COMMENTARY

New "Core Quality Measures": Only a Beginning

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A plethora of quality measures are used in health care for quality improvement, accountability (including reimbursement), and research. The Core Quality Measures Collaborative, with input from the American Academy of Family Physicians, recently released several groups of reduced core measure sets, including one for primary care. The proposed measures are less helpful for the increasing proportion patients with multiple morbidities or advancing illness. Going forward, the development of quality measures that assess multidimensional patient experiences and how closely the health care patients receive matches their goals in the face of multiple morbidities and advancing illness should be the focus. (J Am Board Fam Med 2017;30:4–7.)

Quality measures in health care are used for quality improvement, accountability, and research. They can be used to measure structures, processes, and/or outcomes of health care, and thousands of quality measures now exist, covering virtually every area of health care.[1] Indeed, one important problem with the proliferation of quality measures is the burden they place on clinicians and systems of care.

Recognition of this proliferation has spawned several efforts to consolidate and align measures, with significant overlap in the groups involved in developing these measures (Table 1). In an effort to streamline measures, the Core Quality Measures Collaborative (Centers for Medicare & Medicaid Services, America's Health Insurance Plans, National Quality Forum, physician organizations, and patient advocates) recently released 7 new core sets of quality measures.[2] These proposed new measurement sets are designed around "3 R's"[2]: reducing the number of measures, refining measures to reduce the burden of collection, and relating measures to "what matters."[3] The 7 sets of measures are applicable to different medical specialties.

The measurement set for primary care includes condition-focused measures for patients with asthma, hypertension, diabetes, low-back pain, and depression. Preventive measures include cervical, breast, and colorectal cancer screenings; tobacco use; and obesity screening and follow-up. In addition, cross-cutting measures address medication reconciliation and items from the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) set related to patients' experience of care. Not surprisingly, this is a relatively parsimonious set of measures that works well for common conditions seen in primary care practice, with the addition of 1 or 2 that begin to address the patient experience of care.

The new core quality measure set is, however, less useful for the increasing proportion of adults who have multiple morbidities and/or advancing disease. Based on 2010 Medical Expenditure Panel Survey data, nearly one-third of adults in the United States have multiple chronic conditions; this group accounts for 64% of clinician visits, 70% of hospitalizations, and 71% of health care spending.[4] For such patients, a focus on disease-specific measures is not known to be helpful and may be harmful.[5–7] Measure selection is important because quality metrics increasingly drive reimbursement and reporting efforts consume tremendous practice resources. Commitment of such resources has significant opportunity costs and may prevent implementation of quality activities that may be more

This article was externally peer reviewed.
Submitted 4 July 2016; revised 25 September 2016; accepted 27 September 2016.
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Funding: none.
Conflict of interest: none declared.
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Table 1. Examples of Quality Measurement Consolidation and Alignment Programs

Program	Oversight	Areas of Measure Recommended Thus Far	Patient-Centered Measure
HHS Measurement Policy Council (subgroup of the National Quality Strategy)	HHS/AHRQ	Hypertension control Smoking cessation Depression screening Hospital-acquired conditions Care coordination Patient experience HIV/AIDS Perinatal Obesity/BMI	Hospital Consumer Assessment of Health Providers and Systems
Committee on Core Metrics for Better Health at Lower Cost	Institute of Medicine	Length of life Quality of life Healthy behaviors Healthy social circumstances Prevention Access to care Safe care Appropriate treatment Person-centered care Affordability Sustainability Individual engagement Community engagement	Patient-clinician communication satisfaction (a measure of care matched with patient goals)
CMS Quality Measure Development Plan: for Merit-based Incentive Payment System and Medicare access and CHIP Reauthorization Act	HHS	Safe care (reduce harm) Person and family engagement Care communication and coordination Disease prevention and treatment Healthy living Affordable care	In process; will use input from MAP and AHIP/CMS/NQF collaborative
Measure Applications Partnership	NQF	Preventive care Maternal and perinatal health Behavioral health and substance use Acute and chronic conditions care Care coordination Experience of care	CAHPS
Core Quality Measures Collaborative	AHIP/CMS/NQF/provider and patient representatives	Primary care/ACOs/PCMH Cardiology Gastroenterology HIV/Hepatitis C Medical oncology Obstetrics/gynecology Orthopedics	CAHPS

ACO, accountable care organization; AHIP, America's Health Insurance Plans; AHRQ, Agency for Healthcare Research and Quality; BMI, body mass index; CAHPS, Consumer Assessment of Health Providers and Systems; CHIP, Children's Health Insurance Program; CMS, Centers for Medicare & Medicaid Services; HHS, Health & Human Services; MAP, Measure Applications Partnership; NQF, National Quality Forum; PCMH, patient-centered medical home.

meaningful to patients and clinicians alike. How can we measure good care for these challenging and increasingly common patients?

