

Starfield III Conference Brief

The Historical Context in Which 2017 Work on Primary Care Measures Takes Place

Why This Matters

Primary care is essential, foundational, fragile, and shrinking. Primary care sees over 50% of all patient visits annually and yet its workforce, scope of work, and funding in the US continue to decline.¹ Primary care's effects are known to be better healthcare, better health, contained expenditures, and reduced disparities.² Sustaining the platform and its focus is a high priority and requires measures able to promote continual improvements and investment in primary care.

What We Know

- *Unshakeable truths regarding the needs of primary care measures are well known and have been shared in Starfield Summits before this one.* Starfield I included a specific focus on measures as speakers shared the following wisdom:
 - A measure framework will not work without a clear and shared vision regarding what you need to measure and the purpose of measuring it. (Howe)
 - When we prioritize solving the need to identify measures, we tend to gravitate to the easily itemized and easily counted. However, in primary care some of the most important things to measure are also the most difficult. (Safran)
 - The key elements of primary care do not operate independently. They exist in common as a whole and must be measured simultaneously. (Rich and O'Malley)
 - Above all – measure what matters most. (Pisacano Scholars)³
- Most attempts to create measures for primary care have focused on pieces of primary care, rather than the whole. These often center on disease pathways, work pathways, or decisional pathways, and fail to address key elements through which primary care provides value.⁴
- *The US approach to health and healthcare is undergoing a period of rapid transformation making this a possible tipping point in the creation of meaningful primary care measures.*
 - There are several defining issues to this historical moment: cost, patient reported information, social determinants of health, the creation and mining of big datasets, and the integration of behavioral health, public health, and primary care.
 - New primary care payment models are being tested: legislative changes, such as MACRA 2015, have connected measurement systems and payment systems in ways intended to promote “value over volume,” and demonstration projects, such as Comprehensive Primary Care Plus, intended to identify best options among blended and bundled payment models.
 - New primary care practice redesign efforts are being organized at a national level. CMS's Transforming Clinical Practice Initiative and AHRQ's EvidenceNOW initiative provide technical and capacity building assistance to enable rapid adoption of best practices among thousands of primary care settings.
 - Leaders in public health and primary care have noted an absence of meaningful measures and have called for measures appropriate to the task of assessing primary care, public health, stakeholder identified needs, and the certainty of health equity.

What Needs to Change

There is an acute need for an immediate reduction in the number of primary care measures.⁵ Thousands of primary care measures exist; hundreds are frequently used. The administrative burden and financial costs related to the over measuring of primary care is high.⁶ To reduce the number of primary care measures, we must change some of the more pernicious leading narratives:

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- “Structure, Process, Outcomes assessed for categorized groups of patients measures care.” Primary care measures cannot be confined to pieces, diseases, and the biological as isolated from the social. The divide and conquer approach to measuring primary care has led to a proliferation of inappropriate measures, undermining the core mechanisms by which primary care delivers value. This isolating focus on care delivery capacity, process, and immediate measurable outcomes precludes any measure-based attention to healing and personal goals defined as part of a life ongoing.
- “If it isn’t measured, it doesn’t happen.” Primary care is relational. It is the social framework of the relational that provides meaning to experiences and interactions over time and within care settings. The needs of individuals cannot be predicted in advance of knowing individuals. Measures that solely focus on the predictable fail to capture those aspects of care most important and most valued. This can also have the damaging effect of care designed around our limited understanding of how to measure what can be counted, rather than measuring what matters.
- “Incentives drive quality.” Primary care is ill served by an accountability that undermines value. We need to abandon measures that target specific behaviors and yet fail to evaluate care. Clinicians want patients to get better, to achieve the best they can within the context of their lives, and to know how they are doing with enabling patients on that journey. The definition of what matters in measurement must incorporate what matters to primary care and the people who feel compelled to go there. This will require the many stakeholders of primary care to work together with regard to the primary care needs and interests they hold in common, providing vision for a parsimonious measurement set.
- “That measure isn’t fair because I can’t control that.” Health and illness are dynamic states of being and beyond the control of any one thing or individual. Limiting measures to what can reasonably be assigned as the impact of an individual action is antithetical to the human condition and the interrelational foundation of primary care.
- “Measure the next best thing.” Much of primary care exists in the world of intangibles. It is a platform designed to balance best practice, best evidence, and best experience with the need to prioritize, personalize, and customize. Current systems of measurement are unable to assess this dynamic so we settle for the next best thing – outcomes most related to secondary care that stand in as “the next best thing” to primary care knowing. Failure to assess primary care ways of knowing, doing, and understanding will always result in failure to assess primary care.

How This Informs Starfield III

Primary care is over measured and under evaluated. Quality measures currently fail to serve clinical decision making, policy decision making, or the health needs of the American public. There is no national consensus regarding how best to measure primary care delivery and performance.⁷ Any effort to create a meaningful set of primary care measures must build upon the wisdom preceding it, respond to the challenges that remain, and do so in concert with other national initiatives within health and health care, not in isolation of them.

References

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