

A Better Practice

Quality measures everywhere



The case for parsimony

Elsbeth Kalenderian, DDS, MPH, PhD; Rachel Ramoni, DMD, DMSc; Heiko Spallek, DDS, PhD; Joel White, DDS, MS; Muhammad Walji, PhD

We exist in an era in which quality measurement has received a tremendous amount of attention. In 2008, the Dental Quality Alliance (DQA) was established with the mission “to advance performance measurement as a means to improve oral health, patient care, and safety through a consensus-building process.”¹ The 2009 Health Information Technology for Economic and Clinical Health Act includes incentives for the “meaningful use” of certified electronic health records (EHRs) requiring the reporting of clinical quality measures.² The 2010 Patient Protection and Affordable Care Act includes payment incentives tied to outcomes.³ Purchasers and consumers of care also influence the quality of care and, hence, should have an interest in quality measures.⁴ The credibility and structure of the dental profession rely on dental professionals to monitor themselves;^{5,6} hence, it befits us to encourage a culture of self-evaluation through measurement. As we begin to walk this path, there are lessons to be learned from the health professions that have gone before us in pursuit of quality improvement and the realization of the power of knowledge generation that is an integral part of the practice of care.⁷

We are making the case for parsimony: focusing on a standardized, valid, and meaningful set of core oral health quality measures (understanding that not every dental practice will adopt rapidly the idea of routinely monitoring a standardized set of quality measures). In so doing, we would avoid the quality measure proliferation that has troubled medicine. A 2015 report by the National Academy of Medicine (NAM) noted that

thousands of measures are in use today to assess health and health care in the United States. Although many of these measures provide useful information, their sheer number, as well as their lack of focus, consistency, and organization, limits their overall effectiveness in improving performance of the health system.⁸

In addition to the obvious burden to capture these measures, there are other downsides to measurement bloat. Comparison across settings and people is a primary use of quality measures, and even slight variations in how a measure is defined can prevent valid comparisons. More fundamentally, having such a wide range of measures means that our quality improvement attention lacks focus. The approach of adding measures also violates 1 of the core criteria of the vision of the continuous

learning health system⁹ that data need to be generated as part of routine care and not as an additional task to be completed after-hours or in addition to clinicians’ already heavy workloads.¹⁰

We already are heading down the path of too many measures. There is measurement bloat because of a lack of data infrastructure to transmit information seamlessly from 1 dentist-patient encounter through to the top of the health care system. This lack has created a need for multiple levels of measurement. Furthermore, clinical practice guidelines developed by professional dental organizations as well as Healthy People 2020¹¹ targets form the basis of additional quality measures.

WHY MEASURE AT ALL?

NAM defines health care quality as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”¹² Clinical quality measures are tools to help assess how well we are doing with respect to health care quality. There is all-around agreement that to improve quality, we must measure it. As the Agency for Healthcare Research and Quality (AHRQ) puts it, “The ability to measure the quality of dental care is a key to improving it.”¹³ We should ensure that the measures we select truly capture what is important rather than narrowly focusing on technical aspects—too often we feel good about having provided more care than in the previous reporting period. However, there is variable evidence for the relationship between measures and meaningful health outcomes.¹⁴ Most importantly, the decision to measure or not to measure must not be driven by the ease of how something can be measured but rather by the relevance to patient health.

WHAT SHOULD WE MEASURE?

The NAM report calls for us to identify a limited number of core measures—the “vital signs”—for the health and well-being of Americans. To decide which dental quality measures (DQMs) should belong to this limited data set, we have 2 principles to adhere to: the DQMs need to cover the full range of measurement domains, and the quality measures must themselves be of high quality. The National Quality Forum (NQF) upholds these principles. The NQF is a coalition of public and private sector leaders that promotes health care quality through measurement. The government and private sector organizations use NQF’s endorsed measures to evaluate

