

# Consumer-Purchaser DISCLOSURE PROJECT

Better information. Better decisions. Better health.

AUGUST 2011

## Nine 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 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.
- Give providers information that supports their efforts to improve care.
- Enable purchasers and health plans to reward providers based on quality of care and patient outcomes rather than on volume.

More ambitious standards for measures are required to meet these growing demands for more and better information.

In response, the Consumer-Purchaser Disclosure Project (CPDP) developed **nine criteria** for meaningful and usable measures. These criteria reflect the perspectives of consumers and purchasers, and are intended to guide the development, endorsement, and use of performance measures. This is critical, as 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.
2. Use direct feedback from patients and their families to measure performance.
3. Build a comprehensive “dashboard” of measures.
4. Focus 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. Assess patient and provider follow-through.
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 data efficiently.

To learn more about the Consumer-Purchaser Disclosure Project contact [info@healthcaredisclosure.org](mailto:info@healthcaredisclosure.org) or visit [www.healthcaredisclosure.org](http://www.healthcaredisclosure.org).

## Nine Criteria for Meaningful and Usable Measures of Performance

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### 1 MAKE CONSUMER AND PURCHASER NEEDS A PRIORITY.

**PROBLEM:**

Health care reform asks consumers and purchasers to take a larger role in improving care (e.g., patients should actively participate in their care and be able to select providers who meet their needs; and purchasers should offer providers the right incentives to pursue value instead of quantity of care). Unfortunately, only a small number of the provider performance measures currently available or in use supply adequate information for consumers and purchasers to take such actions.

**OPPORTUNITY:**

Those working in measurement should involve consumers and purchasers meaningfully so that their needs are a priority in decisions related to measure development, endorsement, and use at national and local/regional levels.

### 2 USE DIRECT FEEDBACK FROM PATIENTS AND THEIR FAMILIES TO MEASURE PERFORMANCE.

**PROBLEM:**

Most measures currently in use rely on administrative and clinical data, which reflect the viewpoints of clinicians and the health care system. These measures 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 care plans, and their feedback on whether care made a difference. Measure developers should consider how patient surveys can be administered electronically as health plans and providers connect electronically with their members/patients.



# The Patient-Centered Measure Dashboard

Better Health	Better Care	Lower Cost
<ul style="list-style-type: none"><li>• <b>Clinical outcomes of treatment</b> – The results of care that are typically reported by a doctor or other clinician. Examples of clinical outcomes include treatment complications, morbidity, mortality, preventable readmissions, signs and symptoms, and laboratory determinations of physiologic values.</li><li>• <b>Patient-reported outcomes of treatment</b> – Assessments by patients of whether treatment is “working.” These may include patients’ reports of well-being, resolution of pain, improved functioning, etc.</li></ul>	<ul style="list-style-type: none"><li>• <b>Appropriateness of care</b> (i.e., underuse and overuse of diagnostic and treatment resources – this includes process measures that effectively assess underuse and overuse* – and misdiagnosis) – Underuse and overuse focus on whether the net clinical benefit of a given treatment or procedure for a given patient justifies the expenditure of resources, exposure of patient to radiation, and so forth (potential benefit versus potential risks). Misdiagnosis refers to a wrong diagnosis.</li><li>• <b>Patient experience with care</b> – Captures patients’ perspective on their experience with a provider’s care (i.e., how well a doctor communicates, knows their patients, coordinates care, and provides quick access to appointments and care, and whether the outcome reflects a patient’s expectations).</li><li>• <b>Patient activation and engagement</b> – Measures the extent to which providers and systems actually give patients and their caregivers the guidance they need to participate effectively in their care and thus to benefit from it optimally. Examples include whether a provider involves patients in creating care plans; whether both providers and patients follow through on care plans; and whether patients understand their treatment options and are well equipped for self-management.</li><li>• <b>Care coordination and care transitions</b> – Assesses how well providers work together to provide seamless care to a patient as he or she moves from one care setting to another.</li><li>• <b>Effective use of health information technology (HIT) by patients and care providers</b> – Evaluates whether HIT helps patients become more engaged in their care and/or improves how providers deliver care.</li><li>• <b>Patient safety</b> – Assesses the use of processes and management practices proven to promote patient safety, ranging from hand hygiene to medication reconciliation to effective teamwork.</li></ul>	<ul style="list-style-type: none"><li>• <b>Total cost to and expenditures by (1) the patient; (2) the insurer; and (3) the health care system:</b><ul style="list-style-type: none"><li>• Over the course of a year</li><li>• Per case or acute episode</li></ul></li><li>• <b>Efficiency of resource use</b>, including key utilization metrics such as emergency department visits, hospital admissions, and readmissions.</li></ul> <p><i>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 address it in the near term.</i></p>

