



GUIDANCE FOR DEVELOPING PRIMARY CARE MEASURES

STARFIELD SUMMIT III CONFERENCE BRIEF



Why This Matters

Measurement of primary care can improve performance, reflect shared parameters of improvement, foster learning, set aspirational targets, and reflect shared understanding of what is valuable. Such assessment must be guided by criteria for what makes for a good measure based in a shared understanding of the purpose(s) of measurement.

What We Know

Primary care measures “allow us to consider what is being done well, what might be better left undone, what needs to be changed, and what is essential and therefore needs to remain unchanged”.¹ The purpose of primary care measures is to:

- Monitor the care provided to patients and families
- Evaluate performance of primary health care and primary care practice settings
- Guide self-assessment and continuous learning within primary care settings
- Estimate alignment of care delivered with the needs/expectations of those who receive and provide it
- Inform decision making for primary health care practice, policy, and investment
- Foster aspirations for improvement

What Needs to Change

A new measurement paradigm might be unleashed by new assumptions:

- Primary care is more than a basket of easily defined and commoditized goods and services. Services offered within primary care exist within relationship-based interactions in a personalized setting.
- When done well, primary care enables the right care to be delivered in the right way, at the right time, and in the right place (defined by both the clinician and patient and informed by relevant information.)
- Efficient process is not synonymous with effective care. Care that is not effective is not efficient. The fastest means to a narrow end using the fewest resources may presume the ability to isolate individual services associated with predictable outcomes given certain actions. This is misaligned with the complex, contextual nature of primary care.
- Individual measures do not drive care – they are each part of a larger picture. Measures done well offer guidance and evaluation of the extent a larger vision is being accomplished. When a measure itself becomes a target, it is no longer an effective means for evaluation.² Payment models that encourage narrow and singular measure-directed care motivate a shrinking sense of professional responsibility.
- The maxim “if it isn’t measured, it won’t happen” often causes a maladaptive chain reaction: a narrow interest in doing what is measured, leading to a multiplication of measures to ensure everything gets done, leading to measures of activity and process, rather than measures related to health, healthcare, performance, or quality. Measures reflecting how primary care provides value are needed to complement the easier, narrow measures sometimes needed to serve external interests. Measures are best when they provide guidance and direction, not specific activity mandates.
- Measures should inform and support accountability, not enforce it. That is, primary care measures track what is important about primary care and are not centered on how to pay people and hold them accountable. Payment and “enforcement” are important “off-label” uses of primary care measures, but too often constrain measure development, distracting from measurement purpose. Measures are unlikely to reflect a one-to-one relationship between an individual clinician’s actions and an individual

patient's or population's outcomes. Health and illness are social conditions beyond the direct impact of any one individual. Measures must be responsive to this basic fact. Environments are needed in which measures are used to identify how to support valuable primary care functions and relationships.

- Measures of care of diseases and specific problems are part of the picture, but do not by themselves add up to measurement of primary care. Rather than allow measurement to be dominated by diseases and organs or life expectancies and what we already know how to count, we should reorient measures to include alignment with how we live, how we experience, what makes for quality care, and what is valuable about primary care to persons.

How This Informs Starfield III

The measurement enterprise incorporates many needs, some of which are tangential to the core purpose of primary health care (e.g., proof of service delivery; ability to differentiate practice settings). Measures that focus on these needs serve a function, are useful in many settings, and to a variety of stakeholders. However, these same measures can do harm if considered, all by themselves, an evaluation of the primary care function, the quality of care provided there, or the experience of those who go there. Though necessary and useful, measures developed to meet external needs should not be mistaken for core measures of primary care performance, even if some measures are able to do both jobs. *Primary care measures*, i.e., those intended to assess primary health care function and value, must satisfy the need of the platform and its future.

Primary care measures should be parsimonious – the smallest meaningful set based on the needs of those within the system.³ The description and building of this vital set of primary care measures will be supported at Starfield III by a commonly held set of guidance.

Guidance for Developing Primary Care Measures

Development of the guiding attributes below began before the conference and this development will continue during Starfield III and after. These items are *guidance*, not universal mandates. They will not all be appropriate in all settings and at all times. The need to assess must always be balanced with the purpose, burden, necessity, and use of the information collected. Based on previous research^{1,3} and the contributions of Starfield III attendees thus far, meaningful and useful primary care measures are ones that:

1. Are meaningful – to patients, families, health systems, policy makers, and clinicians
2. Assess primary care as defined, practiced, experienced, and co-created between patients and clinicians
3. Assess the intended outcomes of primary care, e.g., achievement of health and health goals, illness prevention and health promotion, healing, avoidance of unnecessary pain and suffering, and equity
4. Balance the tensions endemic to primary health care: standardization along side customization, predictability along side ambiguity
5. Are flexible – adaptive to size (roll up and down), life span (infant to elderly), health state (changing health status), and individual differences (context, family, and preferences)
6. Provide evaluation and improvement information actionable at the local, regional, and national level
7. Support self-assessment, self-learning, and aspiration
8. Are feasible, reliable, and without undo data collection burden
9. Point out and establish the importance of things that cannot yet be counted
10. Inform evaluation of a broad vision that understands health and illness exist within a social and cultural framework.
11. Reflect the complexity of the discipline – the whole is more than an additive sum of parts. Embrace interconnectivity, reject reduction to cause and effect of individual elements, assess and support emergence – where just adding up what happens to parts (diseases, individuals) doesn't equal the whole (people, populations)

References

1. Stange KC, Etz RS, Gullet H, et. al. Metrics for Assessing Improvements in Primary Health Care. *ARPH*. 2014:423-42.
2. Strathern M. Improving Ratings: audit in the British university system. *Euro Rev*. 1997;5(3):305-321.
3. Blumenthal D, Malphrus E, McGinnis JM, eds. *Vital Signs: Core Metrics for Health and Health Care Progress*. 2015.