

Seven Policy Recommendations To Improve Quality Measurement

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by [Robert Berenson](#)

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Performance measurement — if done right — can be a core activity to move the health care system to higher value for the American public, while rewarding health professionals and health care institutions for doing the right thing for their patients. Yet, policy makers, private and public, have a duty to the public, patients, and providers to get it right — to measure and report accurately and meaningfully.

Harlan Krumholz and Peter Pronovost have been among the most important contributors to the development of performance measures for quality and safety of health care. At the same time, each has written powerful critiques of particular aspects of the current measurement enterprise with suggested improvements. I work mostly inside the Beltway in a world of policy makers who, despite good intentions, by their actions often display a lack of understanding of the challenges associated with measures, measurement, public reporting, and pay-for-performance. For example, the physician value-based modifier, which was mandated as part of the Affordable Care Act and now must be implemented by CMS, cannot produce a valid snapshot of an individual physician's "value" but will be imposed nevertheless, unfortunately feeding those within the physician community who resist all efforts to improve accountability and transparency of performance.

With the encouragement of the Robert Wood Johnson Foundation, [Harlan, Peter, and I joined in a collaborative endeavor to produce a comprehensive look at the state of play of performance measurement and public reporting](#) — their conceptual underpinnings and limitations, successes and failures, and, perhaps most importantly, recommendations for major steps that are needed now to put the measurement enterprise on track to achieve its potential to improve the value of U.S. health care without doing harm.

Here are the seven major steps we propose:

1. Decisively move from measuring processes to outcomes.

The operational challenges of moving to producing accurate and reliable outcome measures, as opposed to the process measures that currently dominate performance measurement, are daunting but worth the commitment. Patients, payers, policymakers, and providers all care about the end results of care, not the technical approaches that providers may adopt to achieve desired outcomes. Simply, process measures are not strong predictors of outcomes that matter and may divert attention from work process improvements that would actually improve outcomes.

2. Use quality measures strategically, adopting other quality improvement approaches where measures fall short.

CMS's current value-based purchasing efforts ("pay for performance" with a new name) require reporting on a raft of measures of varying usefulness and validity, which may divert providers' attention from efforts to make culture and work process improvements that could produce larger improvements in outcomes. In their place, Congress should refocus its directives to CMS to emphasize using performance measures more strategically to improve specific quality deficiencies — relying more on promoting collaborative quality improvement activities and new payment approaches that incorporate performance measures than on public reporting and pay for performance per se.

3. Measure quality at the level of the organization, not the clinician.

Consistent with the broad movement toward population-based accountable care, performance measurement should move to the organizational or departmental level, allowing measures to assess and promote team-based care, while addressing many of the technical issues that can undermine measurement efforts at the level of the individual clinician.

4. Measure patient experience with care and patient-reported outcomes as ends in themselves.

Given the inevitable gaps in both process and outcome measures for specific areas of clinical care, it is important to realize that patient experience is ubiquitous and can be drawn upon to measure a broad range of health care dimensions. With the growing array of scientifically rigorous surveys of patient experiences with care, we now have the capacity to incorporate standardized assessments of that experience into the measurement enterprise.

5. Use measurement to promote the concept of the rapid-learning health care system.

The dissemination of quality measure data should be viewed as one prong in a multi-pronged strategy to improve health care quality. Accompanying strategies should include offering technical assistance to strengthen providers' capacity to improve care and creating formal accountability systems. Collaborative activities among institutions can produce insights that may elude them individually: measures can help identify top performers, and detailed analysis can then identify what distinguishes those who excel.

6. Invest in the "basic science" of measurement development.

An infrastructure is needed to gain national consensus on: what to measure; how to collect the data needed to calculate measures; the accuracy of EHR data for use in performance measurement; how to measure the cost-effectiveness of particular measures; how to reduce the costs of data collection; what thresholds to use to ensure measure accuracy; and how to prioritize which measures to collect. Establishing general standards for performance measures could help move the policy discussion from whether measures are good enough to use despite their flaws to a more fundamental discussion of how to design good measures, how to assess current measures, and whether the costs of producing better measures are worth the benefits.

7. Task a single entity with defining standards for measuring and reporting quality and cost data, similar to the role the Securities and Exchange Commission (SEC) serves for the reporting of corporate financial data, to improve the validity, and comparability, and transparency of publicly reported health care quality data.

The National Quality Forum does a good job of reviewing and approving proposed measures presented to it, but it lacks the authority to establish definitive quantitative standards that would apply broadly to purveyors of performance measures. As a result of this lack of standards, most quality measurement efforts struggle to find measures that are scientifically sound yet feasible to implement with the limited resources available; too often, feasibility trumps sound science. The field of quality measurement could advance significantly if providers and policymakers agreed on validity thresholds and voluntarily reported the validity of their quality measure data, all supervised by an entity modeled after the SEC. Policymakers will need to consider whether such an entity should be housed at the Agency for Healthcare Research and Quality (AHRQ), should be a public-private partnership such as NQF, or should be a new government entity. Such a commission could promote standardization, transparency, and auditing of the reporting of quality and cost measures.

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Karen Feinstein Says:

[May 23rd, 2013 at 10:39 am](#)

Thanks to Berenson, Pronovost, and Krumholz, for surfacing the dilemma of often contradictory information – and misinformation – related to performance measurement. Their call for better science, standardization, transparency, and accountability in performance measurement could “reduce the noise” generated by multiple measurement development and reporting entities, which is highly confusing to patients, providers, and purchasers seeking information on which to act.

Our mission at the Pittsburgh Regional Health Initiative, as with other regional quality improvement collaboratives, is to provide performance information that is useful to providers and to payers; data that “cause providers to engage in broader approaches to quality improvement activities.” Improvement collaboratives exist to surface and prove better ways to deliver health care and achieve better outcomes. But we can only sell our ideas for better care if we have credible data that substantiate our discoveries.

There are a number of obstacles to applying credible, actionable measures and measurements for quality improvement and, hence, achieving convincing outcomes of experiments and demonstrations. What could slow progress is a shortage of healthcare professionals able to play in this brave new data-driven world. Not only are QI tools needed, but physicians and nurses, pharmacists, medical assistants, and others all need to master the fundamentals of data collection, analysis, application, and evaluation. They have to be able to recognize the limitations of any data, understand the implications or qualifications of findings, and know how to engage in substantive demonstrations and hypothesis-testing.

PRHI and six other organizations have recently received the designation of Qualified Entities. We are pleased to engage in this new initiative to apply previously unavailable Medicare data to public reporting on cost and quality. Could we launch these activities in a “learning collaborative” mode to accelerate our understanding of what data we report to consumers and purchasers, as well as providers and plans, and how we can best report it, to stimulate better decision making, quality improvement initiatives, value based purchasing and payment?