

Measuring the Quality of Health Care in the US: Why We Are Failing and What We Can Do About It

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President Trump's June 26, 2019 [Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First](#) has reignited debate about the accessibility, usability, and effectiveness of health care quality data in the U.S. The order makes clear that it's critical to pair price transparency with usable quality information: "To make fully informed decisions about their health care, patients must know the price and quality of a good or service in advance." This is perfectly reasonable logic and makes sense for almost everything we buy, from cell phones to avocado toast.

However, in health care, neither price nor quality is easy for consumers to assess or act upon. Much has been written about the [challenges](#) of providing actionable [pricing information](#) in health care. This article will focus on the state of quality measurement in the U.S., and why our quality measurement system isn't getting us to a demonstrably better value proposition.

There is notable dissatisfaction with the current quality measurement system, including the large number of metrics in use; the unintended consequences of reliance on reported measures and incentive programs; excessive reliance on process measures over outcomes measures; disagreement over how to effectively measure outcomes; information that's confusingly reported in a multitude of formats; and high collection and reporting costs. A portion of these challenges can be attributed to lack of a universally agreed upon definition of what quality means in health care and dozens of stakeholder organizations that have at least partial focus on quality measurement or improvement, leading to consumer confusion, overlapping efforts, and sometimes conflicting results.

In short, we're not getting what we want out of measuring health care quality because we don't know what we want out of measuring health care quality.

Why do we measure the quality of health care? Is it for determining payment? Improving health outcomes? Transparency? Consumer decision-making? How about health and safety regulation, professional certification and facility accreditation, prevention, health promotion, population health management, benchmarking, to improve value? Right now, the answer is all the above. The multitude of goals hampers the ability to improve health care quality, as providers struggle to simply keep up with the multitude of measure sets, overlapping and sometimes conflicting reporting requirements, and lack of a holistic overarching measurement purpose. Without an overarching goal, how would providers know what success looks like? They may need to reach certain thresholds at the micro level, such as providing smoking cessation counseling to patients, but when that is just one of dozens or hundreds such thresholds, it fails to serve a broader purpose in the holistic care of an individual. It's just a number that must be reached, and measures often don't relate to each other at the macro level.

Given the fragmentation of measure sets, proliferation of measurement organizations, and the [sizable administrative burden it creates](#), it isn't surprising if health care providers focus myopically on collecting and reporting measures and meeting minimum thresholds for their own sake, not in concert with some greater purpose. This is a huge dissatisfier for clinicians, a frustration for health care administrators, and a source of confusion for consumers trying to wade through a dizzying array of measures reported in varying formats. Further, there is no single organization empowered to centralize and rationalize the measurement system. Without an industry-accepted central source of quality leadership, there is little incentive or ability to rationalize the measurement system, as each payer, state health department,

accreditation organization and consumer report provider creates their own methodologies and reporting requirements. In fact, the lack of an agreed-upon central arbiter of national health quality goals perversely incentivizes the proliferation of measure sets as quality measurement organizations seek to differentiate their products and services from others through unique methodologies and measure sets.

The good news: there is broad acceptance of the idea that quality of health care can and should be measured; there are some efforts to standardize and rationalize the number of quality measurements in current use; and there are some interesting proposals out there that would significantly overhaul and simplify the quality measurement system in the U.S.

Below we discuss six structural issues in the current system of measuring health care quality in the U.S., followed by some recommendations to address these issues. While we focused only on macro level structural issues, there are also intense debates at the micro level, such as the most accurate way to risk-adjust an outcome measure, whether the scientific evidence supports the use of a specific measure or a threshold, or the best way to construct a composite measure. These micro-level disagreements add further complexity to the challenge of overhauling our quality measurement system. However, we believe that many of them would be resolved or become moot if we tackle the broader structural challenges first.

Structural Challenge #1: Too Many Cooks in the Kitchen

The sheer number of organizations involved in health care quality measurement is a sizable challenge for providers, payors, consumers, and policy makers. There are numerous organizations involved in developing standards for measurement, vetting proposed standards, applying the standards, utilizing and interpreting quality data, advocating for improved quality, and reporting quality to providers, consumers, payers, and others. A brief and non-comprehensive overview of the quality measurement landscape highlighted over 40 organizations with varying objectives, NOT including dozens more stakeholder organizations sponsored by state or local level organizations, such as California's Hospital Quality Institute, private payers, or institutes housed at academic institutions, such as Johns Hopkins' Armstrong Institute for Patient Safety and Quality. State- and payor-specific quality data collection and measurement add additional layers of complexity for providers, payors, policy makers, and consumers, and make it harder to draw conclusions based on comparable information.

