Performance Measurement: Accelerating Improvement

Our health care system does not consistently deliver safe and effective care for all of our citizens despite enormous expenditures and startling breakthroughs in biomedical research and technology. Performance measurement is essential to accelerate improvement in health system quality.

Congress, concerned about the uneven, often sub-optimal, quality of care and slow pace of improvement, mandated in the Medicare Modernization Act of 2003 that the Institute of Medicine (IOM) should examine specific aspects of the quality improvement infrastructure. In response, the IOM has produced a series of reports, Pathways to Quality Health Care, which is sponsored by the Centers for Medicare and Medicaid Services. This report is the first of three in response to the congressional request; it focuses on performance measurement and recommends a starter set of performance measures. Later reports in the series examine other performance improvement strategies, including payment incentives for health providers and the strengthening of Medicare’s Quality Improvement Organization program to offer technical support to providers.

Improving the Health of Americans

The ultimate purpose of performance measurement is to improve the health of everyone in the United States. Performance measures are yardsticks by which all health care providers and organizations can determine how successful they are in delivering recommended care and improving patient outcomes—for example, whether all diabetic patients receive regular blood tests and eye exams or if a facility’s 30-day survival rate among cardiac bypass patients is increasing. Public reporting of performance data holds health providers accountable to both consumers and purchasers of care; transparency builds trust. Patients can also learn what the expected professional standards of care are and where they can go to receive it.

Coordinating Current Performance Measurement Efforts

A host of performance measurement initiatives has emerged in recent years. They represent important breakthroughs in describing clinical effectiveness, quality improvement, and patient satisfaction. Governmental agencies, such as the Centers for Medicare and
Medicaid Services and the Agency for Healthcare Research and Quality, as well as private sector groups such as the National Quality Forum, the National Committee for Quality Assurance, the Joint Commission on Accreditation of Healthcare Organizations, and others have made pioneering efforts to move this field forward and to build upon each other’s work.

But these independent voluntary initiatives have led to duplication in some areas, significant gaps in knowledge in others, and multiple independent reporting systems. Individual stakeholders understandably focus on certain features of care that they consider their highest priority for improvement. While these piecemeal efforts indicate progress, they impose serious duplicate reporting burdens on providers and confuse consumers. Also, they frequently overlook areas of national interest that are difficult for individual providers to quantify, such as population mortality rates.

Building on these previous efforts, IOM endorses a starter set of performance measures that are currently acknowledged by major stakeholder groups and have a strong scientific evidence base. The starter set includes: Ambulatory care Quality Alliance measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Survey, Hospital Quality Alliance measures, CAHPS Hospital Survey, Health Plan Employer Data and Information Set (HEDIS), CAHPS Health Plan Survey, nursing homes Minimum Data Set (MDS), home health Outcome and Assessment Information Set (OASIS), end-stage renal disease measures in the National Healthcare Quality Report, and selected longitudinal measures of outcomes and efficiency. IOM also recommends development of measures, based on rigorous research, to address certain aspects of care:

- Neglected areas of focus (efficiency, equity, and patient centeredness)
- Longitudinal care (care transitions between providers, mortality)
- Systems-level measures (doctor-specific mortality, hospital wide mortality)
- Shared accountability (among multiple practitioners and providers delivering care to the same patient)

Typically, performance measurement has been provider-based, relating to hospitals, nursing homes, physicians office or other care settings, rather than patient-based. There is no accountability to monitor when a patient moves from one care setting to another or to ensure that care is timely enough to prevent avoidable hospitalizations or death. Left unmeasured and with no one responsible, these areas are likely to be left unaddressed and unchanged.

Moving toward individual patient-level measurement, reflecting the many medical conditions a patient may have, rather than using existing provider-based measurement approaches can improve even the starter set of measures. This increased detail provides more flexibility to aggregate data in different ways to answer multiple research questions. Additionally, composite measures can be tracked for complex patients who receive care from multiple providers. Measuring single measures can be misleading; one study shows that even though from 46 percent to 99 percent of diabetic patients received single elements of recommended care, only 18 percent received the complete bundle.

BUILDING A PERFORMANCE MEASUREMENT SYSTEM FROM A NON-SYSTEM

If reporting and payment systems are to be effective in improving quality, a universally accepted system is needed to measure and fairly report on the performance of individual health care providers and organizations. A federal role that only specifies a uniform set of measures is not enough. No stakeholder currently has the authority, resources
or leverage to articulate national goals for health care and achieve the required degree of coordination. Inconsistencies persist among stakeholders relying on fragile consensus-driven procedures that often do not address important areas of need.

Thus, IOM recommends establishing a new independent board—National Quality Coordination Board (NQCB)—within the U.S. Department of Health and Human Services that will:

- Set clear short and long-term goals for improving the health care system,
- Designate, or if necessary develop, standardized performance measures,
- Ensure a data repository system capable of reliable, validated data collection at the individual patient level (public, private and uninsured) and open to participation by all payers and providers,
- Develop and release useful reports responsive to all stakeholders, including reports meaningful to consumers,
- Identify and fund a research agenda, in conjunction with stakeholder groups, for the development of new measures to address gaps in performance measurement, address methodological issues such as making adjustments for providers caring for high risk patients, and examine how to best use measurement to foster improvement.
- Evaluate over time (a) how much the performance of providers and quality of care improves, (b) to what extent the nation makes progress toward its overall goals, and (c) whether policy levers such as public disclosure of performance data, utilization of electronic health records, and payment for performance policies have the intended impact.

NQCB will eliminate wasteful inconsistencies inherent in multiple reporting systems by substituting a uniform reporting framework and will ensure confidentiality in strict compliance with HIPAA (Health Insurance Portability and Accountability Act). Public reporting of provider measures will become more meaningful with the integration of performance data for public and private payers. Effective comparative reporting will support the decisions of consumers, purchasers, referring physicians and other stakeholders in choosing plans, providers, or treatment options.

ENSURING ADEQUATE INVESTMENT IN PERFORMANCE IMPROVEMENT

The NQCB will need adequate and sustained funding to carry out its agenda and assure the creation and inclusion of measures of national importance. Congress should authorize $100 million to $200 million in annual funding for the NQCB directly from the Medicare Trust Fund, and allow NQCB bypass authority to request an appropriation directly from Congress. The proposed funding level amounts to less than one-tenth of 1 percent of annual Medicare expenditures.

NQCB needs standards-setting authority, contract authority, financial strength, and external accountability. The board should work with organizations already involved in developing measurement and reporting tools, but it also should be free to contract with other groups to meet its objectives. An annual report to Congress will detail its activities and progress.

While building upon existing stakeholder efforts, the NQCB will provide leadership to currently fragmented programs, align performance measures with national health care goals and serve the needs of public and private payers, providers and beneficiaries.
FOR MORE INFORMATION...

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COMMITTEE ON REDESIGNING HEALTH INSURANCE PERFORMANCE MEASURES, PAYMENT, AND PERFORMANCE IMPROVEMENT PROGRAMS

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