Health Policy in Medicine: Inside the Beltway

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A New Way of Thinking about Measuring the Quality of Primary Care

by Eugene Rich, MD, FACP
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Note: For this column, Dr. Rich responds to questions posed by a colleague at Creighton about this post on the Health Affairs Blog: “Measuring What Matters in Primary Care” by Eugene Rich and Ann O’Malley. http://healthaffairs.org/blog/2015/10/06/measuring-what-matters-in-primary-care/

Questions were prepared by:
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Question 1: Several places you use the word "could" with respect to improving measuring quality of primary care. Do you specifically recommend that the "could" ought to be changed to "should?"

Dr. Rich's Answer: Excellent question - thanks. An example from our article is this sentence: "Key features of primary care could be measured via claims and survey data (and possibly one day via electronic health record data), gathered or acquired through networks of affiliated primary care practices." As health policy "researchers" (as opposed to "advocates"), we phrased this as "could" rather than "should" to acknowledge that there is much work left to do to understand the best ways to measure (and report) the key features of primary care. The most prominent example is the proper measurement of the important concept of "comprehensiveness" in primary care. As we note further under our response to question 3, there are many questions to be answered to determine the most informative way to measure this essential element of primary care practice. Even well-validated survey items are subject to potential refinement if they are to be used in measuring practice performance on essential features of primary care. For example, is the survey item "Frequency with which the primary care provider listens carefully to the patient" a sufficient metric for understanding practice site variations in the feature of "whole-person accountability"? And with the evolving use of email and patient portals, is the survey item "Ease of getting same-day answers to phoned-in questions" sufficiently informative regarding non face-to-face "accessibility" to primary care?

Also, we were reluctant to be overly prescriptive in our recommendations because we recognize that simply adding more performance measures to be considered by currently overburdened primary care practices may make the currently bad situation worse. Reflecting on this question and our original piece, I will note our two uses of the word "should." We call out the current quandary imposed by the over-measurement in primary care: "The challenge for any busy clinical practice is determining which of the innumerable potential performance metrics available *should* be their highest priorities for improvement." And in our conclusion "perhaps it is time to shift the focus of primary care measurement to what clinicians *should* care most about - providing their patients accessible, continuous, coordinated and comprehensive care." We clearly think these core features are what primary care clinicians and their practices SHOULD be focused on. Accordingly, it is fair to conclude that we are arguing any future efforts to measure performance in primary care SHOULD do a better job of emphasizing these core features.

Question 2: What might be barriers to implementation of measurements?

Dr. Rich's Answer: I think my responses to questions 1 and 3 point toward some of the more specific issues. In general, for a performance measure to be useful it must have validity to the clinicians who are to use their results to guide continuous improvement. Notionally the five primary care features are clinically important and valid constructs and thus have face validity to providers. However better evidence is needed that the actual measurement approach yields valid results, such that practice variations in performance are associated with differences in outcomes that clinicians and patients will care about. In addition to the measures being valid, they also must reliably detect meaningful differences across practices that clinicians and practice leaders can use to guide improvement. For example if all internal medicine practices appear highly comprehensive, then this is an unhelpful metric. Furthermore to detect meaningful differences across practices, the approach to reporting results must offer meaningful comparisons relative to practice settings and patient populations. It is unhelpful for reports to simply note that all practices caring for complex patients (e.g. geriatrics) have lower continuity than do practices caring for a relatively healthy population (e.g. pediatrics). These are a few key aspects of performance measurement that must be addressed before we can implement widely our concept of "Measuring What Matters in Primary Care."

Question 3: In the third from last paragraph you mention that “various efforts are underway” to better define comprehensiveness. Can you expand briefly on these?

Dr. Rich's Answer: In August 2015, my co-author on this piece, Ann O’Malley, MD (deputy director of Mathematica’s Center on Health Care Effectiveness), published a thorough review of the challenges, and options, for measuring comprehensiveness in primary care.[1] In this article she addresses the potential advantages, as well as disadvantages, of various sources of data (and measurement approaches) including patient or provider surveys, alternative analytic approaches to claims data, as well as electronic health records. She notes some specific approaches that we have conceptualized that are still being tested. She also notes work by some colleagues at the Robert Graham Center and the American Board of Family Medicine (ABFM). At the June 2015 Academy Health meeting we convened a panel discussion (Measuring What Matters: Assessing Primary Care Practices’ Success in Delivering Primary Care) with these colleagues and those at the NCQA which highlighted a few different approaches to measuring comprehensiveness.[2] Our colleagues at the Graham Center and ABFM have since published an intriguing analysis using some of their approaches to measuring comprehensiveness in primary care.[3] In this paper they conclude “Increasing family physician comprehensiveness of care, especially as measured by claims measures, is associated with decreasing Medicare costs and hospitalizations.” This certainly contributes to the evidence base suggesting that reliable and valid measures of comprehensiveness in primary care may be achievable. However as Dr. O’Malley notes in her JGIM article, given the range of options available for measuring comprehensiveness in claims data, additional work will be required to determine the metrics that are most informative across practice settings and patient populations.

[1] O'Malley AS, Rich EC. Measuring Comprehensiveness of Primary Care: Challenges and Opportunities. J Gen Intern Med. 2015 Aug;30 Suppl 3:S568-75

[2] https://academyhealth.confex.com/academyhealth/2015arm/meetingapp.cgi/Session/1516

[3] Bazemore A, Petterson S, Peterson LE, Phillips RL Jr. More Comprehensive Care Among Family Physicians is Associated with Lower Costs and Fewer Hospitalizations. Ann Fam Med. 2015 May-Jun;13(3):206-13