Perspective

Improving Health: The Reason Performance Measurement Matters

To advance quality measurement, we must bring providers’ and patients’ views to the table.

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Performance measurement in health care is more of a Rorschach test than it is a clearly defined term. The various stakeholders—patients, physicians, hospitals, payers, employers, and the government—have different, even conflicting, views of the various valued features of a health care system they would like to be measured. All would value the best clinical outcome at the lowest cost, but providers may value cost/quality trade-offs differently than employers would, and patients would likely have different views from payers on the importance of access to the broadest array of services and providers. Key performance measures also would be valued differently throughout the country because of differences in geography, culture, and the organization of health care. In his paper on performance measurement, David Eddy focuses on health plans organized as the Kaiser plan is organized (a prepaid group practice that acts as both insurer and provider), but providers are much more variably organized and have very different relations to plans and payers in various parts of the country.

Eddy does acknowledge that there are different perspectives on performance measurement, and he beautifully outlines the methodological challenges. However, when he moves to solutions, he shifts quickly to the perspectives of payers and plans. Since it is the performance of providers that will have the greatest influence on quality, it is unfortunate that their perspective is largely ignored and that they have a seat on the “council on quality” only through plans. Perhaps the discussion of performance measurement could be advanced by bringing providers’ (and patients’) views to the table.

Uses Of And Problems With Measurement

Ideally, performance measurement would be based on the risk-adjusted health outcomes of various providers. A case in point is the New York State Cardiac Advisory Committee. This committee was established in the late 1980s, by providers and the New York State Department of Health, to measure risk-adjusted outcomes and create a quality improvement program in the area of coronary revascularization. Partly as a result of these efforts, the mortality of coronary bypass surgery decreased over the 1990–1995 period, and there is no longer a significant relationship between volume and outcomes in the state.1 By contrast, the elec-
tive repair of abdominal aortic aneurysms, for which a quality improvement program has not yet been established, still shows a significant volume/outcome relationship, with 54 percent of New York hospitals performing this procedure on fewer than five patients a year.

“Desirable” outcomes. Although health outcomes are the ideal, the measurement of risk-adjusted outcomes is still in its adolescence, and major weaknesses lie in the source of the data (which all too often are derived for nonclinical uses) and in our risk adjustment methods. Moreover, even if the sources of data and our ability to adjust for differences in patient populations are improved, we do not know whether the outcomes we are looking at will lead us to maximizing desirable health care.

Desirable health care outcomes depend on what patients desire. For example, a cancer patient might choose a shorter life without the severe side effects from cancer treatment to a longer one with them. Patients have very different preferences for particular outcomes. This is especially important in those conditions, such as prostate or breast cancer, where there are important trade-offs between survival and quality of life. If we do not take into account these preferences of how patients would like to live, we run the risk of wasting our efforts in maximizing less desirable health care.

Flexibility versus standardization. Where outcome measures are not sufficiently evolved, we must rely on adherence to process measures. From the provider’s perspective, the key challenge is not to seek standardization, which removes variation from the process, but to recognize and incorporate appropriate variation as a part of performance measurement. Variations may be an indicator of suboptimal care, or they may be a reflection of quality if they derive from shared decision making between the physician and patient. For example, a physician’s recommendation for surgery for benign prostatic hypertrophy may be modified by the patient’s preferences about the risks and benefits associated with the various treatment options. The result may be a decision ranging from observation to medication to surgery. All choices may be equally sound, and performance measures must be flexible enough to incorporate them all.

Although decisions will vary appropriately given shared decision making, one might argue that the process of care should be easier to standardize once the decision for a particular treatment option has been made. One may grant that proper processes of care require that the physician and patient can navigate the health care system, master subsequent diagnostic and therapeutic choices, use devices and drugs properly, and communicate effectively with other physicians, patients, and families. But assuming that a decision has been made and a pathway pointed out, variation will still very likely arise for any of several reasons.

One possibility is that the practices may not yet be adequately standardized. For example, treatment of a patient with an evolving myocardial infarction includes several options, each with proven efficacy. Unfortunately, there is too little evidence that directs the selection of one strategy among many. Other practices may be standardized to the satisfaction of the methodologist, but they still may not be accepted as proven by physicians. An example is the initial reluctance of physicians to abandon their time-honored treatments for peptic ulcer in favor of antibiotics for H. pylori. Or physicians may accept a new approach as optimal without having mastered the new technology, such as the use of laparoscopic cholecystectomy. Finally, practices can be standardized, but patients are not. Take, for example, the enormous variation in age, comorbidities, sex, and so forth in the...
presentation of patients with a diagnosis of myocardial infarction.

Managing Information

Obviously, the collection and analysis of the clinical data alone are daunting, particularly if the data collection efforts cannot be integrated with evolving clinical management systems. Adding cost data to help assess the economic impact of performance adds another level of complexity. Eddy makes a strong plea for better, more integrated information systems that will allow linkage and comparability among many different providers. His goal is laudable, but those of us who are attempting, even to a modest degree, to build information systems for the integration of care will attest that it is more difficult and expensive than projected.

We need a coordinated approach to developing appropriate information systems. Questions that need to be addressed include the following: Who needs these systems? For what purpose? How do providers, consumers, managed care plans, purchasers, and regulators differ in their demands on and for information? What is currently available? What is the acceptability of these systems to their users, that is, health care providers? What are the costs of these systems and of creating comparability among plans? And through what funding mechanisms can we realize the enormous capital investments that are needed?

Organization, Priority Setting, And Funding

A further critical issue is the funding of performance measurement and whether the public sector or the private sector should support such measures. Eddy suggests a three-fold solution: (1) The public sector should support the research underlying new measures; (2) purchasers should bear the costs of selecting the core measurement set and maintaining a central database; and (3) health plans should finance the collection and reporting of performance data.

Rather than drawing a clear line between public- and private-sector responsibilities, we believe that the future of performance measurement will depend increasingly on finding innovative approaches for joint public/private-sector funding arrangements. Whereas Eddy envisions the creation of a private-sector council to select the core measurement set, we believe that a committee, which draws its members from both the private and public sectors, would be more appropriate. Moreover, because the selection of the ultimate core measures depends on which measures will be developed, it will be critical for such a committee or another public/private organization to develop a research agenda and set priorities among the numerous clinical conditions for which performance measures need to be developed.

Measuring risk-adjusted outcomes is an important step toward quality improvement for providers but is not yet at the stage where it can be of much help to plans and patients who must choose providers. Process measures, at this time, remain indispensable. A healthy patient or a satisfied patient, however, is not a standardized product. Therefore, the processes for making a patient well and satisfied must be varied and flexible, and so must performance standards.

NOTES

2. Ibid.