There are numerous organizations which develop quality metrics ("measure developers"), others that endorse measures developed elsewhere ("endorsers"), and still other organizations that implement the measures ("adopters"), i.e. for payment policies or report cards. And of course, there is overlap between measure developers, endorsers, and adopters.

Examples of the diversity of organizations with an interest in health care quality include:

- Government agencies such as the Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control (CDC), Agency for Healthcare Research & Quality (AHRQ) and the Department of Veteran Affairs (VA);

- Non-profit industry-sponsored groups such as the Leapfrog Group, Bridges to Excellence, and the Midwest Business Group on Health;
- For-profit providers of ranking systems such as U.S. News & World Report and HealthGrades;
- Accreditation bodies such as the National Committee for Quality Assurance (NCQA) and The Joint Commission;
- Scientific and research organizations such as RAND Health Care, National Institutes of Health (NIH) and Institute for Healthcare Improvement;
- Organizations sponsored by medical societies or classes of providers such as Pharmacy Quality Alliance, Ambulatory Care Quality Alliance, and Physician Consortium for Performance Improvement;
- Organizations attempting to promote value in the system by connecting quality and cost for consumers, payers and others such as Catalyst for Payment Reform and Castlight Health;
- Agencies that address certain populations, such as the VA (veterans), Health Resources and Services Administration (geographically isolated, economically/medically vulnerable), and Indian Health Service (IHS);
- Niche players that monitor and track one component of larger quality measurement systems, such as the Office of the National Coordinator of Health Information Technology (meaningful use measures for adoption and use of EHRs), and the Occupational Safety and Health Administration (safe and healthful working conditions); and
- Global organizations such as Organization for Economic Cooperation and Development (OECD), The Commonwealth Fund, World Health Organization (WHO), and International Consortium for Health Outcomes Measurement.

Many of these organizations share similar missions, overlapping goals, and serve multiple stakeholders, which adds complexity for consumers and others looking for definitive sources of information. A consumer searching for a “good” hospital has a dizzying array of places to look, all using different criteria to determine what is a “safe” or “high quality” facility. An [academic study](#) of four rating systems - Consumer Reports, Leapfrog Group, HealthGrades, and U.S. News & World Report - found that, of 844 hospitals rated as a high performer by one rating system, only 10% were rated as a high performer by any other rating system, and *none* were rated as high performers by all four systems.

Many health care quality organizations have similar sounding missions. Based on a review of the various organizations’ missions and product offerings there appears to be quite a lot of overlap. For example:

- **AHRQ’s** mission includes “to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable.”
- **Institute for Health Improvement:** “Improve health and health care worldwide.”
- **The Leapfrog Group:** “Trigger giant leaps forward in the safety, quality and affordability of U.S. health care by using transparency to support informed health care decisions and promote high-value care.”
- **National Quality Forum:** “Catalyze improvements in health care... enhance health care value, make patient care safer, and achieve better outcomes.”

- **National Academy of Medicine:** “Improve health for all by advancing science, accelerating health equity, and providing independent, authoritative, and trusted advice nationally and globally.”
- **Catalyst for Payment Reform:** “Help employers and other health care purchasers get better value for their health care dollar.”
- **International Consortium for Health Outcomes:** “To unlock the potential of value-based health care by defining global Standard Sets of outcome measures that matter most to patients and driving adoption and reporting of these measures worldwide to create better value for all stakeholders.”
- **Premier, Inc.:** “To improve the health of communities...reinventing the next generation of health care, using every tool in our arsenal to lower costs and improve outcomes.”
- **The Commonwealth Fund:** “Promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society’s most vulnerable, including low-income people, the uninsured, and people of color.”

Even the organizations’ names can be overlapping. For example, there’s the National Academy of Medicine and the National Institutes of Health (both government agencies), and the Institute for Health Improvement, which may sound like a government agency, but it’s not.

Many of these organizations attempt to serve multiple purposes. For example, CMS uses quality data to run over 20 pay-for-performance and pay-for-reporting programs, as well as to generate a consumer-oriented star-based rating system.

