

The Promise and Politics of Quality Measurement



National Conference on Correctional Health Care
Chicago, October 20, 2008

Terry Hill, MD

CEO for Medical Services

California Prison Receivership

www.cphcs.ca.gov

We have to get back on those scales again?

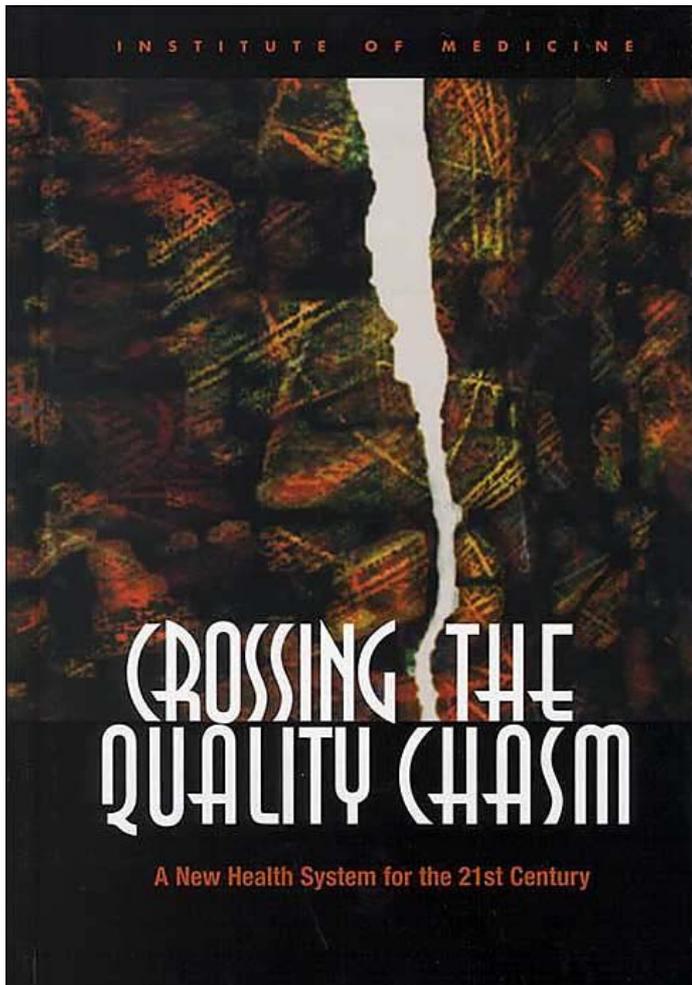


You can't fatten a cow by weighing it, but you can't manage what you don't measure.

Today's discussion

- Flying over the measurement landscape at 30,000 feet, 500 mph
 - Institute of Medicine (IOM)
 - National Quality Forum (NQF)
 - Joint Commission
 - Agency for Healthcare Research and Quality (AHRQ)
 - National Committee for Quality Assurance (NCQA)
 - Centers for Medicaid and Medicare Services (CMS)
- Prisons have had only one toe in the water
 - Courts have been slow to move beyond expert reports and unvalidated audit strategies
- Are we ready for public reporting of quality?

The Institute of Medicine, 2001

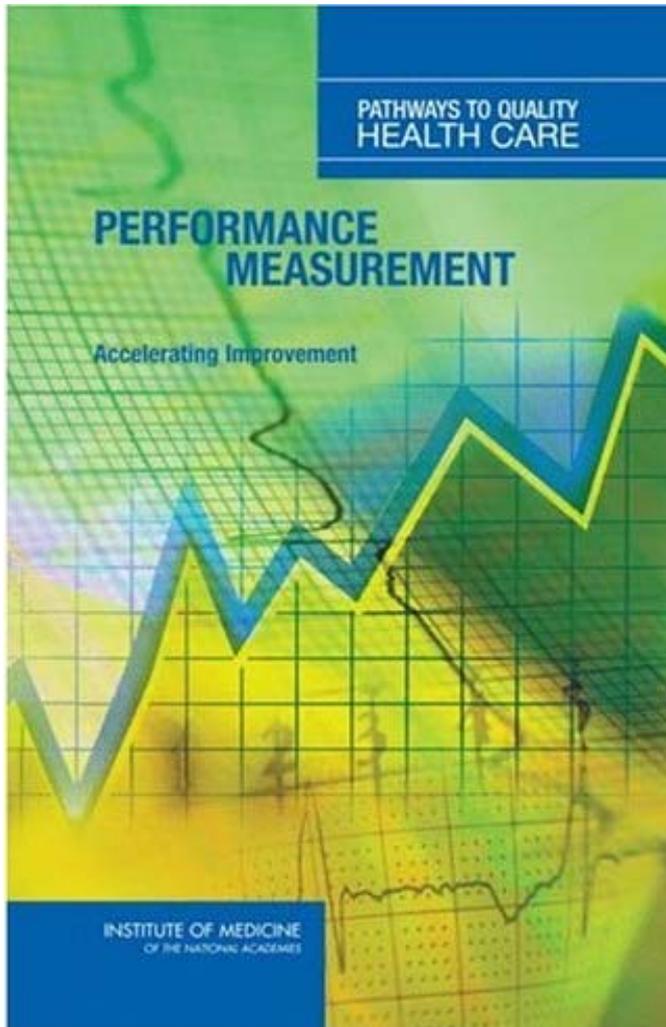


The American health care delivery system is in need of fundamental change ... not because of a failure of goodwill, knowledge, effort, or resources..., but because of fundamental shortcomings in the ways care is organized

Safe, effective, patient-centered, timely, efficient, equitable care via:

- ❑ Redesign of care processes based on best practices
- ❑ Information technologies for clinical information and decision support
- ❑ Knowledge and skills management
- ❑ Development of effective teams
- ❑ Coordination of care across patient conditions, services, and settings over time
- ❑ Incorporation of performance and outcome measurements for improvement and accountability

The Institute of Medicine, 2006



- “Some progress has been made toward reducing gaps in quality and safety”
 - But “racial and ethnic disparities are pervasive”
- Re the measurement system:
 - “Substantial scientifically grounded gains... have already been made”
- Measurement is foundation for:
 - Accountability
 - Quality improvement
 - Population health

Core Program Components



Clinical quality measures require:

- ❑ Descriptive statement or indicator
- ❑ List of data elements that are necessary to construct and/or report the measure
- ❑ Detailed specifications that direct how the data elements are to be collected (including the source of data)
- ❑ The population on whom the measure is constructed
- ❑ Timing of data collection and reporting
- ❑ Analytic models used to construct the measure
- ❑ Format in which the results will be presented.

Measures may also include thresholds, standards, or other benchmarks of performance

National Quality Forum criteria for evaluating measures

- Importance to Measure and Report
 - Extent to which the specific measure focus is important to making significant gains in health care quality and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance.
- Scientific Acceptability of Measure Properties
 - Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented.
- Usability
 - Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making.
- Feasibility
 - Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement.

“A measure is good enough when acting upon it results in a net improvement in quality.”

The direct benefits of implementing a particular measure cannot be outweighed by the indirect harms, e.g.,

- resource and opportunity costs,
- antagonizing providers,
- incentivizing perverse behaviors, or
- negatively affecting other domains of quality.

The National Quality Measures Clearinghouse currently contains 1528 individual measures.

National Quality Measures Clearinghouse

www.qualitymeasures.ahrq.gov



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Welcome!

You have accessed the National Quality Measures Clearinghouse™ (NQMC).

NQMC, sponsored by the [Agency for Healthcare Research and Quality \(AHRQ\)](#), U.S. Department of Health and Human Services, is a public repository for evidence-based quality measures and measure sets. To learn more about the key components of this site and other user-friendly features, visit [About NQMC](#).

NQMC offers an [Expert Commentary](#) feature on issues of interest and importance to the quality measure field.

NQMC News

What's New this Week

- New/updated AAAHC and ICSI measures. Go to ["What's New this Week"](#) to view the measure summaries.

Coming Soon

- New [Australian Council on Healthcare Standards \(ACHS\)](#) Anaesthesia Indicators. Look for these measures in NQMC in the near future!

Conference News

- [AHRQ's 2008 Annual Conference](#) is **September 7-10** in Bethesda, MD. Learn about AHRQ's latest research aimed at improving quality, safety, efficiency, and effectiveness of care from leading experts involved in AHRQ-sponsored research and implementation projects. [Register now](#).
- **Sunday, September 7, 2008:** NGC/NQMC Clearinghouse Day (by invitation only)
- An AHRQ-sponsored Web conference on "Using Clinical Decision Support to Make Informed Patient Care Decisions" will be held on **September 19, 2008**, from 3:30 PM - 5:00 PM EDT. [Registration](#) is free.
- **A Free Webcast Event:** [The Evolution of the CAHPS Clinician & Group Survey: An Update from AHRQ's CAHPS Consortium](#) September 25, 2008, from 1:00 PM - 2:30 PM EDT.
- The 5th annual **Guidelines International Network (G-I-N) conference**, will be held **October 1-3, 2008**. [Register online](#) now. The theme of the conference is "Implementation in Practice."

