10 Criteria for Meaningful and Usable Measures of Performance

Executive Summary

Consumers, purchasers, policy makers, and other stakeholders seek improved quality and affordability in our health care system. A strong set of meaningful and usable performance[1] measures is an essential tool in this pursuit. Currently, there are not enough of these measures, which are vital to:

- Determine whether new models for care delivery and payment are substantially improving health outcomes.
- Help consumers choose health care providers and treatments.
- Engage patients in decisions about their care.[2]
- Give providers information that supports their efforts to improve care.
- Enable purchasers and health plans to reward high value care.

To meet these acute needs, more ambitious standards are required to produce the kinds of quality measures that will drive meaningful improvements in care.

The Consumer-Purchaser Alliance (C-P Alliance) developed **10 criteria** for meaningful and usable measures. These criteria reflect the perspectives of those who receive and pay for care and should be used to guide the development, endorsement, and use of performance measures. Performance measures must address the needs of those whom the health care system is intended to serve and those who pay the price for poor and inefficient care – *consumers and purchasers*. These criteria are:

1. **Make consumer and purchaser needs a priority in performance measurement.**
2. **Use direct feedback from patients and their families to measure performance.**
3. **Build a comprehensive "dashboard" of measures that provides a complete picture of the care patients receive.**
4. **Focus measurement on areas of care where the potential to improve health outcomes and increase the effectiveness and efficiency of care is greatest.**
5. **Ensure that measures generate the most valuable information possible.**
6. **Require that all patients fitting appropriate clinical criteria be included in the measure population.**
7. **De-emphasize documentation (check-the-box) measures.**
8. **Measure the performance of providers at all levels (e.g., individual physicians, medical groups, ACOs, etc.).**
9. **Collect performance measurement data efficiently.**
10. **Align standardized measures across payers**

The Patient-Centered Measure Dashboard

Better Health

- **Clinical outcomes of treatment:** The results of care that are typically reported by a doctor or other clinician. Examples of clinical outcomes include treatment complications, health status, morbidity, mortality, preventable readmissions, and laboratory determinations of physiologic values.
- **Patient-reported outcomes of treatment:** Assessments by patients of whether treatment is "working." These may include patients' reports of well-being, resolution of pain, improved functioning.

Better Care

- **Appropriateness of care:** Underuse and overuse of diagnostic and treatment resources (which are typically assessed by the process measures in use today) and misdiagnosis. Overuse focuses on whether a treatment or procedure is appropriate given its net clinical benefit, expenditure of resources, and risk to the patient, e.g., exposure to radiation or complications from surgery. Underuse occurs when patients do not receive medically necessary care, or when proven health care practices are not followed.
- **Patient experience with care:** Evaluates people's perspectives of their experiences with their provider's care, i.e., how well a doctor communicates, knows their patients, coordinates care, provides quick access to appointments and care, and whether the outcome reflects a patient's expectations.
- **Patient activation and engagement:** Evaluates people's ability and willingness (e.g., knowledge, skills, and confidence) to manage their health and health care. Providers can play an important role in developing these qualities.
- **Care coordination and care transitions:** Assesses how well multiple providers work together to provide seamless care to a patient, including as he or she moves from one provider or care setting to another, or to their home
- **Effective use of health information technology (HIT) by patients and care providers:** Evaluates whether HIT is used to improve how providers deliver care and/or to help patients become more engaged in their care.
- **Patient safety:** Assesses the presence of medical errors and the use of processes and management practices proven to promote patient safety (e.g., hand hygiene, medication reconciliation, and effective teamwork).

Lower Cost

- **Total cost to and expenditures by (1) the patient; (2) the insurer; and/or (3) the health care system:**
  - Over the course of a year
  - Per case or acute episode.
- **Efficiency of resource use**, including key utilization metrics such as emergency department visits, hospital admissions, and readmissions.

Many of the identified measure types may fit into more than one section of the three-part aim.

1 Make consumer and purchaser needs a priority in performance measurement.

PROBLEM:

Transforming the health care system requires that consumers and purchasers take a larger role in improving care (e.g., patients should have information to select providers that meet their needs, and purchasers should offer providers the right incentives to pursue value instead of quantity of care). Although we have made some progress in recent years, we have not yet met the goal of providing adequate information for consumers and purchasers to take such actions.