Most of the projects identified in Table 1 recommend integration of person-centered care as a key measure. The Institute of Medicine suggests only a measure of patient satisfaction with provider communication,[8] whereas the Core Measurement Collaboration recommends the use of the CG-CAHPS,[9] including a multiple-item standardized questionnaire that evaluates important domains of primary care. Neither clearly helps direct care that is appropriate for patients with complex, multimorbid, or advancing illness. The Centers for Medicare & Medicaid Services Quality Measure Development Plan documentation identifies these patients and their needs,[10] but the identification process is not far enough along yet to see whether or how specific measures will address these concerns. Patient perspectives about their needs in such situations often focus less on medical issues and more on factors such as function, quality of life, family concerns, financial issues, and spiritual needs. How would a provider assess such needs? Implementation of patient-reported outcome measures (PROMs) assessment is likely needed for this group of people.[11,12]

Several such PROMs exist to assist patients and providers with a multidimensional assessment of needs in the face of advancing or complex illness. Some use various modules to assess patient function, multiple dimensions of quality of life, and informational and supportive needs. Examples of these modular systems include the How's Your Health program[13] and the Patient-Reported Outcome Measurement Information System.[14] Instruments developed for palliative populations assess multiple dimensions relevant to patients using fairly short, multidimensional surveys. These include the Support Team Assessment Schedule,[15,16] Palliative (or Patient) Outcome Scale (POS),[17] the Needs Near the End-of-Life Care Screening Tool,[18,19] and the Needs Assessment Tool for Progressive Disease.[20,21] Each of these can be completed by clinicians, and the POS can be completed by patients. Among these, the POS has been used most widely, has the best-described psychometric properties, and has been used internationally in a variety of settings and for a illnesses.[22] The POS assesses physical symptoms; emotional, psychological, and spiritual concerns; and needs for information and support. A newly developed decision support tool aids physicians and practices in responding to patient needs identified through the POS.[23] The Needs Assessment Tool for Progressive Disease also provides support for clinicians to respond to identified patient needs.

These tools are likely to identify multiple areas of unmet need; however, prioritizing what is most important to people as they live with their chronic conditions is not as easy. How's Your Health has a question addressing this. A new patient-reported quality-of-life instrument in development asks what patient's biggest concerns are. Though some patterns exist, the range of personal preferences for potential health outcomes is large and cannot be predicted for individual patients.[24] In addition, patient perceptions of what is an important outcome may shift over time, even if the underlying value structures may not. Here is the crux of shared decision making: an informed, activated patient with several unmet needs that may be at odds with each other in the face of progressive or uncertain health outcomes, and an informed physician listening carefully and probing to learn the patient's value preferences. The patient and doctor work together to prioritize potential valued outcomes and then decide on a course they believe most likely will lead to those outcomes. While some conversation guides exist,[25,26] tools to help prioritize important patient goals that reflect their values and help to direct care are uncommon.

The new core quality measure set is a step forward for quality assessments in primary care practice. Having a smaller set of measures with broad support is helpful, and including the CG-CAHPS to capture patient experiences helps make sure this step is moving in the right direction, and the collaborative is clear that it plans to modify these measures over time. However, practices, payers, and policymakers using these measures should not become complacent. These measures still fail to capture information about multidimensional health-related domains in patient's lives—the health outcomes most relevant for patients with multimorbidity and advancing illness. In part, this is because few such instruments exist. Beyond that, we have virtually no way of identifying or measuring quality medical care after prioritizing care for these patients. Because patients with multimorbidity are increasing, and because quality measures play a critical role in reimbursement and resource deployment, primary care quality measurement should begin to focus on multidimensional assessments of health-related do-

mains and, for those patients with advancing illness, on prioritization of health-related life goals.

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