Visit NQMC's Sister Sites

- [Health Care Innovations Exchange Web site](#) -- Find Innovations and [QualityTools](#) classified by disease or clinical category, patient population, stage of care, setting of care, and more.
- [National Guideline Clearinghouse \(NGC\) Web site](#)

Closing the Disparities Gap in Healthcare Quality With Performance Measurement and Public Reporting

EXECUTIVE SUMMARY

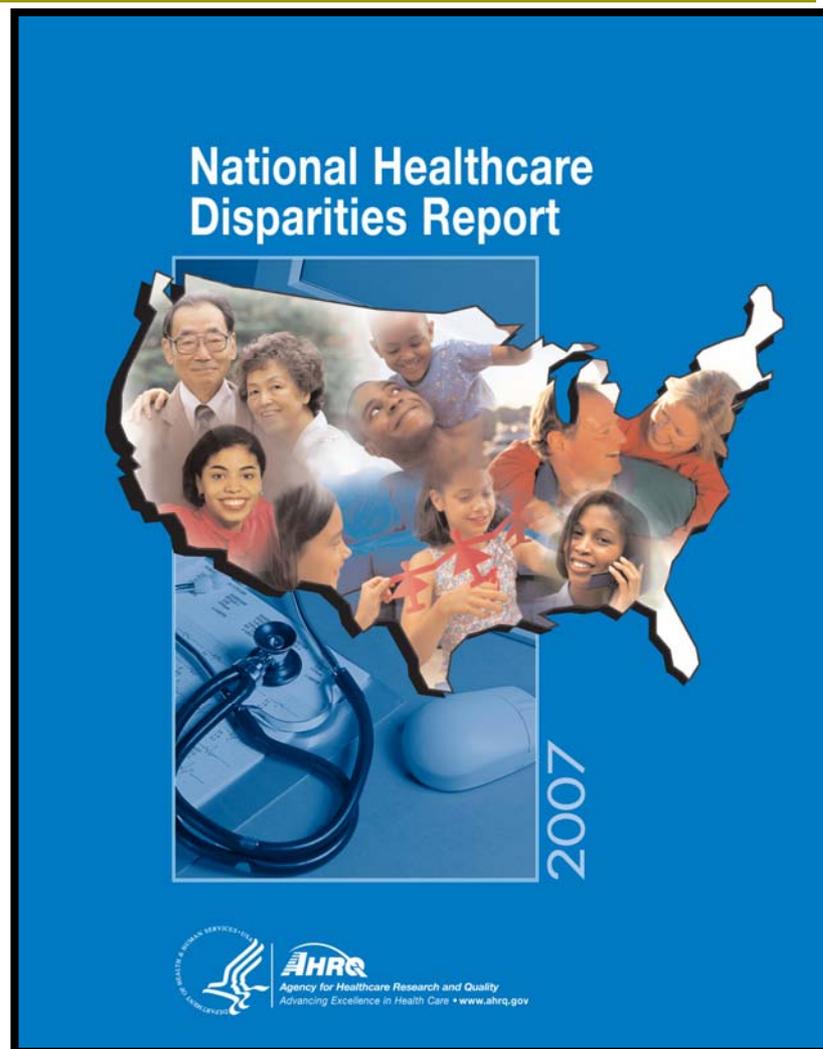
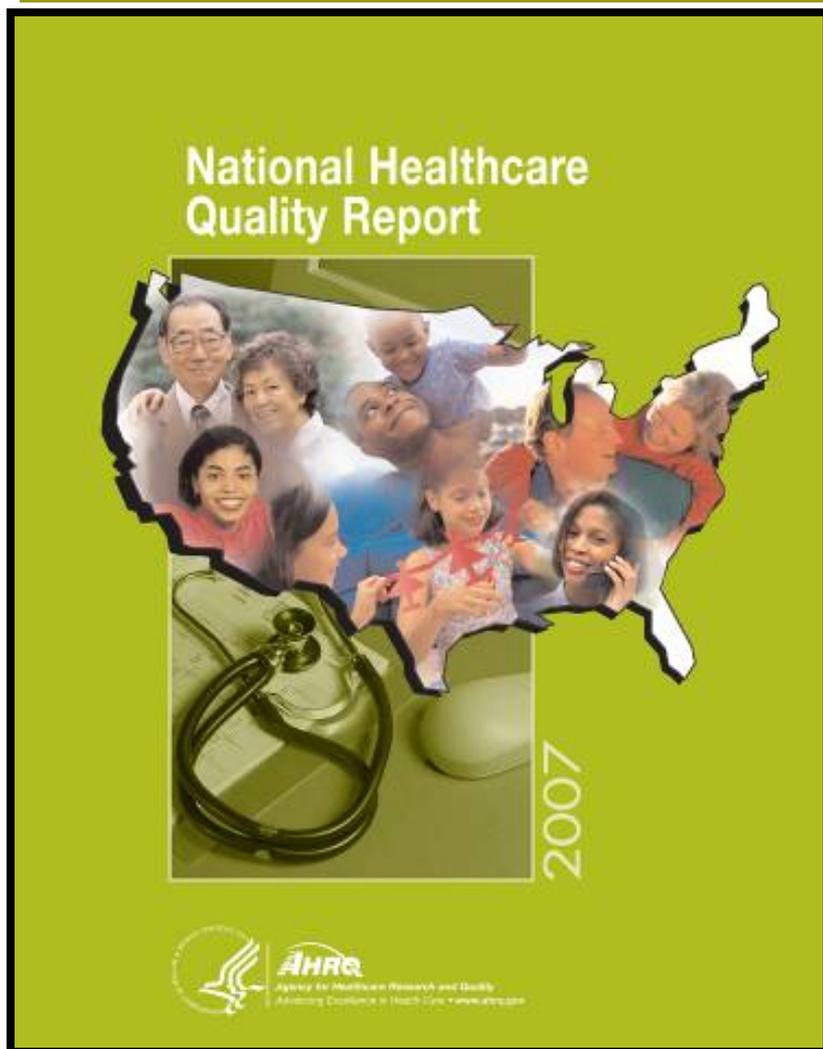
Compared to whites, racial and ethnic minorities in America today face disproportionately higher rates of disease, disability, and mortality, resulting in part from disparities in the quality of healthcare they receive from U.S. healthcare delivery systems. The same is true of low-income populations compared to those who are more affluent. But there are systematic public and private efforts under way to address disparities and deliver measurable improvements in healthcare quality to poorly served groups. The ultimate goal is for all Americans—regardless of their ethnicity, gender, socioeconomic position, or insurance status—to have access to healthcare that meets the Institute of Medicine (IOM) criteria for quality: It must be safe, timely, effective, efficient, patient centered, and equitable.

Understanding the Healthcare Quality Disparities Gap

IOM has contributed two important reports that have advanced the understanding of disparities. In its 2001 study *Crossing the Quality Chasm: A New Health System for the 21st Century*, IOM identified equity as one of six critical domains of high-quality care.¹ Its 2003 report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* provided a policy framework to address the issue of disparities.²

Also in 2003, the Agency for Healthcare Research and Quality (AHRQ) published the *National Healthcare Disparities Report*, the first comprehensive, national report on differences in the accessibility

