Achieving the Potential of Performance Measures (and Recognizing Their Limitations)

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The National P4P Summit

March 24, 2014 San Francisco

Measures are integral to moving from volume-based to value-based payment

- About the only area in health policy that Republicans and Democrats agree on
- See, for example, the apparent deal in the SGR Repeal Bill – close to a 20% swing (9% up or down) on physician payment based on what is now being called Merit Based Incentive Payment (MIPS)

But what do we really mean by "value" in health care?

- In current health care policy parlance, Value = Quality/Costs and is used in a loose sense to mean a "bigger bang for the buck," relying on studies showing that the extra 60% the US spends on health services does not buy better health or health care
- But there is no quantitative precision to this equation -- is value increased when quality increases at higher cost?

The quality numerator

- Quality is measured differently for different quality items, e.g., % compliance with a process of care standard, 30-day mortality rate for a condition, patient experience, etc.
- There is no common metric like quality-adjusted life years (QALYS) as used in cost-effectiveness analysis
- We have good measures in some areas, but few or none in other important clinical domains, e.g., diagnosis errors, appropriateness of services, complex care management
- Identifying a measure gap doesn't mean it can be readily filled (as Congress doesn't seem to understand)

Dueling aphorisms

- “You can't manage what you can't measure.”
  - Apparently not W. Edwards Deming, to whom this is usually attributed

- “Not everything that can be counted counts, and not everything that counts can be counted.”
  - guess who?

Not Albert Einstein
but rather
William Bruce Cameron

The cost denominator

- Costs are usually measured as dollars spent but for some purposes can also be measured as the rate of increase in dollars spent, as in -- “bending the curve”
- Even with something as seemingly straight-forward as dollars spent, there are disagreements on how to measure and report costs, beyond the common error of mistaking charges or payments for costs

Unintended and/or perverse results from this current focus on measurement

- What we can measure is considered important; what we can't or don't is marginalized or ignored
- Behavioral economists express caution about P4P suppressing intrinsic motivation among professionals – may be a difference between incentives for individuals vs. organizations?
  - And don't forget, "corporations are people, my friend"
- Lack of concordance across quality ratings must confuse the public and make quality and value muddled rather than transparent

Seven Policy Recommendations

From the Berenson, Pronovost, and Krumholz Paper –

- Decisively move from measuring processes to outcomes;
- Use quality measures strategically, adopting other quality improvement approaches where measures fall short;
- Measure quality at the level of the organization, rather than the clinician;
- Measure patient experience with care and patient-reported outcomes as ends in themselves;

3 More

- Use measurement to promote the concept of the rapid-learning health care system;
- Invest in the “basic science” of measurement development, including an emphasis on anticipating and preventing unintended adverse consequences; and
- Task a single entity with defining standards for measuring and reporting quality and cost data, similar to the role the SEC services for the reporting of corporate financial data, to improve the validity and comparability of publicly-reported quality data