QUALITY VS. COST-EFFICIENCY

Both are needed to understand value.

While there is widespread agreement that reporting of quality of care is an important component of accountability, many providers believe they should not be accountable for the total cost of resources associated with their care. Such cost-efficiency based measures do tend to be less precise than quality measures; however as consumers bear more health care costs they understandably need such an inclusive measure of total cost associated with a their providers (e.g., physician, hospital, health system, etc.).

ELECTRONIC DATA VS. PAPER MEDICAL RECORD TO GENERATE PERFORMANCE MEASUREMENT:

Electronic data sources are the most feasible near-term path.

Some clinicians and researchers feel that most measurements should be limited to those based on medical record review. Medical records are usually the most complete source of clinical information. However, they are also subject to flaws and providers, purchasers and consumers are usually unwilling to bear the high cost of medical record review. Electronic data from provider bills, insurer enrollment files, laboratories, pharmacies and other sources are the only feasible basis for comprehensive performance measurement in the near term. Looking toward the future, electronic medical records, information exchanges and supplementary coding of provider bills should be designed to support performance measurement and reporting.

The Consumer-Purchaser Disclosure Project is a group of leading employer, consumer, and labor organizationsworking toward a common goal toensure that all Americans have access to publicly reported health care performance information. Our shared vision is that Americans will be able to select hospitals, physicians, and treatments based on nationally standardized measures for clinical quality, consumer experience, equity, and efficiency. The Disclosure Project is funded by the Robert Wood Johnson Foundation along with support from participating organizations

For more information go to:
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Consumer-Purchaser
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A Pocket Guide to Seven Key Measurement Issues

for Purchaser & Consumer Leaders Participating in Performance Transparency Dialogue with Health Industry Leaders

In discussions with clinicians and researchers, consumer advocates and purchasers often encounter common arguments. These talking points articulate purchaser and consumer positions on seven key issues and draw on the Institute of Medicine's definition of health care performance -- a multidimensional concept which includes safety, timeliness, effectiveness, efficiency, equity and patient-centeredness.

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Consumer-Purchaser
DISCLOSURE PROJECT

Seven Key Measurement Issues

LEGITIMACY OF OPINION ON "GOOD SCIENCE":
Your opinion is equally valid!

Clinicians or researchers may imply that their scientific and medical expertise gives their opinion more legitimacy, especially when discussing whether a measure is "good enough" scientifically. These professionals do often have deeper technical knowledge, which does give their opinions legitimacy; however, as in all industries where buyers and sellers interact, customer judgment is final arbiter of value. When providers and researchers assert that measures aren't "scientifically acceptable," it's important to note that the alternative – no measurement – is an unacceptable option for patients who must make health care choices without reliable quality information. The balancing of these two legitimate perspectives – the scientific and the practical – is a matter of values, not science.

IMMEDIATE VS. DELAYED PUBLIC REPORTING OF PERFORMANCE:
Using less precise measures now is better than waiting for more precise measures later. Don't let perfection be the enemy of the greater good.

Some providers feel that public performance reporting should be delayed until most providers are satisfied with the validity or accuracy of measurement. The lesson from all other industries (cars, HMOs, restaurants, packaged food producers and airlines) is that the fastest route to performance improvement and better measures is to begin reporting the best available measures immediately. Though many Los Angeles chefs felt that restaurant hygiene grading with a publicly posted "A", "B", or "C" designation was subjective and improperly assessed, pushing forward with such public performance reporting almost tripled the percentage of "A" scores within 10 years. Most informed consumer leaders agree that consumers are far better served by making current performance measures available rather than waiting in the dark for more precise measures.

OUTCOME VS. PROCESS MEASURES:
Outcomes are the ultimate measures of quality of care and spending.

Some clinicians and researchers promote structural measures (presence of an electronic prescribing system) and process measures (did the doctor perform a foot exam?) rather than outcome measures (did the patient recover full function after a knee replacement and how much did the whole episode of treatment cost?). Process and structural measures provide important guidance for improvement efforts, but they can miss the mark for what consumers and purchasers find most relevant – namely, whether or not the care they purchase is effective and efficient. Providers correctly argue that outcomes are often influenced by factors other than a single treating provider (patient behavior, for example); but that doesn't mean providers shouldn't be assessed via outcome measures, which are the most meaningful marker of value for consumers. Many other industries face the measurement challenge of multiple factors influencing outcomes (a commercial airline's average on-time record is affected by weather conditions). However, in these industries outcomes are nonetheless used for accountability because outcomes are consumers' primary central purpose in buying the service or product.

CROSS-CUTTING VS. CONDITION-SPECIFIC MEASURES
Both are essential!

While condition-specific measures are usually easier to measure, consumers also need measures that cut across multiple health conditions when they must select providers but don't know what health issues they may face in the future. An example of a cross-cutting measure for a physician would be the average overall compliance with all evidence-based guidelines applicable to his/her patient base.

INDIVIDUAL PHYSICIAN VS. GROUP MEASUREMENT:
We need both!

Research shows that quality improvement is accelerated when performance reporting occurs at the individual physician level rather than at the group level alone. Customers are entitled to know when there's evidence of significant performance differences among individual doctors and to select a particular doctor based on these differences. Moreover, physicians deserve and need to know about these differences so they can improve. Some would prefer that measurement be limited to physicians in groups because: (1) often it's difficult to attribute clinical events or spending to the care of a single physician; (2) performance breakthroughs often require the resources of multi-doctor systems; (3) complex care is often best delivered by teams; and (4) sometimes there may not be enough data to measure individual physicians reliably. These reasons are valid, and underscore the importance of measuring systems of care. It is also important to recognize that measurement at the group level does not preclude measurement at the individual level. To best serve the needs of doctors and customers, both are needed.