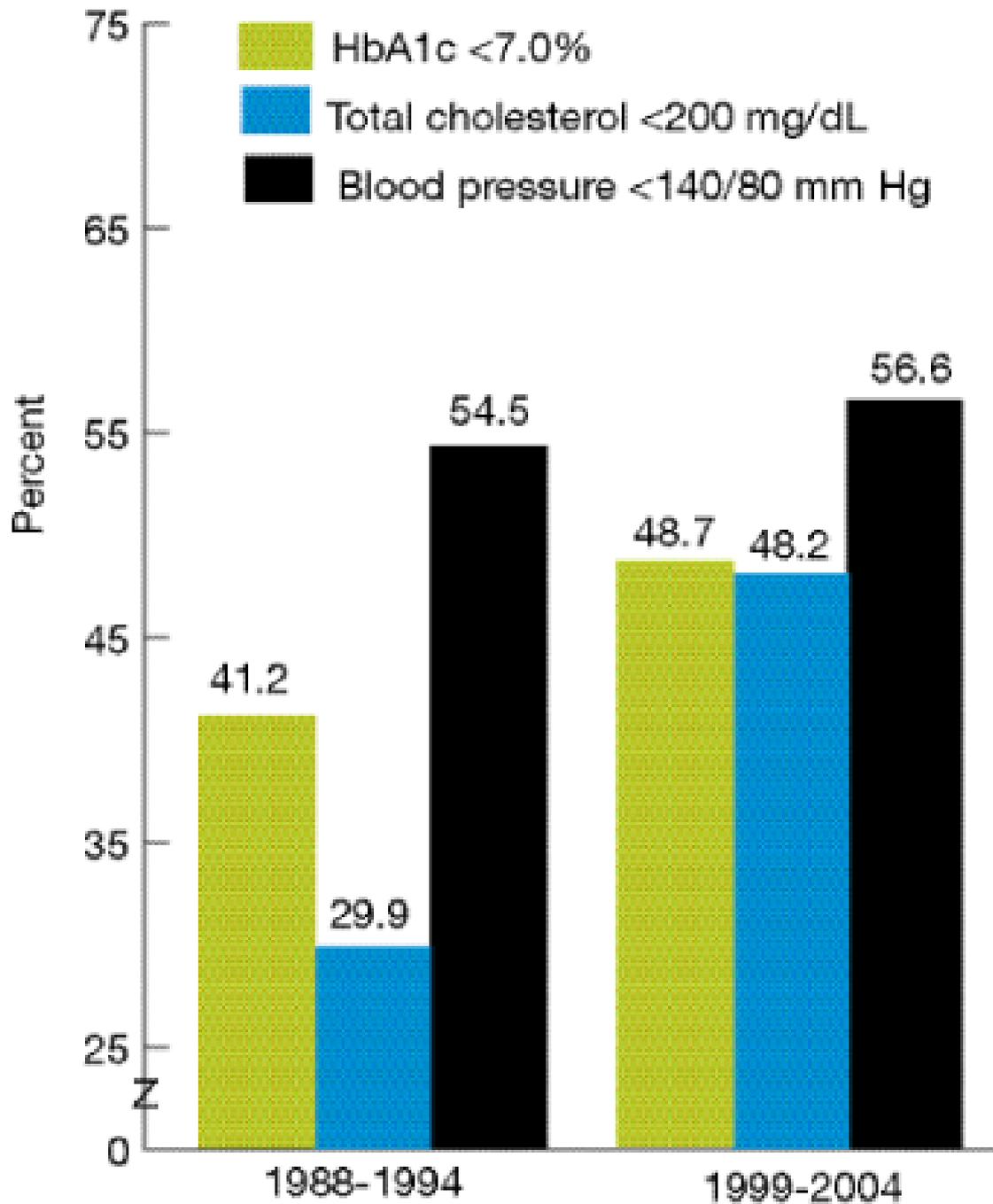
2007 Natl Healthcare Quality Report, Natl Healthcare Disparities Report



Released March 3, 2008, www.ahrq.gov/qual/qdr07.htm

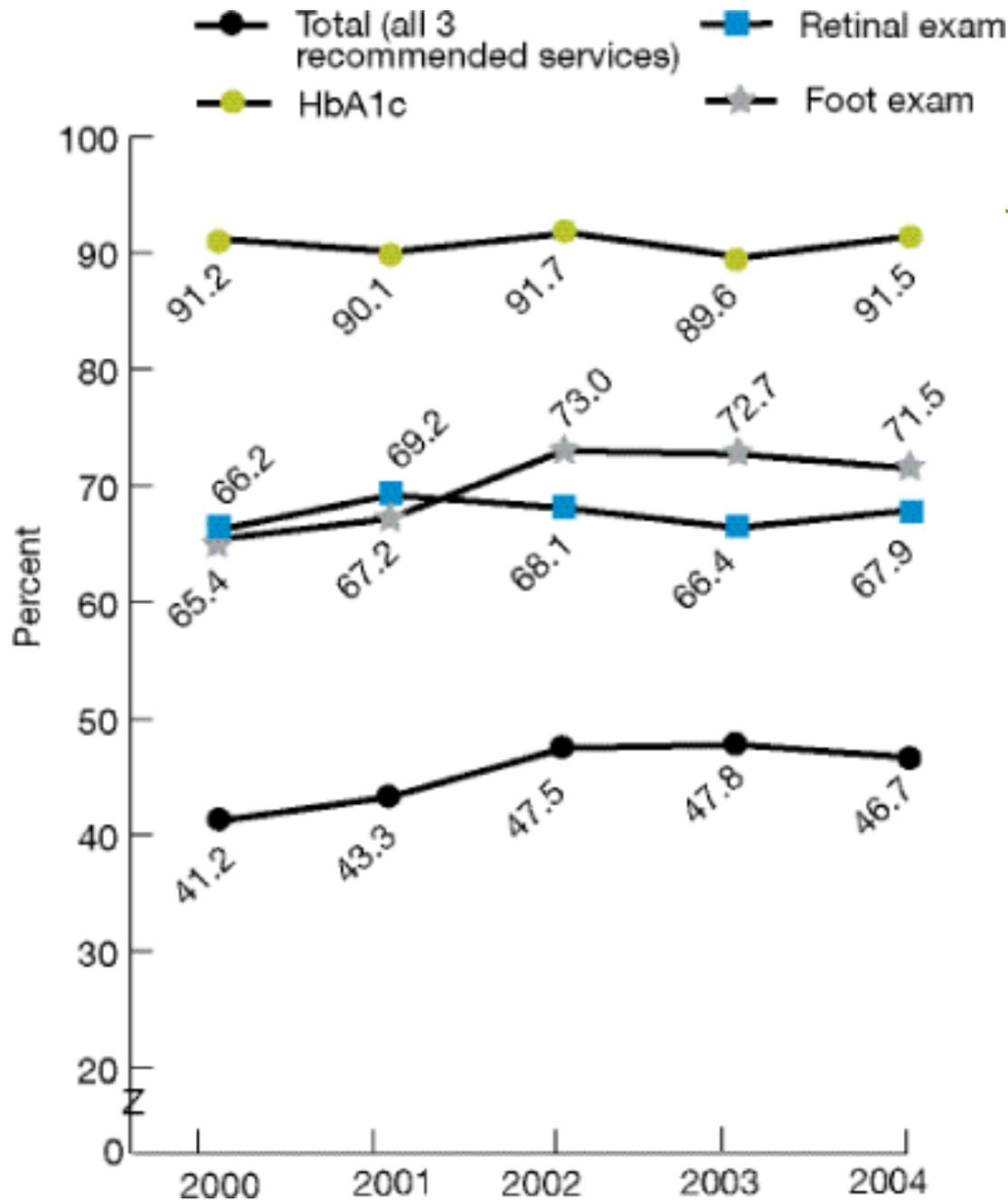
Improvement in core measures

- Most quality measures show some improvement
- Of the 41 core measures reported with data that span 1994-2005:
 - 27 improved
 - 6 declined
 - 6 showed no change



Diabetics \geq 40 with HbA1c, cholesterol, and blood pressure under control

National Center for Health Statistics, National Health and Nutrition Examination Survey, 1988-1994 and 1999-2004



Diabetics \geq 40 who received HbA1c, eye exam, and foot exam in the past year

AHRQ, Medical Expenditure Panel Survey, 2000-2004

Natl Healthcare Quality Report vs Natl Healthcare Disparities Report

| NHQR | NHDR |
|---|--|
| Snapshot of quality of health care in America | Snapshot of disparities in health care in America |
| Quality | Quality + access |
| Safety, effectiveness, timeliness, patient centeredness | Safety, effectiveness, timeliness, patient centeredness + equity |
| Variation across States | Variation across populations |

NHQR/NHDR organization

□ Effectiveness

- Cancer
- Diabetes
- End Stage Renal Disease (ESRD)
- Heart Disease
- HIV and AIDS
- Maternal and Child Health
- Mental Health and Substance Abuse
- Nursing Home, Home Health, Hospice

□ Patient Safety

□ Timeliness

□ Patient Centeredness

□ Access to Health Care

□ Priority Populations

NHQR*

NHDR

*Also includes Efficiency

Disparities in quality and access

- ❑ Disparities in quality are staying same or increasing
- ❑ Disparities in access are staying same or increasing
- ❑ Over 60% of disparities in quality of care have stayed the same or worsened for Blacks, Asians, and poor populations
- ❑ Nearly 60% of disparities have stayed the same or worsened for Hispanics
- ❑ For Blacks, Asians, Hispanics, and poor populations, disparities in about half the core measures of access to care are lessening

HEDIS & Quality Measurement



The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.

[More | How measures are developed](#)

Technical Resources

- [HEDIS 2009](#)
- [HEDIS 2008](#)

Reducing Health Care Disparities

NCQA recognizes innovation in multicultural health care annually. See how you can support this important effort to combat health care disparities.

[Learn More →](#)

NCQA Policy Support

FAQs

New FAQs are posted on the 15th of every month and provide answers to our most commonly asked questions.

