COMPETING DISCOURSES AND PARADIGMS

STARFIELD SUMMIT III CONFERENCE BRIEF

Why This Matters

Starfield III aims to establish a unified vision for a foundation of measurement for high-performing primary care – continuing work already done. But conversations about measures in primary care can easily veer in many directions due to:

- Heartfelt interests or concerns about measurement and its consequences
- Different unspoken assumptions around the table about the scope or purposes of measurement (what *must* be measured rather than *might* be measured for one purpose or another, according to one stakeholder group or another).

These different directions are all legitimate conversations, but when they remain unspoken, they can lead people to believe they are having one conversation when instead, they are having many competing conversations. The most frequently encountered of these competing conversations are outlined here to make it easier to recognize and name them—and place them constructively in context during the.

What We Know

- **Different people have views of the purposes for measurement**: from a scorecard for getting paid; return on investment for a payer; ensuring provider accountability; quality of care actually delivered; the health of individuals or a clinic population; quality, service, and system improvement; societal value or cost, in particular through conversations that often drift toward payment.
- **People have seen measurement go wrong in various ways**: conscious or semi-conscious "gaming"; patients "fired" when hard to manage or "drag down numbers"; not taking on risky patients because of expectable complications; taking on underserved, disadvantaged, or distressed populations leading to lower performance numbers.
- **Primary care is "more than a basket of easily defined and commoditized goods and services"**: presumes the ability to isolate services and predictable outcomes given certain actions. This is misaligned with the complex and contextual nature of primary care: Interconnectedness, complexity, and ambiguity.

What Needs to Change

- The cacophony of competing discourses regarding what *might* legitimately be measured in primary care must be replaced with a single, coherent discussion that identifies what *must* be measured.
- We must be continuously and immediately aware of all the ways that the conversation can be taken into unintended directions based on 1) heartfelt concerns and experiences with measurement; and 2) different assumptions or conclusions about the purposes of measurement.
- Specific approaches to keeping the conversation moving forward in the conference are needed that do not exclude the legitimate issues or shut down the conversation (see below).

How this Informs Starfield III

- Starfield III table conversations can be loaded for success using conscious precautions
    - Quickly name such competing discourses on measures when they arise, so they can be defined or put in a constructive context without distracting much from the task at hand. This will include but not be limited to the seemingly inevitable confounding of measures and payment and the different purposes for measurement. At the very least point out which purpose we are talking about at any given time.

- Cast some of the many dilemmas with measurement into “balances to strike” rather than debate in ”either-or” terms. Sometimes both things are true at the same time even though they appear to be completely opposed. Often enough, there is value and wisdom on both sides, neither side is complete without the other, people have strong feelings, and the tension cannot be made to go away. If we can identify which measurement discourses entail polarities to balance, we could begin to balance them rather than struggle over which side to take.
    - Examples: How do we get the best of both...
        - “Primary care measures free from gaming and adverse payment incentives” **AND** “Primary care measure that assess quality delivered, not other stuff”
        - “A concise set of primary care measures, focused on core primary care performance (not an ungainly list that satisfies every curiosity from anyone)” **AND** “A set of primary care measures among which will be found things that appeal to what matters to the broad range of stakeholders in primary care”
- Accept that with a value on parsimony will come a price in “neatness and completeness”. Certain things will need to find a place somewhere, even if not in the main formulation. Otherwise people will constantly ask, “What about….?” For example:
    - **Process measures:** Are these to have a place in the measures formulation? Whether yes or no, they need a place somewhere and an explanation for why they are or are not in the conference product.
    - **Work environment measures:** We now have the “quadruple aim” that includes clinician experience – satisfying and sustainable careers for clinicians.[1] But do we measure this as part of a parsimonious primary care measure set? If not, where does it go and where is it honored?
    - **Cost measures:** Containing escalating costs of care and insurance is a national priority, perhaps the strongest issue in healthcare today. Are they part of a parsimonious set of primary care measures? If so, what will we mean by “cost” – a term understood differently by different people? For example: Total cost of care? Total “spend” on primary care? etc.
    - **Measures related to risk and adjustment:** Seasoned providers with longitudinal panels may see quality or health scores decrease over the years as their stable panels age. Others serving distressed populations may see lower health or performance scores. Can measures reflect good care, whether or not the patient is old and sick or not? Or socially disadvantaged?
- Share a good enough framework of fundamentals early on. For example, guidance for developing primary care measures, shared understandings about the purpose and key attributes of primary care, or a shared and easily conveyed visual representation of primary care capacities.

Reference

1. Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. AFM. 2014;12(6):573-576.