Perspective

Reordering Performance Measurement Priorities

A modest proposal for setting priorities, from the president of the Joint Commission on Accreditation of Healthcare Organizations.

by Dennis S. O’Leary

Virtually all who have labored in the vineyard of performance measure development have experienced the frustrations of getting the job done “just right.” Perhaps this is because the process seems so simple on the surface: pick a measure, gather the data, share the results. But deciding what to measure; determining the needed data elements; settling on the right risk adjustment application for the measure; using evidence or other bases to build consensus around the measure; establishing that the measure is measuring what it is intended to measure; evaluating the reliability, discrimination capability, and cost-effectiveness of the measure; and translating the resulting data into actionable information constitute real tasks per measure that themselves are measures of the complexity we are dealing with. Adding to the frustration, the final products often fall short of the expectations of those interested in performance data.

Perhaps we are setting our goals for performance measures too high. Performance measures are in fact only one set of tools in the quality evaluation armamentarium. Additional tools include standards, which articulate expectations regarding organization (or practitioner) function; clinical practice guidelines; critical pathways; and the array of analytic tools used as integrals of the continuous quality improvement (CQI) process. Indeed, it seems somewhat illogical that we are prepared to present performance measurement results as conclusive indices of quality when performance measurement is in fact only the first step in the CQI process.

We need to remember as well that some “performance measurement” is unplanned and comes in the form of serious unanticipated adverse events (such as death or permanent loss of function). These data are often “published” in an uncontrolled fashion and undoubtedly influence consumers’ and purchasers’ perceptions of the involved health plan, provider organization, and/or practitioner. Nevertheless, these events, which conservatively number in excess of 200,000 per year, also are most appropriately the first stage in quality improvement processes whose fundamental goal must be to reduce the likelihood of recurrence in the future. Some would say, first things first.

For those who would say that planned performance measurement comes first (and I have been among them), I offer here the following modest proposal.

1. We should frame the questions that need to be answered before we design the measures to answer the questions. The measurement process must be responsive to its users, whether these be providers, purchasers, patients, or others. This will permit us to conserve scarce resources for the development of measures and provide value for the users.

2. We should select measures of processes and outcomes that offer real opportuni-
ties for future improvement. Good measurement data open windows into understanding how organizations are functioning. If we can gain knowledge about what works and does not work in organizations, we can learn how to manage organizational systems and processes and, thereby, how to manage outcomes. In the long haul, the curious and increasingly sophisticated public will want to know not simply the results but whether the organization is achieving improved, even outstanding, results over time.

(3) We need to recognize that the most useful information is provided by logical groupings of measures, not individual measures. That reality is well established in the industrial quality improvement model. For example, a measure of the technical effectiveness of a cardiovascular intervention would be more meaningful if it were placed in the context of measures that address access to the intervention, its appropriateness for the patients treated, the timeliness of the intervention, the adequacy of follow-up, and patients' perceptions of the quality of care received.

(4) We need to ensure that in the growing number of complex organizations being evaluated, integrated groups of measures are being applied that collectively and separately address accountabilities at the health plan, provider organization, and practitioner levels. Today the measurement initiatives of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), and the American Medical Accreditation Program (AMAP) are functioning as three separate “silos.” Health plans and integrated delivery networks will not long tolerate the current expensive and confusing silo approach to measurement, nor should they.

(5) We need to be able to adapt our measurement requirements to the service characteristics of the organizations to be evaluated and the populations they serve. To be sure, we must have standardized core measures—fully capable of meeting the needs outlined above—but we need not apply all measures to all organizations. Asking organizations to measure activities that are not integral to what they do wastes resources and undermines the credibility of the performance measurement process. For each core measure, or group of measures, there will be ample opportunities for comparison.

Performance measurement has the potential to bring us to new plateaus in quality evaluation and quality improvement. The recent announcement of a trilateral performance measurement partnership among the NCQA, the JCAHO, and AMAP should provide a substantial boost in that direction. And if this partnership plays itself out in the context of the proposed Forum for Health Care Quality Measurement and Reporting, as recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, all the better.

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