[Policy Clarification Support \(PCS\)](#)

Variations reveal opportunities

FIGURE 10. AVOIDABLE DEATHS AND MEDICAL COSTS DUE TO UNEXPLAINED VARIATIONS IN CARE: SELECT MEASURES AND CONDITIONS, U.S. POPULATION, 2006

| MEASURE | AVOIDABLE DEATHS | AVOIDABLE HOSPITAL COSTS |
|---|------------------------|--------------------------------------|
| Beta-Blocker Treatment After a Heart Attack | 500 - 1,200 | \$6.1 million - \$10.8 million |
| Breast Cancer Screening | 200 - 700 | \$89 million |
| Cervical Cancer Screening | 600 - 800 | N/A |
| Cholesterol Management | 4,400 - 9,400 | \$20.1 million - \$60.9 million |
| Colorectal Cancer Screening | 6,000 - 12,600 | \$284 million - \$411 million |
| Controlling High Blood Pressure | 9,200 - 22,800 | \$292 million - \$708 million |
| Diabetes Care - HbA1c Control | 7,100 - 15,900 | \$1.3 billion - \$1.7 billion |
| Osteoporosis Management | N/A | \$9.9 million - \$10.4 million |
| Prenatal Care | 1,000 - 1,600 | N/A |
| Smoking Cessation | 7,000 - 10,700 | \$673 million - \$725 million |
| TOTAL | 35,000 - 75,000 | \$2.7 billion - \$3.7 billion |

Plans that make their performance public routinely perform better

**FIGURE 14. HEDIS EFFECTIVENESS OF CARE MEASURES
PUBLIC VS. NON-PUBLICLY REPORTING PLANS: SELECT COMMERCIAL AVERAGES, 2006**

| MEASURE | PUBLIC | NON-PUBLIC | DIFFERENCE |
|--|--------|------------|------------|
| Adolescent Immunization Status - Combo 2 | 58.9 | 42.9 | 16.0 |
| Beta-Blocker Treatment After a Heart Attack | 97.9 | 93.4 | 4.5 |
| Breast Cancer Screening | 69.1 | 66.9 | 2.2 |
| Cervical Cancer Screening | 81.4 | 77.6 | 3.8 |
| Childhood Immunization Status - Combo 2 | 80.7 | 71.3 | 9.4 |
| Comprehensive Diabetes Care - Poor HbA1c Control* | 29.4 | 31.9 | (2.5) |
| Controlling High Blood Pressure | 59.8 | 57.1 | 2.8 |
| Follow-up After Hospitalization for Mental Illness - 30 Days | 76.5 | 66.2 | 10.3 |
| Prenatal and Postpartum Care - Timeliness of Prenatal Care | 91.8 | 79.6 | 11.9 |

* Lower rates are better for this measure; the negative difference signifies higher performance among publicly reporting plans for this measure.

Hospital Compare - *A quality tool for adults, including people with Medicare*

Quality Measures

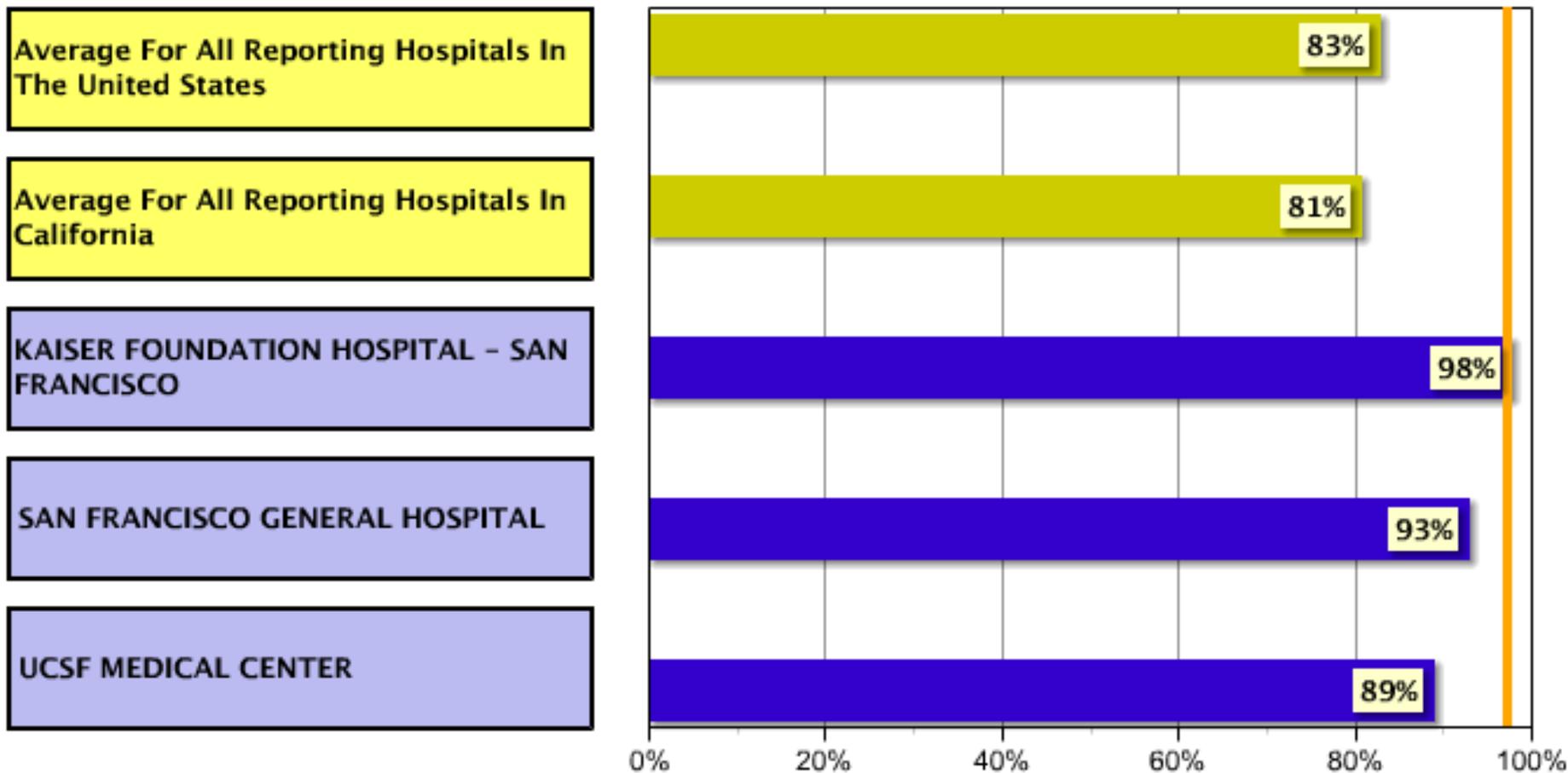
+ Show [What are the Hospital Process of Care Measures?](#)

- Eight measures related to heart attack care
- Four measures related to heart failure care
- Seven measures related to pneumonia care
- Five measures related to surgical infection prevention
- Two measures related to asthma care for children only

+ Show [What are Hospital Outcome of Care Measures?](#)

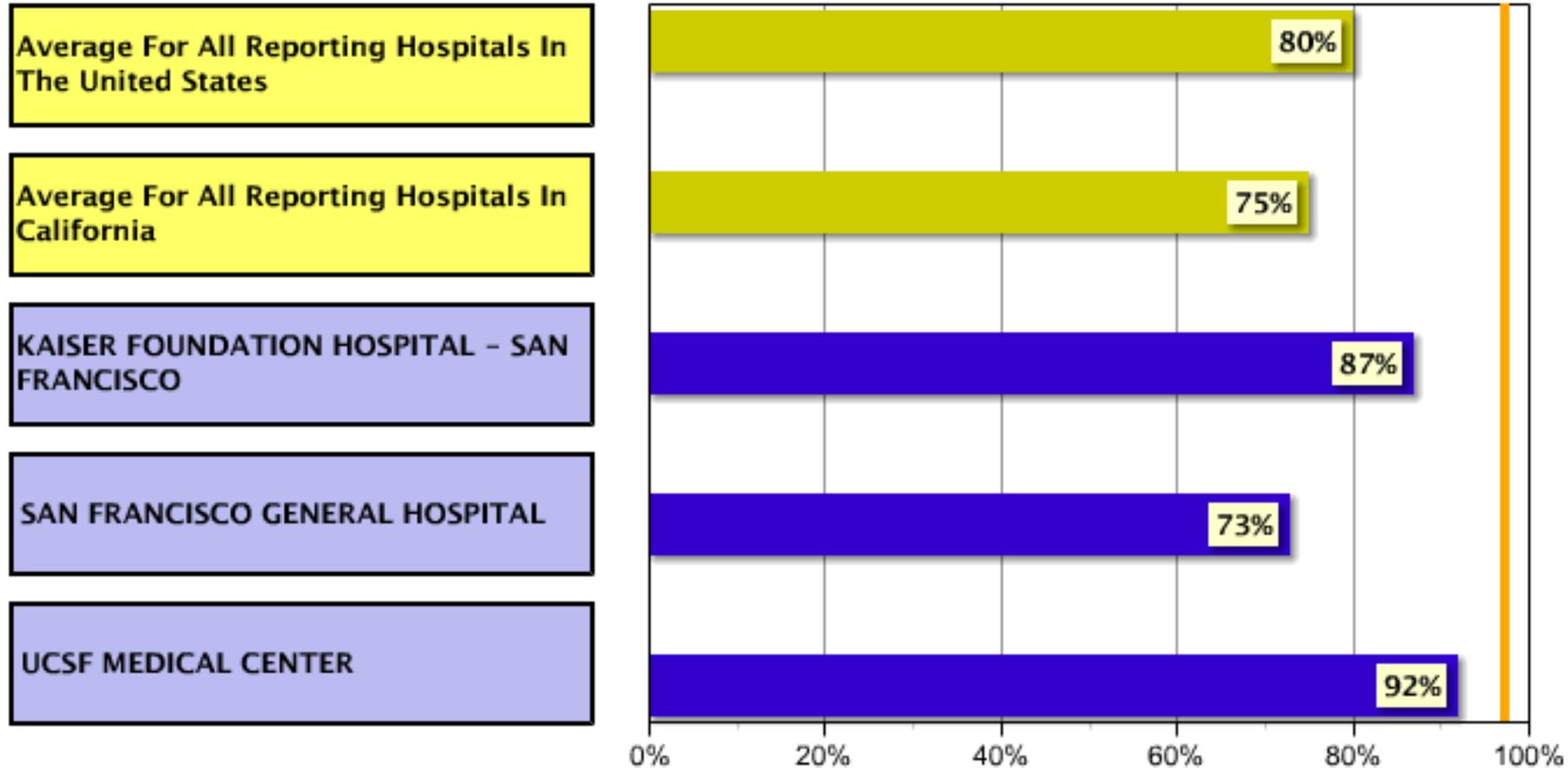
+ Show [What is the Survey of Patients' Hospital Experiences \(HCAHPS\)?](#)

Surgery patients receiving preventative antibiotic one hour before incision



Top Hospitals represents the top 10% of hospitals nationwide. Top hospitals achieved a 97% rate or better.