*\*Where appropriate, process measures should be combined to create composites that reflect the set of processes that should be completed. And, whenever possible, composite measures should be based on a patient-centered approach – i.e., the patient has received all indicated tests and treatments known to provide significant positive health effects for their condition.*

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



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### 3 BUILD A COMPREHENSIVE “DASHBOARD” OF MEASURES.

#### **PROBLEM:**

All too often, measures have focused on discrete treatment processes that may be meaningful to providers. But consumers and purchasers are asking for a wide range of measures that capture whether the care provided made a difference for the patient, reflected that patient's preferences, and was delivered efficiently.

#### **OPPORTUNITY:**

The goal should be a comprehensive dashboard of measures that makes it possible to assess the 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, particularly those with multiple chronic conditions. We call upon measure developers and endorsers to make every effort to fill in the dashboard.

The diagram on the next page 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.<sup>1</sup> **Appendix 1, on page 10, provides an example of how a comprehensive dashboard of measures might look for maternity care.**

### 4 FOCUS 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 frequently unwarranted.
- 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):<sup>2</sup> (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.

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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 **National Priorities Partnership**.
- NQF, in its **prioritization** for measure development and endorsement of the top 20 conditions with a high impact on Medicare.
- **Measure Applications Partnership** (MAP).<sup>3</sup>
- The federal government's **National Quality Strategy**.

### 5 ENSURE THAT MEASURES GENERATE THE MOST VALUABLE INFORMATION POSSIBLE.

#### PROBLEM:

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

#### OPPORTUNITY:

##### **A. Include all patients in the calculations on which measures are based, unless there is a good and specific justification for omitting certain categories of patients.**

Measure definitions and applications often exclude certain patients from calculations of providers' performance. This happens in two ways: exclusions and exceptions.

- **Exclusions occur** when a measure developer excludes patients with specific conditions from the denominator of a measure. This is appropriate when it is based on clinical logic: for example, a measure of whether a physician provides mammography screening to women would not include a patient with a bilateral mastectomy (a woman who had her breast tissue removed and therefore does not require the screening) in the denominator.
- **Exceptions occur** when a source of the measure (e.g., a provider) removes patients from the denominator population based on clinical judgment or reasons other than clinical appropriateness. For example, clinicians may remove patients who, for whatever reason, decline a specific treatment option.

Exclusions and exceptions are *acceptable when they are evidence-based, highly specific, and explicitly defined*. This criterion will ensure that the removal of a patient from calculations of a provider's performance is appropriate and, moreover, the exact reason for the removal will be clear in an audit. Having rigorous parameters will also result in more informative data. Exceptions with extremely broad designations, such as "patient reasons" and "system reasons," should not be acceptable.

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

Measures of outcomes and resource use typically incorporate statistical techniques, such as risk adjustment, risk-stratification, setting standards for reporting through confidence levels, and so forth. However, the quest for a “pure” measure (e.g., striving for perfection over practicality) sometimes washes 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.

### **C. Capture data for disparities analysis.**

Those who collect measures should include basic demographic information, such as race, ethnicity, language, gender, disability, and socioeconomic status, for all patients. This will provide important information to help address disparities.

