

Family Medicine Updates



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AAFP OUTLINES QUALITY MEASUREMENT STRATEGY FOR PRIMARY CARE

The AAFP has released a new position paper (<https://www.aafp.org/about/policies/all/visionprinciples-qualitymeasurement.html>) aimed at helping steer the future development and use of quality measures in initiatives related to practice improvement and physician payment.

It's an important step at a critical point in time, said AAFP Board Chair Michael Munger, MD, of Overland Park, Kansas.

"As the move to value-based care delivery continues, quality measurement has stepped to the forefront," Munger told *AAFP News*. "This position paper will provide the AAFP with the guiding principles with which to advocate for standardized meaningful measures that are relevant for the patient without causing significant disruption of clinical workflows."

The paper, titled "Vision and Principles of a Quality Measurement Strategy for Primary Care," was authored by AAFP staff content experts and reviewed by members of the AAFP Commission on Quality and Practice and 3 additional AAFP members considered well-versed in the field of quality measurement.

The position paper and the principles it outlines build on existing AAFP policy and were approved by the executive committee of the AAFP Board of Directors in mid-December 2018.

The AAFP intends to utilize information in the paper when interacting with policy makers and others—including those who develop and endorse such measures, as well as CMS and other entities that fund measure development.

The principles also will come in handy in Academy discussions with payers and health plans, health IT developers, and others. What follows is a brief overview of the 6 principles outlined in the paper.

Principle 1: Quality vs Performance Measures

Right from the start, the AAFP makes a clear distinction between quality measures and performance measures.

"The main purpose of a quality measure is to accelerate internal clinical improvement," says the paper, while performance measures serve several purposes, including:

- Providing comparative data useful in value-based payment programs
- Supporting patients in their ability to make decisions about the cost and quality of health care
- Ensuring appropriate resources are allocated to community and population health needs

Furthermore, according to this principle, "Quality measures address the details of patient care, administrative processes and medical decision-making" and aim for benchmarks or goals. Health care organizations use them to "accelerate clinical improvement" and to "gain an understanding of care gaps and the impact interventions have on closing those gaps."

On the other hand, performance measures "address high-level patterns and outcomes of care, comparing various dimensions of quality and cost across organizations and geographic areas."

Performance measures are used for value-based payment, resource allocation and to help patients make informed decisions about their care based on quality and cost.

"Publicly reported measures should meet high standards for validity and reliability because measures that lack these characteristics may disengage clinicians from improvement, unjustly harm the finances and reputation of health care professionals, and misinform patients about the risks and benefits of various treatments," says principle No. 1.

"Many performance measures currently used in value-based payment fail to meet these standards," it continues.

Lastly, performance measures should not instigate financial penalties, but "should lead to investment of resources to improve equity, access, and socioeconomic factors that impact health and health care."

Principle 2: Quality Improvement Integration

The 2nd principle notes that to achieve the primary purpose of accelerating improvement, "quality measures must be integrated into a methodological approach."

Furthermore, "Internal quality improvement efforts require transparency and a safe space to allow honest assessment of care without fear of punishment and without pressure to increase revenue or produce bonus payments," says the AAFP.

As to the members of a quality improvement team, it is imperative that physicians have a leadership role in all improvement efforts and secure the assistance of patients, clinical teams, and community partners.

Principle 3: Universal Performance Measures

The AAFP's 3rd principle states the need for a single set of universal performance measures that meet the highest standards of validity and reliability and that are extracted from multiple data sources.

"The measures should focus on outcomes that matter most to patients and that have the greatest overall impact on better health of the population, better health care and lower costs. At the same time, the burden of measurement on practices should be minimized," says the AAFP.

Furthermore, this principle calls for the inclusion of a limited set of measures of quality, cost, and population health in performance measures created for value-based payment.

"Giving in to the temptation to measure everything that can be measured drives up cost, adds to administrative burden, contributes to professional dissatisfaction and burnout, encourages siloed care, and undermines professional autonomy."

Importantly, to avoid cherry-picking of patients and improve representativeness of the data, "the same measures should be standardized across payers, programs, and systems of care, and universally applied to all eligible patients or populations," says the AAFP.

"Measures currently used in various payment programs lack alignment and are applied inconsistently, which reduces their value and usefulness, limits the ability to aggregate data and determine progress toward a goal, and adds to the burden of data collection and reporting."

Lastly, performance measures should center on the most important strategic priorities—those conditions, services and factors "that are known to have the greatest impact on health status, outcomes, and cost."

Principle 4: Performance Measure Application

This principle urges that performance measures be applied at a system level—meaning a group practice, integrated health care system, health plan, accountable care organization, or geographic region—to encourage shared accountability and team-based care.

It also suggests a leveling of the playing field. "Performance measures should be risk-adjusted, when appropriate, for demographics, diseases, severity of illness, and social determinants of health," says the AAFP.

Furthermore, "All populations and geographic areas must be attributed to at least one system to promote health equity."

The principle notes that health care professionals, facilities, and patients could belong to multiple systems. Entities and health care professionals could find themselves in overlapping systems with a competitor, and this would "encourage cooperation and mutual resource allocation to improve factors that influence health outcomes."