Preventative antibiotics stopped within 24 hours after surgery



Top Hospitals represents the top 10% of hospitals nationwide. Top hospitals achieved a 97% rate or better.

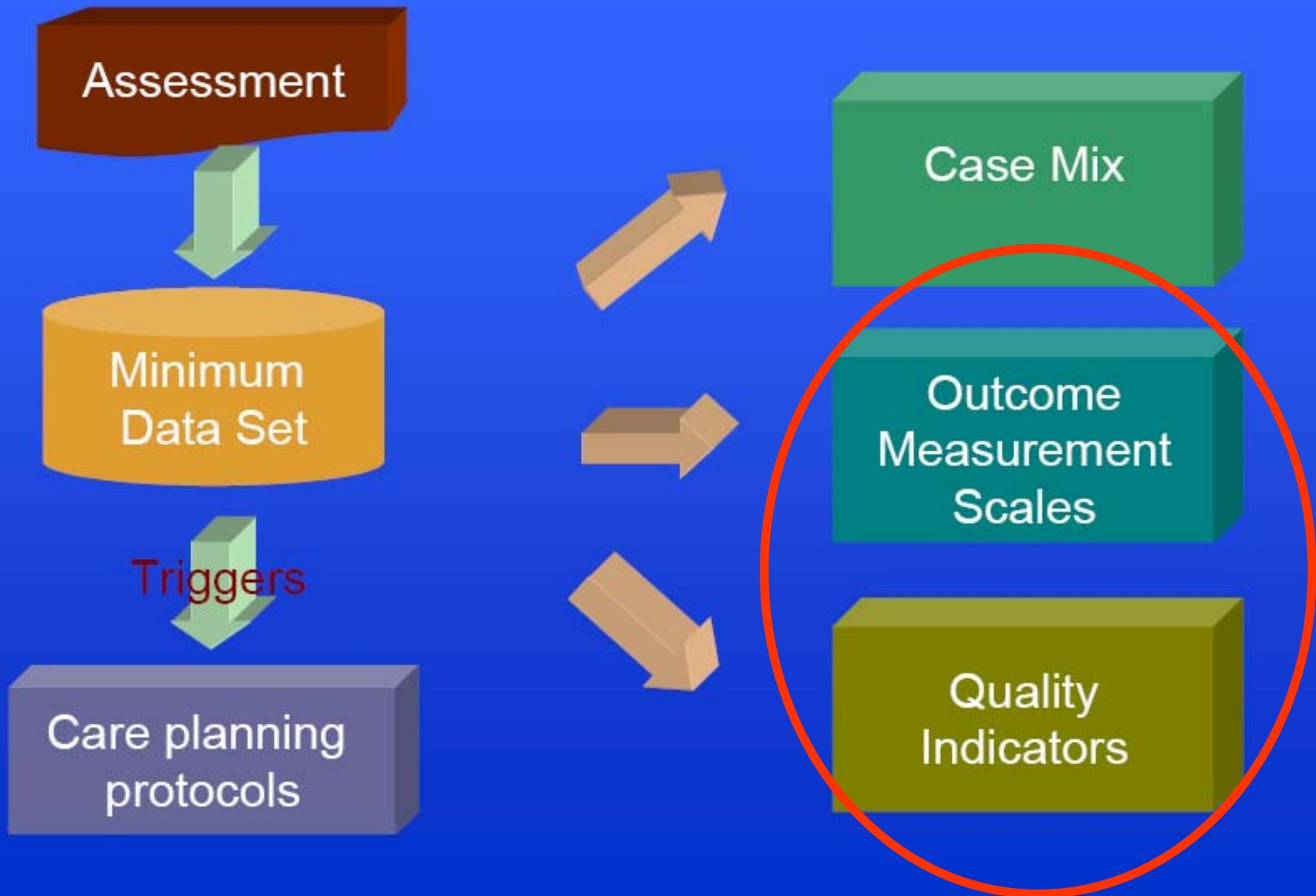
interRAI instruments

interRAI instruments are clinical tools to assess individuals with a view to developing an effective care plan

The information is recorded in standardised format (Minimum Data Set)

The information collected “triggers” more in depth assessment of selected domains