OPPORTUNITY:

Those working in measurement should take seriously the requirements described in these criteria and involve consumers and purchasers meaningfully in decisions related to measure development, endorsement, and use at national and local/regional levels so that their needs are a priority. Meaningful participation includes early and active involvement, not just token representation.

2 Use direct feedback from patients and their families to measure performance.

PROBLEM:

Most measures currently in use are overly reliant on information generated by the health care system and do not capture the perspective of the person receiving health services, who is often in the best position to evaluate their effectiveness.

OPPORTUNITY:

More measures should assess outcomes and effectiveness of care as experienced by patients and their families. These should include measures of patients' understanding of treatment options and involvement in creating care plans, and their feedback on whether care made a difference. Measure developers should consider how patient-reported data can be collected and used efficiently and effectively as health plans and providers connect electronically with their members/patients. Moreover, digital health tools are increasingly able to help create, record, or gather data from patients or caregivers, known as patient-generated health data.

3 Build a comprehensive "dashboard" of measures that provides a complete picture of the care patients receive.

PROBLEM:

Consumers and purchasers want measures that capture whether the care provided reflected the patient's preferences, made a difference for that patient, and was delivered safely and efficiently. All too often, measures focus on discrete treatment processes instead of providing a holistic view of the patient's health.

OPPORTUNITY:

A comprehensive dashboard of measures will make it possible to assess care from a holistic perspective, including overall effectiveness and efficiency of care. Such a dashboard will allow us to hold individual physicians, accountable care organizations, care teams, hospitals and other providers accountable for how well they care for their patients using a multi-dimensional view, which is particularly important for those with multiple chronic conditions.

The Patient-Centered Measure Dashboard on page 2 shows a dashboard that covers the full spectrum of measures, categorized by the three-part aim of achieving better health, better care, and lower cost. We recommend that if a measure set cannot address a specific area due to current data or other technical limitations, a clear course should be charted out to develop methods to fill the gap.

4 Focus measurement on areas of care where the potential to improve health outcomes and increase the effectiveness and efficiency of care is greatest.

PROBLEM:

Measure development, endorsement, and use efforts don't always focus on areas of care with the greatest potential to improve quality and use resources effectively.

OPPORTUNITY:

To ensure the best possible return on investment, measure sets should:

- Focus on areas of practice with high frequency, high cost, wide variation, disparities in delivery, and/or evidence of care that is often inappropriate.
- Address leading causes of morbidity, mortality, and disability.
- Assess care of patients with multiple chronic conditions, a leading cost driver.
- Cover areas identified by the Institute of Medicine (IOM) as needing significant improvement: safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness.
- Meet the four evaluation criteria used by the National Quality Forum (NQF):[3] (1) importance to measure and report – especially to consumers and purchasers, (2) scientific acceptability of the measure properties, (3) feasibility, and (4) usability – especially by consumers and purchasers.
- Include measures of processes of care only if they have strong, evidence-based links to key outcomes and are consistent with current clinical guidelines.
- We encourage decision makers to use priorities identified by national organizations to guide work in measurement. Collectively, these priorities cover a breadth of areas important to consumers experiencing different health needs (e.g., preventive, acute conditions, chronic conditions). Such organizations include:
  - The federal government's **National Quality Strategy**.
  - The **National Quality Forum** (NQF) in its **prioritization** for measure development and endorsement.
  - The **Measure Applications Partnership** (MAP), which is public-private partnership convened by NQF for the explicit purpose of providing input to the Department of Health and Human Services on the selection of performance measures for public reporting and performance-based payment programs.
  - **CMS' Measure Development Plan** for the Quality Payment Program.

5 Ensure that measures generate the most valuable information possible.

PROBLEM:

Measures are not always collected or reported in the best way to aid decision-making by consumers, purchasers, health care providers, and policy-makers.

OPPORTUNITY:

There are a variety of ways to improve the value of information generated. The following are few examples.

Use statistical standards that allow variations in care to show through.