"Holding systems responsible for serving the needs of a geographic population may prevent the closure of clinics, emergency departments, maternity services, and other essential services in rural areas," says the 4th principle.

Principle 5: Primary Care Measurement

The 5th principle states that "measures of primary care should focus on the unique features that are most responsible for better outcomes and lower costs and are under reasonable control of the primary care physician."

Those primary care features include access/first contact, comprehensiveness, coordination, patient and caregiver engagement, continuity of care, and care management.

Authors note that current measures of primary care are "generally indistinguishable from measures of other specialties and do not adequately assess the quality of primary care."

"Additional research is needed on how primary care is delivered and how to improve and measure care in the primary care setting," says this principle.

Principle 6: Health IT Redesign

The position paper's final principle addresses the need for a redesign of health information technology to ensure that this important resource facilitates automated data collection and quality measures and eliminates the need for self-reporting.

"Information should be pushed to clinicians and patients at a point in time when it is most useful for decision-making and action."

Authors note that electronic health records (EHRs) "were not designed to support quality measurement and improvement," and that physicians generally report disappointing experiences with their EHRs; unfortunately, the promise of improved efficiency, better care, and lower costs have not, for the most part, been realized.

To make matters worse, "physicians have been expected to fill current technology gaps by expending their own time, effort, and resources for quality measurement and reporting with little, if any, return on investment."

Still, the AAFP predicts positive change is coming. "Affordable, advanced technology will alleviate administrative burden, siloed data, incomplete and

nonrepresentative data, and lack of timely actionable feedback. Data extracted from claims, EHRs, surveys, labs, pharmacies, public health data, health assessments, administrative data, and other sources will allow computation of measures for virtually any aspect and segment of care," says the 6th principle.

"The redesign of health IT will enable insights into care that are not yet possible with today's information systems."

Sheri Porter
AAFP News



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ASKING HARD QUESTIONS: THE ROLE OF ANNALS OF FAMILY MEDICINE IN ADVANCING OUR DISCIPLINE

Annals of Family Medicine celebrates its 16th anniversary this year; as a community, we celebrate Kurt Stange's accomplishments as Founding Editor. As it happens, the transition in *Annals'* leadership happens at the same time as the 50th anniversary of the American Board of Family Medicine (ABFM) and the specialty in this country. Such times provide an opportunity to reflect on where we have come from and to consider where we need to go.

Annals was a product of the Future of Family Medicine project and is a collaboration of the "family" of family medicine—the organizations that, collectively, shepherd the discipline. This was, in part, a response to the termination of *Archives of Family Medicine*, which was taken as a message that we lacked sufficient intellectual distinction to be worthy of a journal. Under the leadership of Kurt Stange and his editorial team, *Annals* has established itself as a leader in primary care research with impressive impact, a longstanding commitment to interdisciplinary work, and a growing international following. Our specialty needs to be both proud and grateful.

Where now? A direction can be glimpsed in the original Future of Family Medicine report. In March 2004, the leaders of the initiative issued a famous prophecy: "without major changes in both the discipline and the health care system, family medicine may be extinct in a generation."¹ Now, a half a generation later, where are we as a specialty?

The picture is mixed. The Patient Protection and Affordable Care Act (ACA) has increased access to care for many. Chronic care management, electronic health records (EHRs), and quality metrics are an integral part of our practice and there has been a proliferation of new practice models. But we are far still short of where we need to be. Rapid health system consolidation, employment of physicians, and the rapid spread of high deductible insurance plans may undermine robust primary care. US medical student interest has grown only modestly. At the practice level, EHRs take attention away from the patient, burnout is epidemic, and meaningful improvements in quality and equity have often been local, modest, and temporary.

In this context, the ABFM believes that the specialty must act with urgency, thoughtfulness, and passion. In the fall of 2018, we began a new strategic planning process. Over the last 17 years, the ABFM, guided by its Board of Directors and Dr James Puffer, implemented a variety of innovations to improve the certification process, transformed the organization into a digital enterprise, and helped drive innovation in family medicine residency training.^{2,3} Dr Puffer also launched a robust research enterprise⁴ that has documented positive correlations between participation in continuous certification and knowledge base, quality of care provided, and lower incidence of adverse medical license actions. ABFM has also documented dramatic changes in our scope of care, developed a national graduate survey to provide feedback to residencies on their outcomes, and begun to develop quality measures that capture the core of what primary care does. We look forward to reporting soon our directions for the next 5 years.

As the specialty responds to the changing environment of health care, how should the *Annals* guide us? Of course, the core of what *Annals* and other journals do is to cultivate scholarship in our field—the day-to-day working with authors, helping them to develop, and raising the bar for scholarship in family medicine. Equally important is its role in providing guidance to the discipline, assessing the current status of our research, and identifying important directions that should demand our attention now and in the future. This includes inquiring about the state of family medicine research today—who is doing it, what has been its impact, and how will it be funded? What are the "next big things" for research in primary care, as pragmatic clinical trials become a new "bright shiny object"?

But this is what all excellent journals do. What should *Annals* do specifically for the discipline? In March 2019, as we anticipate the ideas of a new editor and editorial team, the American Board of Family Medicine urges the editors to emphasize the asking of hard questions, not only of the delivery of health care,