AAFP Backgrounder: Quality Measurement Burden

At the core of family medicine is the deep interaction between physician and patient — contact that requires time and focus. Documentation burden disrupts that experience by distracting the physician. Left unchecked, documentation burden erodes family physicians' relationships with their patient panels and contributes to burnout.

Medicare, Medicaid, and private payers require quality-measure and performance-measure reporting by clinicians participating in their health plans. In our "Vision and Principles of a Quality Measurement Strategy for Primary Care" position paper, the AAFP makes a clear distinction between quality and performance measures based on the purpose for which a measure is used. Performance measures are not the same as, but may overlap with, quality measures, which are meant to accelerate internal clinical improvement.

- **Quality measure:** a tool to assess the quality of care provided by a health care organization. It can be used to identify areas where care can be improved and to track progress over time. Quality measures can be used at the individual, group, specialty, system, patient, or population level.
- **Performance measure:** a tool used to compare performance among different health care organizations. It can be used to assess the quality of care provided by a health care organization relative to other organizations. Performance measures can be used for value-based payment, resource allocation, and patient decision-making.

Here is a summary of the key differences between quality measures and performance measures.

- **Purpose:** Quality measures are used to assess the quality of care provided by a health care organization, whereas performance measures are used to compare performance among different health care organizations.
- **Level of detail:** Quality measures are typically more detailed than performance measures. Quality measures may be designed for application at various levels, such as individual, group, specialty, system, patient, or population. Performance measures are typically used at a more aggregate level, such as the level of the organization or the population.
- **Use:** Quality measures are typically used for internal quality improvement; performance measures are used for value-based payment, resource allocation, and patient decision-making.

Relieving the burdens of quality and performance measurement will require both advocacy and innovation. Reform is needed to achieve alignment of measures across programs and payers, to drive improvements in data-collection innovations, and to reduce the capture and reporting burden on family physicians and other clinicians. Innovations exist to capture and report measures electronically and more efficiently, but they are so far insufficient to significantly reduce burden.

Quality Measurement: Capturing and Reporting

Too Many Performance Measures and Requirements

"Value-based payment models require measures of quality, patient experience, and efficiency, which is contributing to a proliferation of performance measures and reporting requirements, with a commensurate increase in the burden on clinicians who are recording and collecting the data." (National Quality Forum, 2019).

Too Many Payers Require Submit QMs

The AAFP says family medicine practices contract with an average of 10 payers each. "Keeping track of

and successfully reporting different measures for each of these payers creates confusion and additional reporting burden and can undermine meaningful practice improvements."

QMs Are Difficult to Capture, Enter, Report
Most QM measures are not direct byproducts of routine patient care. They instead require specific additional actions by the physician or practice team, above and beyond standard documentation, to capture and enter correctly. In many cases, QM must be entered into more than one place, such as the EHR and other tools such as registries or population health systems.

Many QMs Are Ineffective and Meaningless
Although many performance measures provide useful information, many do *not* (because they are duplicative, not clinically relevant, have poor methodological design, etc.) and are thus do not improve the performance of the health system. (Berwick, 2016; Dunlap, et al., 2016; IOM, 2015; Panze,r et al., 2013; Safran and Higgins, 2019; MacLean, et al., 2018)

QMs Distract and De-professionalize

- QMs can detract from meaningful clinical activity and deprofessionalize the clinician. *(Khullar, et al., 2018; Pronovost, et al., 2018)*
- QMs add burden even with the use of current health information technology. *(Casalino et al., 2016; Sinsky et al., 2016) (Cohen et al., 2018).*

EHRs Contribute to Quality Measure Burden Due To

- Inability to produce clinical quality reports that align with quality improvement needs
- Inability to produce clinical quality reports at practice, clinical team, clinician, and patient levels
- Data from EHR reports are not credible or trustworthy.
- Delays in modifying specifications when guidelines or measures changes
- Challenges in developing regional data infrastructure (data warehouses, hubs, exchanges)
- Cooperatives developing regional data infrastructure encounter developmental delays.
- Vendors charge excessive fees for connecting practices to a data warehouse, hub, or health information exchange.
- Inability to benchmark performance because data extracted from different EHRs are not comparable.

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Impact

- U.S. physician practices spend ~$15.4 billion per year on QM reporting.
- Physicians and staff spent a total of 15.1 hours per physician per week dealing with quality measures.
- Physicians spend 2.6 hours per week, and staff spend 12.5 hours.
- Physicians spend 12.5 hours on "entering information into the medical record ONLY for the purpose of reporting for quality measures from external entities."
- Average cost to a practice of $40,069 per physician per year.

(U.S. Physician Practices Spend More Than $15.4 Billion Annually to Report Quality Measures
By Lawrence P. Casalino, David Gans, Rachel Weber, Meagan Cea, Amber Tuchovsky, Tara F. Bishop, Yesenia Miranda, Brittany A. Frankel, Kristina B. Ziehler, Meghan M. Wong and Todd B. Evensong *Health Affairs*, March 2016)