Guide for the Selection of Performance Measures for Medical Subspecialty Care

Since 2006, the AQA made significant progress in selecting and promoting a “starter set” of physician- and other clinician level clinical performance measures for use in public and private markets. This guide seeks to provide medical and surgical sub-specialty groups with a framework and support as they develop and promote measures.

Medical sub-specialty organizations are actively engaged in developing measures related to their area of health care delivery. Ideally, measures should be developed from evidence based clinical practice guidelines using a multi-stakeholder approach (such as the AMA Physician Consortium for Performance Improvement). Once complete, measures, along with specifications and evidence documentation, are submitted to the National Quality Forum for a consensus-based endorsement and to gain national standing. The AQA then works with physician and other clinician organizations, CMS, employers, and health insurance plans to implement these measures in the marketplace. The ultimate goal is to achieve a common set of quality measures to be used as widely as possible so that data can be aggregated and shared for performance improvement, pay for performance and public reporting.

The Use of Outcomes Measures to Assess Physician and Other Clinician Performance

Physician and other clinician performance is best assessed using a combination of process, structural, and outcome measures. While AQA realizes the shortage of appropriately risk adjusted outcome measures, it is important for specialty societies to consider the role and use of outcomes measures in the assessment of physician and other clinician performance.

We propose the following guidelines for the consideration of medical and surgical sub-specialty groups as they seek to develop and promote measures through this process:

1. Measures should be consistent with the *AQA Parameters for Selecting Measures for Physician and Other Clinician Performance*. Most importantly, they should be derived from evidence based (EB) clinical practice guidelines. If EB guidelines are not available, then the specialty group should promote the development of guidelines as a first step.

2. Measures should represent a reasonable cross section of conditions or procedures within the usual scope of practice of the specialist.

3. A measure must address one of the IOM’s six dimensions of quality care (safe, effective, patient-centered, timely, efficient and equitable). Ultimately, measurement sets should seek to collectively address all six areas.

4. Measures should focus on conditions or procedures where there exists the greatest opportunity for improvement or where wide variation in current practice is apparent.

5. Measures should consider the importance of good comprehensive care for a condition even if only one or two of the measures will ultimately be used for public reporting. The complete set will be useful for physician and other clinician practice quality improvement efforts.

6. Measures should be important and relevant to all stakeholders, including physicians and other clinicians, consumers, health plans, and purchasers.

7. Collection of measures should be feasible and the path to their collection identified.

8. Measures may address structure, process, or outcomes related to the care of a given condition. The most valuable measures for public reporting tend to be related to outcomes, whereas the structure and process measures are likely to be more helpful in physician and other clinician practice improvement efforts.

9. Measures of appropriateness of care should be utilized, whenever possible.

10. Measures should be based on data that are: as least burdensome as possible, not subject to variations in interpretation, problems of data completeness, or prone to reporting bias.

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[1] *Updated to revised language from "physician" to "physician and other clinicians" per AQA action March 2009.*