### **D. Capture lab values and vital signs on a continuous scale.**

Actual lab values and vital signs that represent valuable intermediate outcomes in treatment (e.g., LDL, HbA1c, blood pressure) should be captured so that the **exact** outcome can be collected. Often intermediate outcome measures are 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 that an HbA1c level of less than 8% (or 7% or 9%) 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.

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### 6 ASSESS PATIENT AND PROVIDER FOLLOW-THROUGH.

#### **PROBLEM:**

Most measures are process measures, which assess whether a doctor wrote a prescription, referred the patient to another clinician, recommended the patient take a test, developed a care plan, etc. But consumers and purchasers also need measures of follow-through. Did the doctor and the patient's care team actually follow the care plan, and did the patient fill the prescription, have the test, or see the referred clinician?

#### **OPPORTUNITY:**

Measures of physician orders and care plans may be appropriate indicators of the extent to which the physician is following clinical guidelines, but they should be paired with measures of adherence to the prescribed/recommended treatment (e.g., prescriptions ordered with prescriptions filled, tests ordered with test completion and results reported, care plan developed and followed). Shifting to a patient-centered perspective requires that measures be developed and specified to allow for data collection from the patient, including assessing the extent to which patients understand and follow recommended care. Measures of adherence will reveal whether or not what should have happened for the patient actually happened. Providers should be held accountable for following through with their patients and doing all they can to help their patients to do their part.

### 7 DE-EMPHASIZE DOCUMENTATION (CHECK-THE-BOX) MEASURES.

#### **PROBLEM:**

"Check-the-box" measures document the occurrence of evaluation, assessment, counseling, care plans, 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.<sup>4</sup> 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 patient's behavior actually changed in the appropriate direction (e.g., whether the patient quit smoking).
- Report the results, not the occurrence, of evaluations and assessments.

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### 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.<sup>5</sup>
- 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.<sup>6</sup>

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 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 to care for their patients. Specifications should call for measures to be populated with electronic data already collected and used for patient care. 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. Measure developers should also consider basing measures on clinically enriched administrative data when possible. Claims data will continue to be an important source of information on the services provided, even when widespread adoption of EHRs occurs.

However, the desire to avoid encumbering physicians with data collection must be balanced with the tremendous need that patients, purchasers and other stakeholders have for information. Patients face challenges 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 must deal with the increasingly out-of-control cost of care and the need to reward higher-performing providers to spur better care.

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<sup>1</sup> Many of the identified measure types may fit into more than one section of the three-part aim.

<sup>2</sup> NQF is a nonprofit organization that uses a consensus process to engage multiple stakeholders in measure standardization at the national level.

<sup>3</sup> MAP is a public-private partnership convened by NQF. MAP was created 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.

<sup>4</sup> Chassin M., Loeb J., Schmaltz S., and Wachter R., "Accountability Measures – Using Measurement to Promote Quality Improvement," *New England Journal of Medicine*, June 2010. <http://healthcarereform.nejm.org/?p=3580>

<sup>5</sup> 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. <http://dcc2.bumc.bu.edu/hs/Health%20Costs%20Absorb%20One-Quarter%20of%20Economic%20Growth%20%202000-05%20%20Sager-Socola%207%20February%202005.pdf>.

<sup>6</sup> Rodriguez et al, "Attributing Sources of Variation in Patients' Experiences of Ambulatory Care," *Medical Care*, Vol. 47, No. 8, August 2009.

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## ABOUT THE CONSUMER-PURCHASER DISCLOSURE PROJECT

*The Consumer-Purchaser Disclosure Project is a coalition dedicated to improving the quality and affordability of health care in America for consumers and health care purchasers. The project's mission is to put the patient in the driver's seat – to share useful information about provider performance so that patients can make informed choices and the health care system can better reward the best performing providers. The coalition is comprised of leading national and local consumer organizations, employers and labor organizations. The Consumer-Purchaser Disclosure Project is funded by the Robert Wood Johnson Foundation along with support from participating organizations.*

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# Appendix 1: Example of a Comprehensive Dashboard of Measures for Maternity Care

