance measurement that managers should be aware of in creating and using performance measurement systems. These concepts all relate to the following basic principle of performance measurement:

*Specific performance indicators represent a sample of all the possible processes and behaviors that need to happen so that the patients receive high overall quality care.*

## Sampling and Scoring

While the result of an indicator relating to colon cancer screening has some intrinsic interest, when managers offer substantial monetary incentives and assess performance through the use of such indicators the explicit assumption is that they measure a broader construct, such as a clinic's or hospital's overall quality, or perhaps the state of primary care or preventive care at a facility. Like the more familiar sampling of people to estimate a population characteristic, the indicators must be sampled in such a way as to represent the entire target population of indicated processes and behaviors. Furthermore, the sampling of indicators to estimate a construct such as quality introduces another source of uncertainty into the estimates. Standard performance measurement approaches do not adequately consider these issues.

First and most obviously, a performance measurement system is irretrievably flawed if the sampled measures do not adequately represent the range of behaviors that are actually important and that we should encourage. A non-representative sample provides a distorted measure of a broader construct such as "primary care quality." A non-representative sample also provides perverse incentives for providers to abandon important processes of

care and concentrate on the incidental processes that are over represented in the performance measures.

**“While seeking the holy grail of comprehensive automated performance measurement, other established but often underemphasized management tools—such as an active and effective emphasis on the perennial challenges of human resources and staff morale—remain critically important to maintaining and improving quality.”**

Second, the usual aggregate scores such as average pass rates—on all measured preventive care or chronic care indicators for example—do not adequately reflect the sampling variability inherent in the choice of a few indicators to represent a broader construct of quality. The result is that these aggregate measures may have a much higher noise to signal ratio than is suspected and may not track well any changes in practice by a provider or clinic. This leads to cynicism and demoralizes those profiled. One way to mitigate this problem is to use a random effects or multilevel analysis, which by explicitly modeling and removing some of the measurement error, results in a more precise quality score.

Third, in designing a performance measurement system, it is important to find the organizational level at which the variation is located, and at which, a response should occur. If a process varies across facilities but not across providers within the facility, and if the best approach to fixing the problem is an organizational rather than an

individual one, then what is the point of constructing provider level profiles?

A corollary of this last point is that if there is not much variation, then there may not be much point in measuring other than at the population level. So, for example, if only 50 percent of patients get a recommended process of care across a health care network and there is little variation across providers relative to this huge absolute gap (from 50 percent to 100 percent), then a network-wide remedy is needed. Furthermore, to assess the remedy a simple measurement based on a modest, network-wide sample is all that is needed to see how the rate changes. This task is much simpler than implementing a performance measurement system that must draw samples, calculate rates, and educate individual providers.

## The Halo Effect

Finally, managers should be relieved to know that there is data to suggest that measurement, feedback, and incentives using well designed performance indicators, such as some of the VA External Peer Review Process (EPRP) indicators, do appear to have a “halo” effect on indicators that are not part of the active measurement and feedback set.<sup>1</sup> However, this halo appears to extend only across the same clinical condition and not to unrelated clinical areas that are not part of the current EPRP system. The implication of this finding is not to start using poor measures for clinical areas that we do not yet monitor, but to recognize that performance improvement using clinical indicators may only be able to cover a finite amount of the waterfront. While seeking the holy grail of comprehensive automated performance measurement, other established but often underemphasized management tools—such as an active and effective emphasis on the perennial challenges of human resources and staff morale—remain critically important to maintaining and improving quality.

## References

1. Asch SM, et al. Comparison of Quality of Care for Patients in the Veterans Health Administration and Patients in a National Sample. *Annals of Internal Medicine* 2004; 141(12):938-45.

# VA's Performance Management Work Group

Tammy Czarnecki, M.S.O.L., M.S.N., R.N., Clinical Quality Program Specialist, Office of Quality and Performance

As Dr. Kussman points out in his lead commentary, the VA's performance measurement system—with over 100 performance measures in the areas of access, satisfaction, cost, and quality—has served VA well. In 1995, VA first incorporated performance measures in the Executive Career Field (ECF) performance contract, an annual plan that establishes standards against which both central office and VISN leaders are evaluated. ECF contracts ensure accountability for both administrative and clinical performance measures and are developed collaboratively by central management and field leaders.

These performance contracts form the basis for quarterly management reviews, and incorporate modest management incentives. Results are also reported broadly within the VA and externally to key stakeholders including Congress, the Office of Management and Budget, and advocacy groups. Linking performance measures to these contracts results in personal accountability throughout the system. The Performance Management Work Group is central to this process. The work group has four key responsibilities:

- Engage in regular and systematic planning for measurement;
- Perform annual review of existing network trends;
- Consider non-VA comparator system trends; and,
- Oversee the development of the annual ECF performance plan.