interRAI model



From MDS: Patients given flu shot during flu season

THIS IS THE AVERAGE FOR ALL THE NURSING HOMES IN UNITED STATES

THIS IS THE AVERAGE FOR ALL NURSING HOMES IN THE STATE OF CALIFORNIA

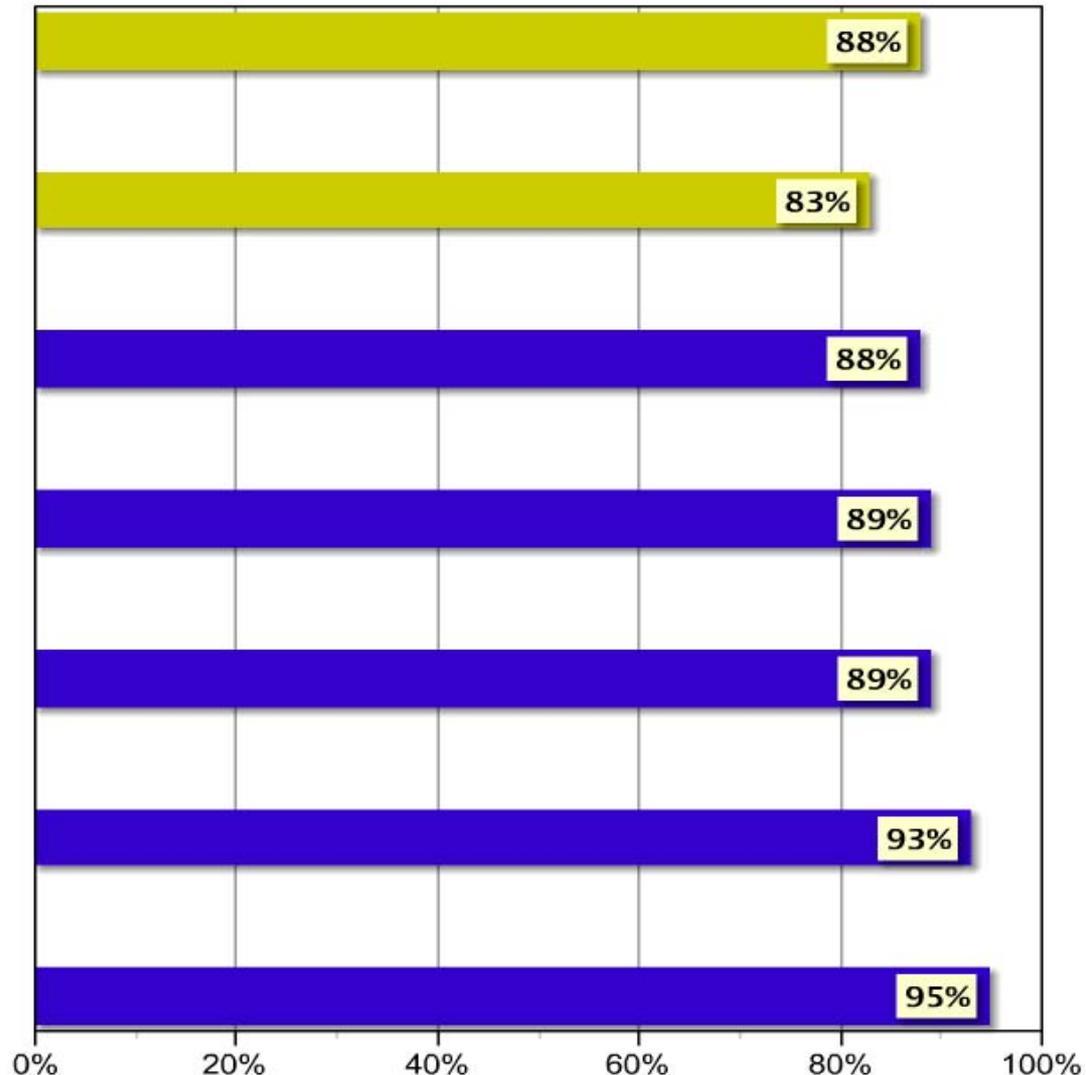
GOLDEN GATE HEALTHCARE CENTER

JEWISH HOME D/P SNF

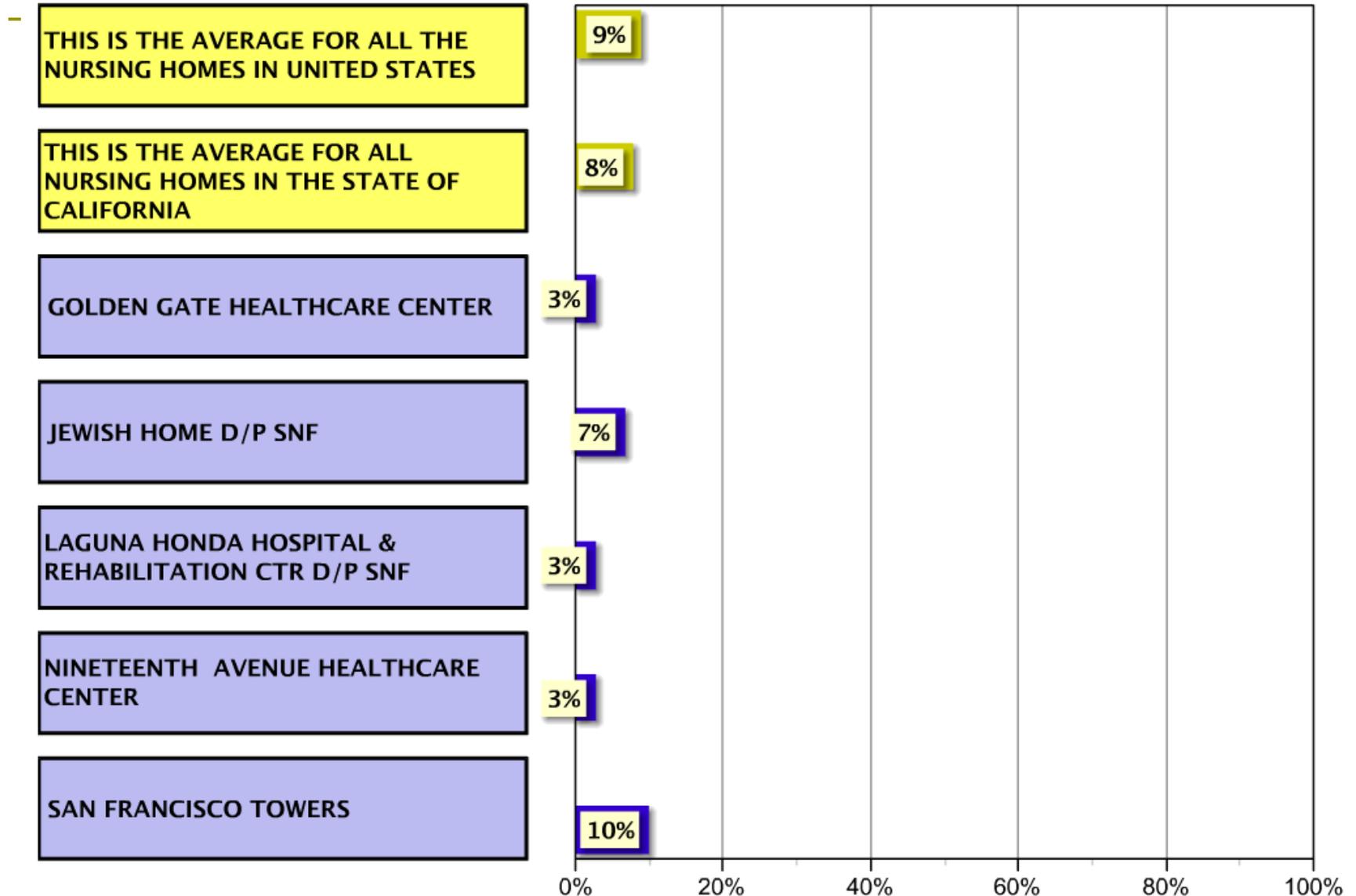
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF

NINETEENTH AVENUE HEALTHCARE CENTER

SAN FRANCISCO TOWERS



From MDS: Patients who lose too much weight



interRAI instruments

INSTRUMENTS

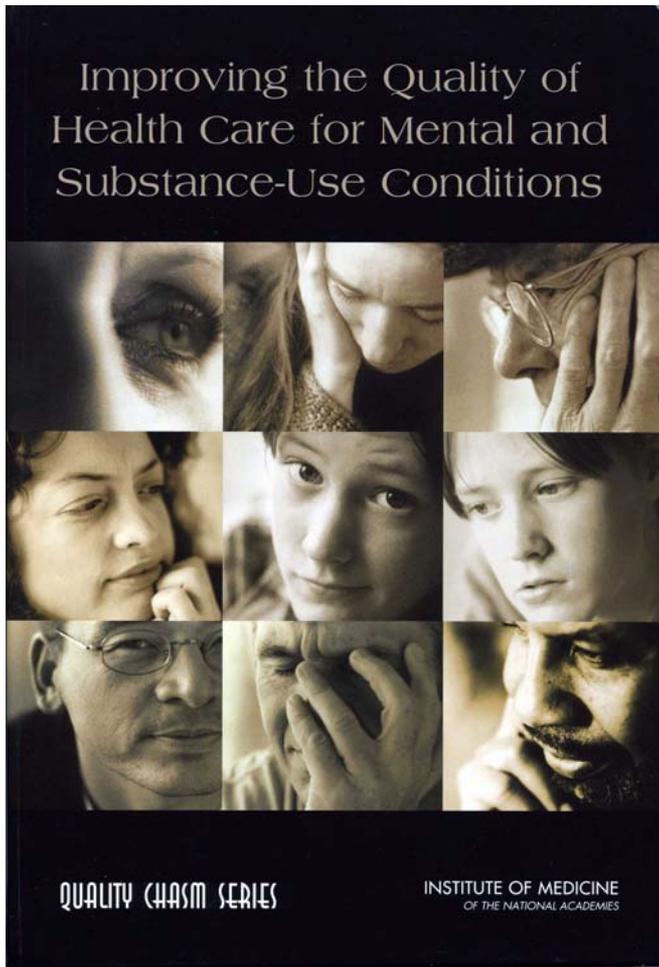
- Long term care facility
- Assisted living (hostel)
- Home care
- Community health assessment
- Mental health
- Community mental health
- Acute care
- Post-acute care
- Palliative care

SCREENERS

- Self-reliance Protocol (community care)
- Contact assessment*
- Emergency room*
- Acute care*

* In development

The Institute of Medicine, 2006



Mental, substance-use, and general illnesses are highly interrelated, especially with respect to chronic illness and injury.

The aims, rules, and strategies for redesign... in Crossing the Quality Chasm should be applied throughout mental and substance use health care..., but tailored....

Performance Measurement Initiatives

National Hospital Inpatient Quality Measures-Hospital Based Inpatient Psychiatric Services (HBIPS) Core Measure Set

Last Updated 7/28/08

Background

UPDATE July 2008: The Joint Commission and the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD) and the NASMHPD Research Institute, Inc. (NRI) have finished work on a set of core performance measures for Hospital-Based Inpatient Psychiatric Services (HBIPS).

- Admission screening for violence risk, substance use, psychological trauma history and patient strengths completed
- Hours of physical restraint use
- Hours of seclusion use
- Patients discharged on multiple antipsychotic medications
- Patients discharged on multiple antipsychotic medications with appropriate justification
- Post discharge continuing care plan created
- Post discharge continuing care plan transmitted to next level of care provider upon discharge

Joint Commission
Inpatient Psychiatric Core Measures

The [Specification Manual for National Hospital Inpatient Quality Measures-Hospital-Based Inpatient Psychiatric Services Core Measure Set Version 2.0a \(July 2008\)](#) and the July 2008 [Release Notes](#) are now available on the Joint Commission website.

Health Care Quality in Prisons: A Comprehensive Matrix for Evaluation

Tamara T. Stone, PhD, Randee M. Kaiser, MS, CCHP,
and Annamarie Mantese, MPA

Health care organizations assess clinical processes and procedures to minimize errors, improve outcomes, and increase patient satisfaction. Many correctional facilities, however, are not able to fully engage in continuous quality improvement activities mainly because of a lack of current, relevant quality models and benchmarks to serve as a basis for evaluation. The Missouri Department of Corrections developed a quality indicator matrix based on information used by civilian health systems and collected benchmark data to systematically evaluate their services and identify evidence-based prevention and treatment processes to improve the delivery and management of specific health risk factors and diseases and conditions.