There are so many organizations involved with collecting, tracking, scoring, and reporting health care quality data that one organization sprang up just to keep track of it all. According to AboutHealthTransparency.org, their goal is to, “track news and health care report cards on quality, pricing and consumer satisfaction.”

Happily, there are a few examples of rationalization among these organizations. For example, the Hospital Quality Alliance, a multi-stakeholder alliance concerned with hospital quality of care founded in 2002, wound down in 2015, effectively transferring its responsibilities to the National Quality Forum (NQF). The National Patient Safety Foundation merged with IHI in 2017. Still, the sheer number of measures out there, the similarity of many measures, and the multitude of purposes for which they are collected, aggregated, disseminated, and used has caused significant frustration in the provider community and confusion among consumers.

Structural Challenge #2: We Try to Measure Too Much

The many stakeholder organizations result in a huge proliferation of quality measures. There are so many metrics in use by so many different parties that it’s hard to even say how many metrics there are. Even CMS, which is highly transparent, has so many programs and so many categories of measures, some of which are used by multiple programs, that it’s hard to even say how many measures CMS uses. A look at CMS’ [Measure Inventory Tool](#) at first appears to reveal 2,270 measures. If you sort by “Current Status”, there are 2,269 results, including many with status markers that are confusingly similar. For example, there are 40 measures marked as “rescinded,” 33 that are “discontinued,” while another 571

are “removed.” Similarly, there are 309 measures “finalized” and 520 “implemented.” So, the simple question, “How many quality measures does CMS use?” doesn’t seem to have a simple answer. The complexity of this question is replicated across dozens of other organizations that develop, approve, or implement quality measures. Most literature discussing the number of quality measures in use simply say the number is “in the thousands” but stop short of a more refined estimate.

Federal agencies, states, payers, employers, and providers have their own approaches, often focusing on different measures, or the same things measured differently. An analysis of [48 state and regional measure sets](#) found an incredible 1,367 measures in use, and a sizable amount of customization of measure sets - only 20 percent of all measures were used by more than one program.

Even within a single agency and disease state there can be a sizable number of measurements. The HHS Measure Policy Council [initially found that](#) across six HHS measurement programs, 61 different measures were in use for smoking cessation, 113 for HIV, 19 for obesity, and 68 for perinatal health.

The proliferation of programs and reporting requirements seems to have diminished their effectiveness. The fragmentation of measures and use of non-standard or modified measures make it hard to compare performance across payers, populations, and geographies, and results in wasteful redundancies and high costs of collection. Further, most measures are too narrow to inform us about the overall health of an individual or population, and they don’t capture the richness and complexity of interactions between patients and their physicians, such as in primary care. Individual performance measures also raise questions about the relative importance of one measure versus another. There is an implicit assumption that all measures are equally important, which is unlikely to be the case. Collecting data on thousands of disconnected measures that are overlapping, not standardized, and lack connection to a national health strategy is inefficient at best and more likely counterproductive.

Structural Challenge # 3: We Don’t Agree on What Quality is

There are a variety of views on how quality should be defined, and what a “high performing” system would look like. We found at least 6 working definitions of “quality” in use at various organizations and in published research.

1. *CMS*: Quality measures are tools that help us measure or quantify health care processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include: effective, safe, efficient, patient-centered, equitable, and timely care.
2. *Institute of Medicine*: The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
3. *National Committee on Quality Assurance*: Health care quality means getting the right care, in the right amount, at the right time.
4. *World Health Organization*: The extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centered.

5. *Organization for Economic Cooperation and Development (OECD)*: Quality in health care means that care provided is: *Effective*. achieving desirable outcomes, given the correct provision of evidence-based health care services to all who could benefit, but not to those who would not benefit; *Safe*. reducing harm caused in the delivery of health care processes; and *Patient-centred*. placing the patient/user at the center of its delivery of health care.
6. *Millbank*: Providing patients with appropriate services in a technically competent manner, with good communication, shared decision making, and cultural sensitivity.

These differences hamper the ability to agree on a common set of goals, which is a prerequisite to a functional measurement system. Which brings us to structural challenge #4.

