A New Vision for Quality and Equity

Helen Burstin, MD, MPH

Despite discontent with the current U.S. health care system, consensus on how it should evolve has been lacking. In this *Annals* supplement, the American College of Physicians (ACP) provides a bold and comprehensive vision for a health care system that puts patients at the center and provides access to affordable, high-quality care for all (1). The ACP believes that a new payment and delivery system should have quality as its cornerstone (2). To achieve this vision, we must carefully consider how to measure, incentivize, and improve health care quality and equity.

Outcome measures that are meaningful to both physicians and patients must underlie a new paradigm for quality and equity. Current quality measurement efforts are frequently tethered to claims-based process measures that are often distant from outcomes. It is time to acknowledge the high burden and opportunity costs associated with quality measurement that does not result in improved outcomes. We must ask ourselves whether "the juice is worth the squeeze." As ACP wisely notes, we need to avoid "flawed and misaligned metrics" that will not support improved delivery and payment models (2).

To reduce the burden on physicians and other clinicians, we must implement timely, valid measures that result from seamless integration of clinical workflow with electronic health records, clinical registries, and cloud-based platforms. The ACP and other specialty societies should serve as the content experts in their respective fields and ensure that the electronic data we need to measure and improve care are valid, reliable, and current.

A newly envisioned health care system must also consider equity. Even with equitable access to care, it is imperative that we routinely assess and address differences in care for subpopulations. As data systems improve, we must weave attention to disparities into the fabric of quality measurement, improvement, and incentives (3). The ACP's vision emphasizes the need to routinely assess and use data on a broad range of social determinants of health to improve care for all (4).

Further, we must recognize that performance measurement can have unintended consequences for both patients and clinicians. It is essential that we consider whether a measure is evidence-based, valid, and feasible and how it will be used. As ACP notes, "quality is complicated by the measurement approach" (2). Complicating factors include who is measuring, who is paying, and the measure's intended use. We cannot examine measures without considering whether they are fit for their intended use. According to Goodhart's law, when a measure becomes a target, it ceases to be a good measure (5). Measures are misused if clinicians and health systems seek to optimize performance regardless of unintended consequences. Thus, the ACP recognizes the critical need to assess the potential unintended consequences of quality measures and programs before they are implemented. This assessment should include the adequacy of risk adjustment where appropriate for selected outcome and cost measures. Inadequate risk adjustment or stratification for clinical and social risk factors can penalize providers who care for the most vulnerable patients. Frakt recently noted the lack of rigorous evaluation of health policy (6). Our newly imagined health care system should embed field assessment and evaluation into new incentive and payment models to ensure that they are working as intended for all patients.

If the United States fails to pivot toward more meaningful quality measurement, we risk overemphasis on cost and available claims-based quality measures by payers for provider selection and payment. As ACP notes, cost measurement is complex, but we need consistent measures and fair attribution methods. We should also consider how best to link cost and quality information (7). For example, we should not consider health care costs until a certain threshold for quality has been achieved. Regardless of the new model that emerges, we must take an evidence-based approach to understanding the effect of any new models on both quality and costs.

The ACP offers a vision for a system that reflects the care of patients in multidisciplinary teams (2). Different disciplines and specialties bring unique skills and knowledge to the team, and meaningful quality measures should reflect team competencies, including quality and costs across patient-focused episodes, shared decision making, and patient reports of the care experience and outcomes. Quality is a team sport, and the patient should be a highly valued member of the team. There is limited evidence that transparency alone improves decision making by patients and caregivers, so a new health system should ensure not only that information is provided but also that it is understandable and actionable.

The ACP's vision emphasizes the central role of primary care and internal medicine subspecialists, but it is critical that high-value care reflect coordination and collaboration across a broad range of care. This new delivery model should encourage and incentivize collaboration across specialties, including virtual care and consultations to improve patient outcomes. A study by Johnston and colleagues found that patients in rural communities had lower mortality and fewer preventable hospitalizations when they had access to appropriate specialty care (8). A new and improved health care

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system should incentivize care across the house of medicine to do what is best for patients.

The ACP deserves applause for putting forward a bold new vision for a value-driven health care system that works to achieve what is best for patients. To make this a reality, we should drive toward measurement and incentives to ensure the highest levels of quality and equity for all.

Helen Burstin, MD, MPH
Council of Medical Specialty Societies
Washington, DC

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Corresponding Author: Helen Burstin, MD, MPH, Council of Medical Specialty Societies, 20 F Street, NW, Suite 1000, Washington, DC 20001; e-mail, hburstin@cmss.org.

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