POLICY BRIEF

Less AND More Are Needed to Assess Primary Care

Rebecca S. Etz, PhD, Martha M. Gonzalez, BS, E. Marshall Brooks, PhD, and Kurt C. Stange, MD, PhD

Significant federal investment is now being directed toward lessening the burden of clinical quality measurement; at the same time, there is growing recognition that current measures are inadequate to capture the domains of primary care that result in improved person and population health at sustainable cost. Our study reveals a significant gap between the universe of what is measured and those elements most critical to good quality primary care, indicating that the important efforts to reduce measurement burden must be accompanied by efforts to increase the relevance of measures to domains of care that affect patient-centered and community health outcomes. (J Am Board Fam Med 2017;30:13–15.)

Keywords: **Community Health Care, Patient-centered Care, Primary Health Care**

Significant federal investment is now being directed toward lessening the burden of clinical quality measurement.[1,2] At the same time, there is growing recognition that current measures are inadequate to assess the domains of primary care that result in improved person and population health at sustainable cost.[3–5] Our study reveals a significant gap between the universe of what is measured and those elements most critical to good quality primary care, indicating that efforts to reduce measurement burden must be accompanied by efforts to increase the relevance of measures to domains of care affecting population health outcomes.

This article was externally peer reviewed.
Submitted 28 June 2016; revised 9 September 2016; accepted 13 September 2016.
From the Department of Family Medicine and Population Health, Virginia Commonwealth University, Richmond, VA (RSE, MMG, EMB); Departments of Family Medicine & Community Health, Epidemiology & Biostatistics, and Sociology, Case Western Reserve University, Cleveland, OH (KCS).
Funding: This work was supported by the American Board of Family Medicine Foundation and Family Medicine for America's Health.
Conflict of interest: none declared.
Corresponding author: Rebecca S. Etz, PhD, VCU Department of Family Medicine and Population Health, One Capital Square Building, 830 East Main Street, Rm 629, Richmond, Virginia 23298-0101 (E-mail: Rebecca.Etz@vcuhealth.org).

See Related Commentary on Page 8.

Exemplified by the Institute of Medicine's *Vital Signs* report last year,[1] the United States has experienced an increase in calls to identify an effective means to assess and pay for health care. The foundational role of primary care draws attention to the need for broad assessment and support of accessible, coordinated, whole-person, relationship-based care.[3,5] Yet, funders, physicians, and policy makers agree: we have too many measures, creating tremendous administrative burden, leading to high cost and limited return.[1,2] In addition, most measures used share a myopic focus on clinical processes and limited short-term outcomes.[3] National efforts to fix this problem have focused on reducing the number of measures on which primary care is required to report.[2] Although that effort may result in reduced administrative burden, it fails to address systemic gaps in the assessment of primary care characteristics most responsible for its added value and its ability to avoid the pitfalls associated with fragmented care.[3]

We administered an open-ended, electronic survey to primary care clinicians, allowing 1 to 5 free text responses to each of 2 questions, paraphrased: 1) how do you know good primary care when you see it, and 2) what questions would you ask a practice to know if they are helping to deliver health and wellness?[6] Questions were first pilot-tested and then vetted among 30 multi-disciplinary primary care experts before fielding. The survey was distributed among 4 groups: practice-based research net-

Table 1. Clinician Responses (n = 3,524) Coded Using a Combination of 1) Measures-based Coding and 2) Emergent Coding