Structural Challenge #4 – We Don't Agree on the Why

There are many good reasons to measure health care quality, and each considered alone may have a lot of merit. Improving health outcomes, increasing transparency, adherence to health and safety regulations, professional certification and facility accreditation, calculating pay-for-performance incentives, prevention, population health management, consumer decision-making, benchmarking, improving value – these are all laudable and defensible goals. But in aggregate it is unwieldy, expensive, fragmented, and ineffective. Measuring quality for the purpose of improving patient safety in cardiac surgery procedures requires very different focus than measuring whether a patient feels that their doctor listens to and respects their lifestyle choices, or whether the health care system is contributing to an individual's quality of life.

Our insistence on retaining all of these goals, and our resistance to yield authority to a central arbiter of measurement purpose hampers our ability to focus on what kind of quality measurement system we should have and how to improve the current system.

The Bipartisan Policy Center discusses this challenge in their 2015 report [Transitioning from Volume to Value: Consolidation and Alignment of Quality Measures](#):

Failure to reach consensus is a disagreement on the purpose of the measures (i.e., improved patient safety, or other care outcomes; reimbursement; or making information available to businesses, plans, and consumers) and whether the measurement actually achieves its purpose (i.e., prevention of hospital-acquired conditions or improved patient satisfaction).

The President's Executive Order of June 26, 2019 recognizes the need for an overarching quality measurement strategy, more centralized planning, and rationalizing the measurement system:

Within 180 days of the date of this order, the Secretaries of Health and Human Services, Defense, and Veterans Affairs shall develop a Health Quality Roadmap (Roadmap) that aims to align and improve reporting on data and quality measures across Medicare, Medicaid, the Children's Health Insurance Program, the Health Insurance Marketplace, the Military Health System, and the Veterans Affairs Health System. The Roadmap shall include a strategy for establishing, adopting, and publishing common quality

measurements; aligning inpatient and outpatient measures; and eliminating low-value or counterproductive measures.

Structural Challenge #5 – It’s Not Clear That We Measure Stuff That Matters

Industry experts and consumers agree that quality can and should be measured, that it has altered the culture of health care delivery for the better and [improved outcomes in certain clinical areas](#). However, there is widespread dissatisfaction with what we measure, what we don’t, and who the measurement should apply to. Aside from general support for the *idea* of measuring quality, we found nobody supporting *how* we measure quality. A sample of views from around the industry reveal opinions that measures are too narrow, lack connection to a holistic view of health, don’t reflect relative importance, fail to measure certain things entirely, focus too much on process rather than outcomes, and sometimes apply to providers at the wrong level of organization. Some examples:

Measuring complex clinical decisions, multiple conditions, and primary care

“The current set of quality measures cannot evaluate various complex clinical decisions and processes. For example, physicians’ ability to manage patients with multiple chronic conditions or technical skills such as accuracy of radiologists’ reading of imaging studies” [Congressional Budget Office, Issues and Challenges in Measuring and Improving the Quality of Health Care](#)

“Current measurement systems have poor applicability to complex chronic diseases whose treatment involves multiple practitioners and is heavily influenced by factors beyond the control of practitioners. Yet chronic illness now affects 45 percent of the U.S. population.” [Vital Signs: Core Metrics for Health and Health Care Progress](#)

“Primary care...depends on meeting a wide variety of patient needs. More than one-third of health problems initially encountered at a primary care center do not lend themselves to a diagnosis, and about one-half are unlikely to result in a definitive diagnosis that would trigger a standard care pathway. Input variables for primary care processes and health outcomes are often beyond the control of the physician and patient, such as socioeconomic factors and poverty.” [Annals of Family Medicine, The Challenges of Measuring, Improving, and Reporting Quality in Primary Care](#)

What we don’t measure

“We don’t currently measure any of the following:

- Diagnosis errors (which are alarmingly common and outnumber surgical errors as the leading cause of outpatient malpractice claims and settlements);
- The appropriateness of diagnostic and therapeutic interventions;
- Providers’ ability to skillfully manage complex patients with varying combinations of multiple clinical and psychosocial problems.”

[RWJ Foundation and Urban Institute: Achieving the Potential of Health Care Performance Measures](#)

“Gaps in current measurement efforts:

- Patient engagement—few capabilities to assess patient-centered care and patient engagement;

- Care quality—limited scope of quality measurement for certain areas, such as special populations (e.g., children/adolescents, patients with multiple chronic conditions);
- Value—limited capacity to assess value, affordability, waste, and overuse;
- Healthy people—small number of measures that assess population health and well-being outside of the health care system.”