Measure developers should strike an even balance in correcting for measurement errors that inadvertently identify providers as "outliers" and those that fail to identify those providers that are. Measures typically incorporate statistical techniques, such as risk adjustment, risk-stratification, setting standards for reporting through confidence levels, and so forth. But the application of these techniques can be too conservative and wash away important variations in care. Measures may be *over-adjusted* for risk and/or set overly stringent statistical standards, such as requiring a 95% certainty that the results precisely represent a provider's performance on a measure or labeling most providers as "average" when large variations in care are known to exist. This is problematic because patients and purchasers need information that distinguishes performance among providers.

Capture lab values and vital signs on a continuous scale.

Actual numerical lab values and vital signs that represent valuable intermediate outcomes in treatment (e.g., LDL, HbA1c, blood pressure) should be captured so the exact outcome can be collected. Intermediate outcome measures are often structured in a "yes" or "no" form, otherwise known as binary measures. An example is whether a patient with diabetes has "controlled blood sugar," meaning "yes" that an HbA1c level of less than 9% (or 7% or 8%) has been achieved. These binary measures generally ask whether the outcome of care meets a threshold based on guidelines or opinions that are often subject to change. For measures like these, data should be captured on a continuous scale so that thresholds can be adjusted without needing to recapture the data from the source. For example, the exact HbA1c value would be captured (e.g., 7.6%).

Knowing the exact value of the outcome for each patient allows:

- Different thresholds to be set.
- Better evidence to inform clinical guidelines and identify which treatments work best for which patients.
- Providers to focus their improvement efforts.

Capture data for disparities analysis.

Measures should be stratified by demographic information, such as race, ethnicity, language, gender, disability, and socioeconomic status. This will provide important information to help identify and address disparities.

6 Require that all patients fitting appropriate clinicial criteria be included in the measure population.

PROBLEM:

Sometimes measures are constructed to allow patients to be excluded (using "exclusions" and "exceptions") from the measure population for poorly defined reasons. This can:

- Lead to inappropriate removal of patients and promote "gaming" of results.

- Discourage providers from engaging patients.
- Mask the exact reason a patient is removed, resulting in loss of transparency and valuable information.
- Leave room for interpretation, thereby undermining comparability.

These concerns frequently arise when the reasons for exclusions and exceptions are too broad and/or not well substantiated.

OPPORTUNITY:

To avoid these problems, reasons for exclusions and exceptions should **be *evidence-based, highly specific, and explicitly defined***. Examples of **justifiable, well-defined reasons** for removing a patient are:

- A measure of whether a physician provides mammography screening to women would not include women who have had their breast tissue removed. These women do not require the screening and therefore should not be included in the measure.
- A measure of whether a patient received or filled a prescription would not include a patient with an allergy to the medication.

7 De-emphasize documentation (check-the-box) measures.

PROBLEM:

"Check-the-box" measures document the occurrence of evaluation, assessment, counseling, and other steps by a provider, but tell us little about the quality of care provided or its outcomes. For example:

- Current measures of whether a clinician provided counseling on smoking cessation – an important element in caring for individuals and populations – don't reveal how effective the counseling was.
- Measures of whether a physician performed an evaluation of a patient's ability to walk after hip surgery don't tell us whether the surgery actually made a difference. Rather, we need the results of the evaluation.

In fact, there is a poor relationship between such measures and patient outcomes.[4] And when a measure is defined as a simple "check-the-box" (yes/no) item, it is often subjective and easy to "game."

OPPORTUNITY:

- Ask the patient to provide feedback on the quality of the interaction with the physician on particular issues (e.g., smoking cessation); and in the longer term, determine whether the outcome was positive (e.g., whether the patient quit smoking).
- Report the results, not the occurrence, of evaluations and assessments.

8 Measure the performance of providers at all levels (e.g., individual physicians, medical groups, acos, etc.)

PROBLEM:

Many argue that measures, especially those involving patient outcomes, should only be applied at a higher level in the chain of care providers (e.g., at the level of the practice group, the ACO, etc.) rather than at the level of the individual physician. But consumers need to select individual physicians to be a part of their care team, even where team-based practice occurs.

OPPORTUNITY:

Performance should be measured at all levels, including the individual physician level, when sample sizes are sufficient. Consider that:

- Individual physicians make decisions that control 87% of personal health spending.[5]

- Data on practice groups do not always well represent an individual physician's performance. The way physicians within the same group care for their patients can vary significantly, and individual physicians greatly impact the care that a patient receives.[6]

Even where sample sizes are small, performance information can be very valuable to physicians themselves to help them accelerate quality improvement. While patients and system factors related to the physician's practice setting also affect clinical performance and its outcomes, we should measure performance and, once adjusted for critical patient risk factors, attribute it jointly to individual physicians, their team, and the system they practice in. In other words, we subscribe to a concept of shared accountability.