Code Group	Codes in code group	Percent responses to which group code applied*
Measure-based codes used (n = 27) informed by measures used and located with the following entities: National Committee for Quality Assurance, Healthcare Effectiveness Data and Information Set, National Quality Forum, and the Agency for Healthcare Research and Quality		
Measure-based	Chronic disease; control of disease; counseling; evidence-based medicine, guidelines, benchmarks; prevention, immunization, vaccination; risk stratification; access; continuity; documentation or recording; follow up; medication management; patient received something; patient satisfaction; patient understands doctor; productivity; referrals, tracking systems; cost and utilization; written care plan; compliance or adherence; specific targets; quality of life; functional status; rates or percentages of population	57.7%
Emergent codes used (n = 65) based on concepts identified through the patterned appearance of key words, phrases, or ideas as determined through iterative data reading and discussion by three co-authors (RSE, MMG, EMB)		
Patient-focused	Ask the patient; family; patient real understanding; patient as partner or team member; patient experience and perspective; patient feels known; patient goals or values; patient involved in decisions of care; patient needs are met; patient outreach; personalized or tailored care	7.5%
Patient-centered	Engagement; patient centered; patient education; patient grade of practice; patient responsibility	18.8%
Tenets of primary care	Comprehensiveness; coordination, including transitions; equity and social justice; longitudinal; problem recognition; relationship or trust; wholism or whole person	12.5%
Employee focus	Collaborative; employee satisfaction, joy, retention, turnover; interprofessional or multidisciplinary; staff; team talk; top of license/ skill set; training, continuing education	12.0%
Work processes	Efficiency; electronic medical record; information management; learning organization; self assess, adapts, changes; quality improvement; timeliness	13.6%
Practice qualities	Communication; integration; promotion of health or wellness; qualities a practice should have; health information technology; transparency	10.8%
Outside clinic walls	Community connections, practice networks; more, less, limit, too much, too little of something; payment; social determinants of health	4.5%
Clinicians	Advocates for patients and communities; understands the patient; competent and up to date; empathy, caring, compassion, respect; complexity and ambiguity, listens to or talks to patient; qualities a clinician should have; setting priorities	13.5%
Care focus	Appropriate; behavioral health, substance use; care agnostic to constraints; right care, right time, right place; targeted condition or type of care; weight, food, nutrition, physical activity	11.2%
Patient talk	Care management; litmus test; missing measures; social history and habits (not smoking); symptom reduction; weighing of risks and benefits	2.6%

*Percentages in this column exceed 100% when added. This is because one response could be assigned more than one code.

works (n = 167), listservs (n = 8), a national cohort of innovating practices (n = 190),[7] and a purchased list of 10,000 physicians evenly distributed among family medicine, internal medicine, and pediatrics. 412 clinicians provided 3524 unique survey responses.

Responses were coded using 92 codes, 27 of which were based on commonly used measures and 65 of which were based on code groups emergent from the data (see Table 1). Three coauthors reached agreement on code definitions and coded independently, using consensus to resolve any discrepancies. Forty-two percent of clinician responses could not be assigned measure-based codes, indicating a significant gap between how primary care is assessed and what those on the frontlines of its delivery identify as valuable. Concepts reflected among code groups using the (non-measure-based) emergent codes include ability to prioritize care, accurate problem recognition, management of patient complexity, focus on patient preferences and goals, investment in longitudinal relationships, and ability to adapt care based on personal and communal social determinants of health.

None of the emergent concepts share an overlap with current measurement focus on clinical processes and outcomes. Such misalignment risks inadequate reporting of the work of primary care, and chronic undermining of the role of primary care within the larger health care system.[4,5] Policies able to support both reduction in number of measures and creation of measures specific to primary care would allow for improved assessment of primary care and appropriate identification of areas on which to focus quality improvement.

This study was funded by awards from the American Board of Family Medicine Foundation and Family Medicine for America's Health. This study was approved by Virginia Commonwealth University IRB (HM20004302).

To see this article online, please go to: http://jabfm.org/content/30/1/13.full.

References

1. IOM (Institute of Medicine). Vital signs: Core metrics for health and health care progress. Washington, DC: The National Academies Press; 2015.
2. Core Measures—Centers for Medicare & Medicaid Services. Available from: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html. Accessed June 16, 2016.
3. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q 2005;83:457–502.
4. Green LA, Klinkman M. The foundational and urgent importance of a shared primary care data model. Ann Fam Med 2015;13:305–11.
5. Stange KC, Etz RS, Gullett H, et al. Metrics for assessing improvements in primary health care. Annu Rev Public Health 2014;35:423–42.
6. Primary Care Measures. Available from: https://www.surveymonkey.com/s/PrimaryCareMeasures.
7. Etz RS, Hahn KA, Gonzalez MM, Crabtree BF, Stange KC. Practice-based innovations: More relevant and transportable than NIH-funded studies. J Am Board Fam Med 2014;27:738–9.