[Vital Signs: Core Metrics for Health and Health Care Progress](#)

Lack of relative value

“The current system doesn’t adequately take into account the relative value of measuring certain things. It treats all measurements as equally valid. Examples:

- Clinical interventions to decrease smoking have a far greater impact on health than glycemic control for type 2 diabetes, yet current approaches obscure these relative contributions.
- Dental care, effective treatment of alcohol and opiate addiction—highly meaningful to patients and strongly contributory to health (in terms of disability-adjusted life years)—are currently not quality measures.”

[Care That Matters: Quality Measurement and Health Care](#)

Micro focus

“There has been much research about and dissemination of high performance as it applies to narrow clinical areas, such as a high-performing hospital for cardiac surgery or a high performing health system delivering preventive services, but not as it relates to the health care system more broadly.” [The Joint Commission Journal on Quality and Patient Safety, What Defines a High-Performing Health Care Delivery System: A systematic Review](#)

“The quality metrics in use are primarily ‘micro’ in their orientation and are frequently more focused on complications or errors associated with an event such as an episode of illness or a treatment. In contrast, a more fully outcomes-focused assessment would include whether a selected treatment was the most appropriate intervention, given the patient’s condition; whether a diagnosis was clinically accurate; or whether a treatment actually improved the patient’s health, particularly in ways that are important to the patient.” [The JAMA Forum: The Need to Simplify Measuring Quality in Health Care](#)

Provider level of measurement

“Improved health is often the result of actions by multiple parties at multiple levels, not individual providers.” [Care That Matters: Quality Measurement and Health Care](#)

“The attribution of a particular care process or outcome to a particular clinician is often difficult, if not impossible, to make. For example, several specialists, hospitalists, nurses, technicians, and others will typically care for a patient with a heart attack...For some aspects of care, such as diagnosis errors and patient experience, measuring at the individual physician level might be considered.” [RWJ Foundation and Urban Institute: Achieving the Potential of Health Care Performance Measures](#)

Structural Challenge #6 – It’s Too Hard to Use Quality Data

There is support among consumers and health policy experts that public reporting requirements improve health care quality. [Overwhelming majorities say](#) requiring doctors to report the effectiveness of their treatments and patient satisfaction with care would improve quality of care.

However, there appears to be a notable gap in the ability of consumers to digest and use quality information effectively. Health care quality information is available to consumers in a wide variety of displays. For example, there are 5-star rating systems, 0-100 systems, letter grades A-F, there are scores for entire hospitals, for service lines within the hospital, for individual providers and for clinical procedures. Each system of measurement uses different ways to calculate, weight, and synthesize the data, often with [controversial results](#). Sometimes the scoring systems are transparent, while others use proprietary methods.

Health care futurists have predicted a consumer revolution in health care for years, where empowered consumers, armed with great data on health care quality, will vote with their feet to the highest performing providers, resulting in higher quality and better value for all. That day may come, and perhaps on the margins some consumers are already leading the way towards the envisioned revolution, but mostly, consumers seem to be unaware about the availability of quality data, confused by it, or unsure how to use it. For example, [a study published by the Robert Wood Johnson Foundation and the Urban Institute](#) found that

There is mixed evidence about how well public reporting informs consumer choice. Public reports seem to have negligible impacts on the selection of providers by patients and families or their representatives, primarily because patients are often not aware that the quality information is available, the information provided in public reports is not what they need or value, the information is outdated, the information is not always available when they need it to make a decision, or the information is not presented in an easily understandable way.

It isn't even clear that health care consumers use the same concept of quality as most quality measurement organizations. [Finding Quality Doctors: How Americans Evaluate Provider Quality in the United States](#) noted that "When it comes to defining provider quality, most Americans tend to focus on certain aspects of quality relating to doctor-patient interactions and doctors' personality traits, rather than the effectiveness of the care provided or the patient's own health outcomes."

The challenges of interpreting and using quality data are not limited to consumers. For payers, conflicting ratings make it difficult for them to recognize and reward hospitals for high quality. For hospital leadership, differences across rating systems complicate decisions regarding the focus of their improvement efforts.