Missouri quality indicators

- For 2005, 40 indicators in 11 categories
 - Developed with assistance from NCQA, JCAHO, AHRQ, NCCHC, Healthy People 2010, et alia
- Results show improvements vs. drops compared with previous years
 - Often better than free-world benchmarks
- Vision includes dissemination of QI matrix to other states
 - Predicated on electronic health record system

WOMEN'S HEALTH

- Response to an abnormal mammogram
- Timeliness of prenatal care
- Checkups after delivery
- Cesarean section rate

HEART DISEASE

- Monitoring hypertension
- Response to an abnormal BP test
- MI, aspirin when sent out
- MI, aspirin at return to facility
- Beta-blocker treatment after a MI
- Cholesterol management after cardiovascular events, LDL screening
- Cholesterol management after cardiovascular events, LDL level

INFECTIOUS DISEASES

- Tuberculosis treatment completed
- HIV viral load levels

PULMONARY DISEASE

- COPD receiving appropriate care
- Response to an abnormal chest x-ray

WELLNESS AND PREVENTION

- Physical exam in past year
- Breast cancer screening
- Cervical cancer screening
- Yearly influenza immunization
- High blood cholesterol levels
- High blood cholesterol management
- Cholesterol management

ASTHMA

- Frequency, preventable acute episodes

DIABETES

- Annual eye exams

MEDICATION ADMINISTRATION

- Tegretol levels

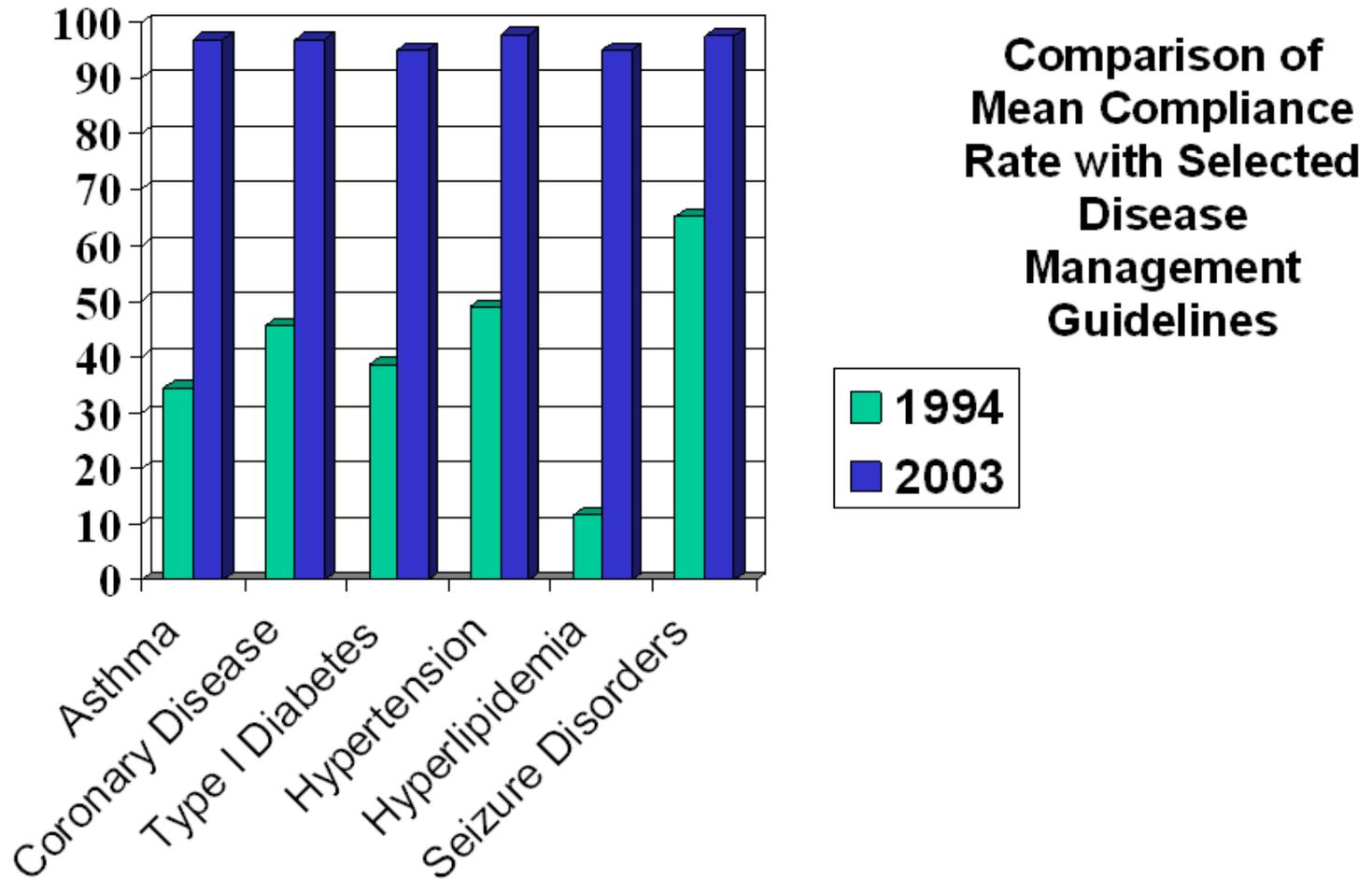
SCREENING

- Physical appraisal exam within 1st week
- Dental exam within 1st week

BEHAVIORAL HEALTH

- Optimal practitioner contacts for depression
- Effective acute Rx for depression
- Effective continuation Rx for depression
- Follow-up within a week of intake
- Suicide attempts after positive screen