This last responsibility involves a multi-step process, which begins with the work group integrating the priorities it receives from the Under Secretary for Health and other central and local VA leaders. The work group then convenes to identify

measurement priorities and to assure measurement initiatives are developed, and approves proof of concept proposals from subject matter experts. The work group must also maintain a clear set of criteria for measurement approval and retirement, and, ultimately, identify and incorporate proposed performance measures into the next year's performance plan. The 2008 ECF plan emphasizes greater personal accountability by utilizing a streamlined set of performance measures, including new measures aimed at the efficiency of care provided to veterans, and also core competencies expected of senior leaders.

The recent adoption of a new VA national performance measure for thiazide diuretic use illustrates the rigorous process by which new measures are vetted by the work group. Despite evidence-based guidelines which favor thiazide diuretics among patients with uncomplicated hypertension, use of these drugs remains low. National hypertension management guidelines such as the Joint National Committee (JNC) 7 and the VA/DoD Hypertension Clinical Practice Guidelines recommend thiazide use for most patients in accordance with the results of the ALLHAT study. However, review of published pharmacy utilization data both in VA and in the private sector strongly suggests that hypertension guidelines are not followed for most patients. The work group approved inclusion of a pilot measure for diuretic use, which eventually led to adoption of the new performance measure for diuretic use in 2007.

Comprised of central and field leaders, and including both administrators and clinicians, the work group is co-chaired by Barbara Fleming, M.D., Ph.D., and Jim

Roseborough, FACHE. The efforts of the group result in performance contracts that are recommended to the Under Secretary for Health and represent the collaborative efforts of central and field leadership, and reflect both administrative and clinical priorities.

## The HSR&D Cyber Seminar Program, A Great Educational Resource

The HSR&D Cyber Seminar Program continues to grow with new courses being added monthly. The new and improved HSR&D Cyber Seminar Catalog now allows users to view, sort, and search the catalog of offerings according to user-defined criteria. Interested in cost-effectiveness? Implementation research? Clinical informatics? A quick search of the catalog points you to an array of seminars on your topic of interest. Sign up to participate in a live session or download a recorded session for viewing on your computer at your convenience. Audio recordings, session slides, and handouts also are available for download from the catalog. Check out the new and improved catalog on the HSR&D website at [www.hsr.d.research.va.gov/for\\_researchers/cyber\\_seminars/catalog.cfm](http://www.hsr.d.research.va.gov/for_researchers/cyber_seminars/catalog.cfm)

## Introducing FORUM's new look!

FORUM is a newsletter of VA's Health Services Research & Development Service. This issue marks the debut of a new format that we hope will improve readability and the overall look and feel of the newsletter. We hope you enjoy the FORUM makeover and we especially welcome your comments and suggestions. Send comments and suggestions via email to [hsrdweb.boston@va.gov](mailto:hsrdweb.boston@va.gov)

continued from page 4

of evidence-based medicine experts is just one example of this trend. This is not to suggest that we should limit ourselves to only measuring bad care, such as A1c > 9 percent or retinal screening exams > two years. However, if we wish to measure “good care,” we will need more nuanced performance measures that consider the benefit of reaching these “optimal” treatment goals, as well as the risks, costs, and patient burden associated with treatments needed to reach these optimal goals.

## References

1. Hayward RA. Performance Measurement in Search of a Path. *New England Journal of Medicine* 2007; 356(9):951-3.
2. McMahon LF, Hofer TP, Hayward RA. Physician-level P4P–DOA? Can Quality-based Payment Be Resuscitated? *American Journal of Managed Care* 2007; 13(5):233-6.
3. Hayward RA. All-or-nothing Treatment Targets Make Bad Performance Measures. *American Journal of Managed Care* 2007; 13(3):126-8.
4. Hayward RA, et al. Causes of Preventable Visual Loss in Type 2 Diabetes Mellitus: An Evaluation of Suboptimally-timed Retinal Photocoagulation. *Journal of General Internal Medicine* 2005; 20:467-9.

## FORUM

Geraldine McGlynn, Editor-in-Chief  
Margaret Trinity, Editor

### Editorial Board

Peter Almenoff, M.D.,  
Director, VA Network #15,  
Kansas City, MO

Martin P. Charns, D.B.A.,  
Director, VA HSR&D Center  
of Excellence, Boston, MA

Seth A. Eisen, M.D., M.Sc.,  
Director, HSR&D

Joseph Francis, M.D., M.P.H.,  
Deputy Chief Research and  
Development Officer,  
Associate Director, HSR&D  
QUERI, Central Office

Rodney A. Hayward, M.D.,  
Director, VA HSR&D Center  
of Excellence, Ann Arbor, MI

Shirley Meehan, M.B.A.,  
Ph.D., Deputy Director,  
VA HSR&D, Central Office

Michael J. Miller, M.D.,  
Ph.D., Chief Medical  
Officer, VA Network #1,  
Bedford, MA

Eugene Z. Oddone, M.D.,  
M.H.Sc., Director,  
VA HSR&D Center of  
Excellence, Durham, NC

Alan S. Perry, M.H.A.,  
FACHE, Director, VA  
Central California Health  
Care System