Unintended Consequences

With all of the structural challenges in our quality measurement system, it is not surprising that there are a [sizable number of unintended consequences](#). For example, the system may incentivize providers to prioritize easier care for healthier people in order to generate better scores, over test, overmedicate, or behave in ways that are not in the best interest of patients in order to meet a measurement standard.

For example, measurement of pain management can lead to over-prescription of pain killers, while penalizing hospitals for patient falls may lead some hospitals to [encourage patients to stay in bed](#), which can reduce overall mobility and lead to blood clots, pressure ulcers, and other adverse outcomes.

Other unintended consequences include the potential to focus myopically on the numeric threshold enshrined in the measure in order to be scored favorably, while de-emphasizing more impactful cases that aren't considered 'success' under the measure. [For example](#), if a systolic blood pressure threshold is 140, helping a patient go from 141 to 139 is counted as "success", whereas going from 180 to 155 is a lot more impactful, but isn't considered "success."

The current measurement system can also result in providers focusing attention on measured aspects of care [to the detriment of aspects that are not measured](#), or to follow performance measures that are incentivized over potentially more meaningful measures that are not.

There are even some concerns about quality measurement causing providers to game the system, such as attempting to improve rankings by avoiding sicker patients or misreporting data, although we found no hard evidence of such practices.

Other unintended consequences include the [time and intensity of updating measure sets](#), which can result in using outdated or even harmful interventions, and may not adequately take into account the benefit that individual patients may achieve.

A Way Forward?

Given the well-documented dissatisfaction with the current quality measurement system, it wasn't surprising to find no shortage of opinions about how to fix the system, including several proposals for comprehensive overhauls. The proposals vary significantly in level of detail from bare bones lists of "guiding principles" to highly developed and well-thought out proposals that include suggested measures and rationales for inclusion.

There are several common themes among proposed alternative frameworks. These include: recognition of the cost of collecting and tracking a quality measure compared with the clinical benefits of the measure; metrics should be meaningful to patients (although not necessarily through measuring patient satisfaction); use of continuous risk scales rather than binary (cut point) thresholds of risk; measurement at the organization level or across a continuum of care instead of at the individual provider or facility level; focus on outcomes instead of process; ability to exclude patients from measurement for various reasons such as multi-morbidities or patient preference choices; and designating a single organization or agency to be the central arbiter of measure sets (although proposals differ about which organization is best positioned to do that. NPSTF, CMS, and NQF were all mentioned as the potential central coordinator).

In our view, the most comprehensive proposal for an alternative quality measurement system is from the Institute of Medicine in its book ["Vital Signs"](#). This publication is the result of the work of a "Committee on Core Metrics for Better Health at Lower Cost." The committee included about two dozen influencers from academia, state departments of health, industry, foundations, health plans, and others. Like others, they believe that one organization should take the lead in centralizing the efforts to

streamline, assess, and implement measures: “The secretary of HHS is the appropriate person to assume leadership of this effort, starting with the programs administered by HHS such as ACOs and Value Based Purchasing.”

Unlike many other measurement efforts, the Committee’s work on developing core measures did not start with the procedures, health care tasks, or conditions that are most commonly measured. Rather, the Committee’s approach identified ways in which a core measure set might help channel and transform the effectiveness of the many otherwise siloed efforts aimed at engaging the various potentially controllable determinants of health:

A measure set that offers a reliable reflection of the status of health and health care at the national, state, local, and institutional levels will draw sustained attention to what is truly important, focus on results rather than processes, reduce the number of measurements required for reporting purposes, increase flexibility and capacity for innovation at the local and institutional levels, and enhance the effectiveness and efficiency of system performance. In short, a core measure set is a tool that can be used to accelerate progress toward better health at lower cost.

They define a core measure set as, "A parsimonious set of measures that provide a quantitative indication of current status on the most important elements in a given field, and that can be used as a standardized and accurate tool for informing, comparing, focusing, monitoring, and reporting change." A core measure set, therefore, is not intended to replace the full range of measures in use today but is intended to help improve the focus of measures to reduce reporting burden while improving impacts.