**PRENATAL**  
(Outpatient setting)

**DELIVERY**  
(Inpatient setting)

**POSTPARTUM**  
(Inpatient and outpatient setting)

## PATIENT-REPORTED OUTCOMES OF TREATMENT

- Health status after delivery (e.g., presence of pain and/or infection, presence of postpartum depression) 4-6 weeks post discharge\*
- Effective treatment for maternal morbidities (e.g., pain and/or infection, postpartum depression)\*

## PATIENT EXPERIENCE WITH CARE

- Patient experience of care\* (e.g., CAHPS modified for maternity care)



## PATIENT ACTIVATION AND ENGAGEMENT

- Patient receives high-quality, understandable information about impact of interventions (e.g., C-section, induction)\*
- Effective use of shared decision-making\*
- Patients with previous C-section are offered a VBAC if available (either directly or through referral)\*
- Patients are offered a range of options for pain management (e.g., non-pharmacological options vs. pain medications such as epidurals, spinal analgesia, narcotics, etc.)\*
- In active labor, mother has right to self-determination (i.e., through shared decision-making)



## CLINICAL OUTCOMES OF TREATMENT

- Healthy term newborns
- Term newborns with hospital-acquired conditions
- Maternal complications (e.g., hemorrhage, infections, DVT)
- Exclusive breastfeeding
- Maternal and newborn readmissions



# Appendix 1: Example of a Comprehensive Dashboard of Measures for Maternity Care

<b>PRENATAL</b> (Outpatient setting)	<b>DELIVERY</b> (Inpatient setting)	<b>POSTPARTUM</b> (Inpatient and outpatient setting)
<b>CARE COORDINATION AND TRANSITIONS</b>		
<ul style="list-style-type: none"> <li>• Patient preferences shared with entire care team</li> <li>• Information exchange between patient's primary physician and delivering provider on patient's health needs</li> </ul>	<ul style="list-style-type: none"> <li>• Adherence to patient preferences*</li> <li>• Prenatal record available at the birth site (should include patient's delivery preferences)</li> </ul>	<ul style="list-style-type: none"> <li>• Maternity care record shared with patient's primary care physician (e.g., patient with gestational diabetes would benefit from this sharing of information)</li> </ul>
<b>APPROPRIATENESS OF CARE</b>		
<ul style="list-style-type: none"> <li>• Screening for domestic abuse and substance abuse</li> <li>• Advice and appropriate referrals for those who are smoking and/or engaging in substance abuse</li> <li>• Patient receives selected essential prenatal care<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Spontaneous births and labor (a composite) (e.g., no induced labor, augmented labor, assisted delivery, or Cesarean section)</li> <li>• VBAC for low-risk women</li> <li>• Low-risk C-section in first births</li> <li>• Elective delivery between 37 and 39 weeks</li> <li>• Elective induction under 41 weeks</li> <li>• Use of episiotomy</li> <li>• Healthy newborns admitted to the NICU</li> </ul>	<ul style="list-style-type: none"> <li>• Skin-to-skin contact in the first hours after birth</li> </ul>
<b>TOTAL COST TO AND EXPENDITURES BY (1) THE PATIENT; (2) THE INSURER; (3) AND THE HEALTH CARE SYSTEM/EFFICIENCY OF RESOURCE USE</b>		
<ul style="list-style-type: none"> <li>• Cost of prenatal care</li> </ul>	<ul style="list-style-type: none"> <li>• Cost of delivery-associated care (e.g., physician, hospital, midwife, birth center) – covering episode of care for mother and baby</li> <li>• Length of stay (mother and baby)</li> </ul>	<ul style="list-style-type: none"> <li>• Cost of newborn (prior to hospital discharge)</li> <li>• Hospital readmission (mother or baby)</li> </ul>

Note: Identified elements of maternity care can apply to more than one domain

\*Elements that could be captured through a patient survey

<sup>1</sup>For example, prenatal care should begin within the first ten weeks and include antenatal corticosteroids for accelerating fetal lung maturation for women at risk of preterm birth.

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