9 Collect performance measurement data efficiently.

PROBLEM:

Providers often raise issues about the amount of effort it takes for them to collect performance data.

OPPORTUNITY:

Ideally, performance measures should be based on the same data that clinicians use – or should use – to care for their patients. Specifications should call for measures to be populated with electronic data that are collected and used for patient care, including patient-reported outcomes. Where the data do not exist in electronic form today, there should be a clearly articulated path for future electronic collection and submission of data by increased reliance on electronic health records, as well as broader efforts by specialty societies, hospitals, nursing homes, and others to collect electronic data.

The desire to avoid encumbering providers with additional data collection requirements must be balanced against the tremendous need that patients, purchasers and other stakeholders have for information. Patients face significant burdens every day when trying to navigate the health care system, including choosing a provider, trying to find affordable care, and determining what treatment will be best for them. At another level, purchasers and payers need information to help them reward higher-performing providers who generate better quality and value of care.

10 Align standardized measures across payers

PROBLEM:

Historically, payers have individually set quality measurement expectations for participation in their network. These expectations overlap, but there is enough variation to make it administratively complex for providers to manage. Moreover, requirements for slightly different measures make it difficult to compare results. For consumers and purchasers, the myriad of differences among quality measures are confusing at best and can result in seemingly conflicting information.

OPPORTUNITY:

Multi-payer adoption of standardized core measure sets sends consistent signals to providers, making it easier to focus on improvement and reducing the effort on measurement. Using data from multiple payers for the same measure also increases the reliability, allowing for more confidence in results. The Core Quality Measures Collaborative is an example of public-private partnership that has made strides in harmonizing measures across payers and programs.[7,8]

Endnotes

[1] Refers to important and worthwhile measures to consumers and purchasers that are good candidates for accountability programs

[2] For brevity, we refer in various places in our comments to "patient" and "care," given that many programs and initiatives are rooted in the medical model. To some, these terms could imply a focus on episodes of illness and exclusive dependency on professionals. Any effort to improve patient and family engagement must include the use of terminology that also resonates with the numerous consumer perspectives not adequately reflected by medical model terminology. For example, people with disabilities frequently refer to themselves as "consumers" or merely "persons" (rather than patients). Similarly, the health care community uses the terminology "caregivers" and "care plans," while the independent living movement may refer to "peer support" and "integrated person-centered planning."

[3] NQF is a nonprofit organization that uses a consensus process to engage multiple stakeholders in measure standardization at the national level.

[4] Chassin M., Loeb J., Schmaltz S., and Wachter R., "Accountability Measures – Using Measurement to Promote Quality Improvement," *New England Journal of Medicine*, June 2010. https://www.nejm.org/doi/full/10.1056/NEJMsb1002320

[5] Sager A. and Socola D., "Health Costs Absorb One-Quarter of Economic Growth, 2000–2005," Data Brief No. 8, Boston, MA: Boston University School of Public Health, February 2005. https://www.bu.edu/sph/files/2015/05/Health-costs-absorb-1-4-econ-growth-Sager-Socolar-summary-%E2%80%A6.pdf.

[6] Rodriguez et al, "Attributing Sources of Variation in Patients' Experiences of Ambulatory Care," Medical Care, Vol. 47, No. 8, August 2009.

[7] Core Measures. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html

[8] Conway, P. "The Core Quality Measures Collaborative: A Rationale and Framework for Public-Private Quality Measure Alignment," *Health Affairs*, June 2015. https://www.healthaffairs.org/do/10.1377/hblog20150623.048730/full/

ABOUT THE CONSUMER-PURCHASER ALLIANCE

The Consumer Purchaser Alliance is a collaboration of leading consumer, employer and labor groups working together to promote the use of performance measurement in health care to inform consumer choice, value-based purchasing, and payment. Funded by the Robert Wood Johnson Foundation, along with support from participating organizations, our mission is to strengthen the voice of consumers and purchasers in the quest for higher quality, more affordable health care.