Table. Clinical quality measure domains.*

MEASURE DOMAIN	DESCRIPTION	EXAMPLES
Process	<ul style="list-style-type: none"> ■ A health care activity done for or by a patient <ul style="list-style-type: none"> ● Supported by evidence that the process improves outcomes ● Usually appears in the form of a fraction, with eligible patients in the denominator and patients who receive the service in the numerator 	Children at elevated risk of developing caries who receive a sealant on a permanent molar
Access	<ul style="list-style-type: none"> ■ The provision of correct and timely care to patients ■ Supported by evidence of an association between the measure and outcomes or patient satisfaction 	Pregnant women who receive an annual dental examination
Outcome	<ul style="list-style-type: none"> ■ The patient's state of health as a consequence of health care ■ Supported by evidence that the measure validly can help detect the effect of the clinical intervention ■ Should include provisions for risk adjustment 	Children who remain caries-free
Structure	<ul style="list-style-type: none"> ■ A characteristic of a clinician or health care institution related to the ability to provide high-quality health care ■ Supported by evidence of an association between the measure and another clinical quality measure domain 	Use of electronic health records and computerized clinical decision support
Patient Experience	<ul style="list-style-type: none"> ■ A patient's report of his or her observation of or participation in health care or his or her assessment of resulting changes in health ■ Supported by evidence that the measure is associated with patients' values and preferences or another clinical quality measure domain 	Willingness to recommend clinic to others

* Source: Agency for Healthcare Research and Quality.¹⁶

care performance.¹⁵ The NQF has endorsed a number of DQMs, mostly measures developed by the DQA.

Measurement domains

With respect to the first principle (DQMs need to cover the full range of measurement domains), the 5 domains of clinical quality as defined by the National Quality Measures Clearinghouse (NQMC) are process, access, outcome, structure, and patient experience (Table).¹⁶ The NQMC assesses quality measure development, whereas AHRQ's 6 domains of health care quality¹⁷ are an analytical framework for quality care assessment, which may help guide measurement development but does not assess it.

Process- and access-based measures are readily available because they often are used for reimbursement purposes. Examples include the placement of pit-and-fissure sealants on permanent first molars as an evidence-based approach for reducing dental caries in children¹⁸ or annual visits to the dentist for patients with diabetes. Many of the access measures have a clear use component in them. Health outcomes, such as how well we keep patients free from dental caries, are the most effective and often most difficult to measure. Structure measures are less common among DQMs. Using a certified EHR or clinical decision support system in a practice according to the meaningful use¹⁴ incentive program is an example of a structure quality measure. Lastly, we measure how patients rate their health care experiences. Investigators have conducted patient satisfaction studies since the 1960s and 1970s¹⁹ and continue today, often through standardized survey processes.

Because it is easier to track the type of treatments patients receive, the dental profession tends to measure access and process. DQMs in all 5 domains are needed to measure fully a patient's oral health status or a patient's "... ability to speak, smile, smell, taste, touch, chew, swallow and convey a range of emotions through facial expressions with confidence and

without pain, discomfort and disease of the craniofacial complex."²⁰

Quality of the DQMs

To be credible, quality measures must be high quality. The NQMC is a public resource for summaries of evidence-based quality measures and measure sets.²¹ As Box 1 shows, the NQMC identified desirable attributes for clinical quality measures. All measures should have been tested within the last 3 years and have accompanying documentation that covers their rationale, definition, specification, and documentation (Box 2). NQF's processes for measures endorsements are even more rigorous than NQMC's. By definition, a quality measure is evidence based, and the NQF has well-established criteria on how to assess whether a measure is feasible, reliable, valid, and usable for it to achieve NQF endorsement.²⁴

As a profession, we need to decide what strength of evidence we require for our quality measures. If the criteria are too stringent, we risk not being able to generate important criteria in a timely fashion. If the criteria are too permissive, we risk undermining the credibility of dental clinical quality measurement as a whole.

As a compromise, we advocate for a middle ground in which a minimum level of evidence is maintained and, beyond that, the strength of the evidence is presented with the measure. The strength of evidence would evolve over time. As a minimum, we suggest the NQMC criteria, cautioning against proliferation of measures based on low-quality evidence. Measures should require both pilot testing in a real-world health care setting within the past 3 years and at least 1 of the following: The measure has to have been cited in at least 1 peer-reviewed journal indexed by the National Library of Medicine and has to have applied or evaluated the measure's properties; the measure has to have submission of documented evidence

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