Performance Indicators: Quality of Care



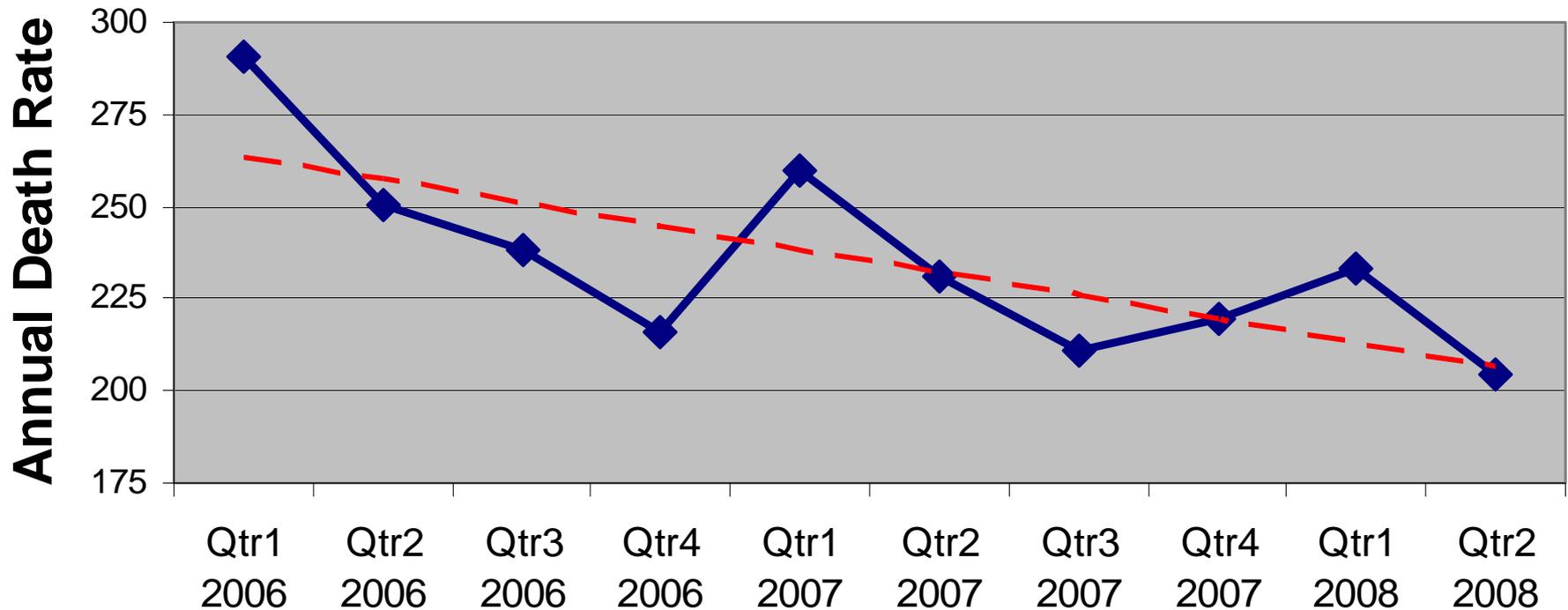
*Correctional Managed
Health Care*



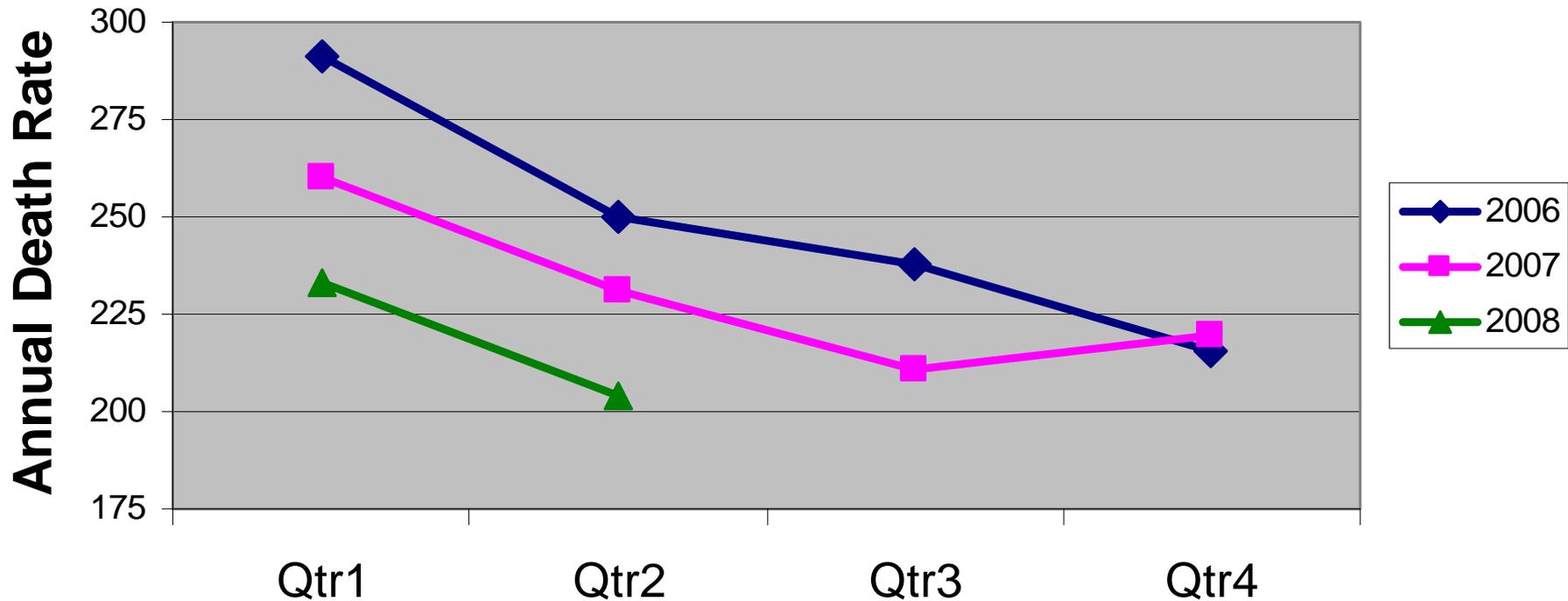
ACA health care outcomes

1. MRSA rate
 2. Active TB rate
 3. TB conversions
 4. Latent TB Rx completions
 5. Hepatitis C rate
 6. HIV rate
 7. HIV on HAART
 8. HIV viral load < 50
 9. Axis 1 rate
 10. Off-site hospitalizations
 11. Off-site emergency visits
 12. Specialty consults done
 13. Hypertensives > 140/90
 14. Hemoglobin A1c > 9
 15. Completed dental Rx plans
1. Staff with lapsed licensure
 2. Staff completing orientation timely
 3. Occupational exposures to blood etc
 4. Staff TB conversions
1. Healthcare grievances sustained
 2. Grievances re safety/sanitation
 3. Lawsuits in favor of offender
1. Rate of quality problems corrected
 2. High-risk events or adverse outcomes identified
 3. Suicide attempts
 4. Suicides
 5. Unexpected natural deaths
 6. Medication errors

Deaths/100,000 inmates in California prisons, 2006-2008



Deaths/100,000 inmates in California prisons, 2006-2008



Controversies and excitement in free-world measurement

1. Burden vs benefit of measurement
2. Administrative vs clinical data
 - Paper vs electronic
3. Reliability and validity of specific measures
4. Number of measures in “starter sets”
5. Paying for performance at the provider level
6. Evidence-based appropriateness measures
7. Skewing attention to easy-to-get measures, away from others
8. Composite (all-or-nothing) measures
9. Relationship between measures and “quality”
10. Evaluating transitions in care (could include re-entry)

Does measure correlate with a meaningful outcome? And does it save money?

Yes (sometimes)

- 62 primary care quality metrics
 - 20 had both clinical and economic evidence of effectiveness
- 16 were cost-saving in the short term
 - NB: Those measures are not routinely found in administrative claims data.

de Brantes F, et al. The value of ambulatory care measures. *Am J Manag Care*, 2008; 14: 360.

| Measure | Clinical Effectiveness Score | Cost-effectiveness Score | Combined Score |
|--|------------------------------|--------------------------|----------------|
| Blood pressure <140/90 mm Hg (HTN) | 6 | 5.5 | 33 |
| Systolic blood pressure <140 mm Hg (HTN) | 6 | 5.5 | 33 |
| Diastolic blood pressure <90 mm Hg (HTN) | 6 | 4.5 | 27 |
| Blood pressure <140/90 mm Hg (DM) | 6 | 4.5 | 27 |
| A1C >9% (DM) | 6 | 4.5 | 27 |
| A1C <7% (DM) | 6 | 4.5 | 27 |
| LDL-C <100 mg/dL (DM) | 6 | 4.5 | 27 |
| LDL-C <130 mg/dL (DM) | 6 | 4.5 | 27 |
| LDL-C <100 mg/dL after discharge for AMI, CABG, or PCI (CAD) | 6 | 4.5 | 27 |
| LDL-C <130 mg/dL after discharge for AMI, CABG, or PCI (CAD) | 6 | 4.5 | 27 |
| LDL-C <100 mg/dL with any CAD | 6 | 4.5 | 27 |
| LDL-C <130 mg/dL with any CAD | 6 | 4.5 | 27 |
| Weight reduction (HTN) | 5 | 4.5 | 23 |
| BB use in HF | 5 | 4.5 | 23 |
| ACE inhibitor/ARB use in LVSD (HF) | 5 | 4.5 | 23 |
| BB post-MI with prescription 7 days after discharge (CAD) | 5 | 4.5 | 23 |
| BB post-MI with prescription 6 months after discharge (CAD) | 5 | 4.5 | 23 |
| Antiplatelet therapy in CAD—aspirin only (CAD) | 5 | 4.5 | 23 |
| ACE inhibitor/ARB in CAD with LVSD (CAD) | 5 | 4.5 | 23 |
| Back pain—bed rest >4 days (ACCs) | 5 | 3.5 | 18 |

Measurement using EHRs is as easy as falling off a log?

1. Translational e-indicators

- Traditional measurement sets, e.g., HEDIS, used in health information technology (HIT) platforms

2. HIT-facilitated e-indicators

- Not conceptually limited to HIT data but not operationally feasible without HIT, e.g., physiologic outcomes on 100 percent of patients

3. HIT-enabled e-indicators

- Innovative measures that would not generally be possible outside of the HIT context, e.g., linked to CPOE, clinical decision support systems, or biometric devices

Five case studies conclude,

“Worth pursuing, despite the challenges”

Composite (all-or-none) diabetes measure at Park Nicollet Clinic

- Individual numerator measures (from structured fields in EHR)
 - % hemoglobin A1c < 7 in the past 12 months
 - % LDL cholesterol < 100 in the past 12 months
 - % blood pressure < 130/80 in the past 12 months
 - % daily aspirin use
 - % not using tobacco
- Denominator
 - All patients in diabetes registry 18-75 seen in clinic at least twice in last two years with diabetes ICD-9
- Composite measure
 - % with A1c, LDL, and BP at goals and up-to-date, who use aspirin daily, and who do not use tobacco (the “Grand Slam”)
 - Calculated monthly for clinician, site, and overall care system.
- Accurate clinician assignment is key to stimulating QI

Do different measurement methods agree on quality?

Comparing 26 VA facilities 3 different ways:

1. Focused explicit criteria
 - ❑ 38 measures for 6 conditions, e.g., HEDIS
2. Global explicit criteria
 - ❑ 372 measures for 26 conditions, e.g., RAND QA Tools
3. Structured implicit peer review
 - ❑ A single global rating of care for 3 chronic conditions and overall acute, chronic and preventive care

“Found moderate to high agreement in quality scores for most clinical areas, indicating that all 3 were measuring a similar construct called ‘quality.’”

California's structured implicit peer review of deaths

Difficult definitions

- Non-preventable death
 - In the judgment of the reviewer, the health care system and individual practitioners probably would not have been able to prevent the patient's death.
- Definitely/probably preventable death
 - In the judgment of the reviewer, better medical management or a better system of care would probably have prevented the patient's death.
- Possibly preventable death
 - In the judgment of the reviewer, better medical management or a better system of care might have prevented the patient's death.

The prison quality measurement discussion circa 2008

1. How do we conceptualize and measure appropriate access to care in correctional settings?
2. Is there a role for structured implicit review (valid, reliable, and feasible)?
3. Should we dictate measure specifications to EHR vendors or vice versa?
4. Should we standardize a starter set of explicit measures (and specifications) for prison systems?
5. Should we develop a system for publicly reporting results?