The Committee’s starting point in identifying the foci for core measures was assessment of the key domains of influence—that is, those with the greatest potential to have a positive effect on the health and well-being of the population and each individual within it, now and in the years to come. The four domains identified in the Committee’s charge follow. The identification of core measures involved an assessment of the most important elements for each of the four domains:

- Healthy people (length of life, quality of life, healthy behaviors, and healthy social circumstances);
- Care quality (prevention, access to care, safe care, appropriate treatment, and person-centered care);
- Care costs (affordability and sustainability);
- Engaged people (people's individual and collective engagement in health and health care - individual engagement and community engagement).

They used criteria for identification of the core measure set as a whole and criteria for identification of the individual measures (Vital Signs, pp 107-112). For the measure set as a whole, measures should have the following characteristics: systemic reach, outcomes oriented, person meaningful, parsimonious, representative, and utility at multiple levels. For the measures themselves, each measure should have: importance to health, strength of linkage to progress, understandability of the measure, technical integrity, potential for broader system impact, and utility at multiple levels.

Using these principles, the committee identified a core measure set with just 15 measures.

TABLE S-1 Core Measure Set
















Domain	Key Element	Core Measure Focus	Best Current Measure	Current National Performance ^a
Healthy people	Length of life	 Life expectancy	Life expectancy at birth	79-year life expectancy at birth
	Quality of life	 Well-being	Self-reported health	66% report being healthy
	Healthy behaviors	 Overweight and obesity	Body mass index (BMI)	69% of adults with BMI 25 or greater
		 Addictive behavior	Addiction death rate	200 addiction deaths per 100,000 people age 15+
		 Unintended pregnancy	Teen pregnancy rate	27 births per 1,000 females aged 15 to 19
	Healthy social circumstances	 Healthy communities	High school graduation rate	80% graduate in 4 years
Care quality	Prevention	 Preventive services	Childhood immunization rate	68% of children vaccinated by age 3
	Access to care	 Care access	Unmet care need	5% report unmet medical needs
	Safe care	 Patient safety	Hospital-acquired infection (HAI) rate	1,700 HAIs per 100,000 hospital admissions
	Appropriate treatment	 Evidence-based care	Preventable hospitalization rate	10,000 avoidable per 100,000 hospital admissions
	Person-centered care	 Care match with patient goals	Patient-clinician communication satisfaction	92% satisfied with provider communication

TABLE S-1 Continued

Domain	Key Element	Core Measure Focus	Best Current Measure	Current National Performance ^a
Care cost	Affordability	 Personal spending burden	High spending relative to income	46% spent >10% income on care, or uninsured in 2012
	Sustainability	 Population spending burden	Per capita expenditures on health care	\$9,000 health care expenditure per capita
Engaged people	Individual engagement	 Individual engagement	Health literacy rate	12% proficient health literacy
	Community engagement	 Community engagement	Social support	21% inadequate social support

Source: “Vital Signs”: <https://www.nap.edu/catalog/19402/vital-signs-core-metrics-for-health-and-health-care-progress>. Click on “Download free .pdf”

The Committee also identified 39 supplemental measures:

The Committee recognizes that, while ripple or multiplier effects are anticipated as a result of their use, the 15 core measure foci identified will not be sufficient to meet all of the interests of a given organization. To begin to accommodate this challenge, the Committee also identified 39 “related priority measures” for consideration, presented in Table S-2. These measures, together with the core measures, give a more detailed view of the state of the health system are sufficiently granular and specific to be actionable by stakeholders as needed for their particular circumstances, and serve as example components of composite measures to be developed. (See Table S-2 in Vital Signs of the 39 measures).

We like this proposal because it was created by a broad-based committee of experts, has strong basis in research, provides clear explanation of the challenges the proposal aims to correct, clearly articulates the methodology used to develop the proposal, and goes a step further than most in proposing the actual measure set that would replace much of what is in use today. The proposed measure set is simple, highly meaningful for individuals and populations, and provides the basis for more detailed measure sets for specific diseases or conditions. But whether the industry coalesces around “Vital Signs” or something else, is not the point. We are certain that scientists, clinicians, politicians, payors, and consumer advocates could find holes to poke in the proposal, but before they do that, we hope they will ask themselves if they prefer the current system to this, and whether there are better alternatives out there that are as well developed. To get to a better and simpler measurement system, everybody will have to compromise, give up a degree of control, and focus on the greater good. It’s the right thing to

do for American health care consumers, who have waited too long for the information they need, “to make fully informed decisions about their health care,” as the President’s executive order demands.

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