Defining quality care for people with complex health care needs who are at high risk for adverse outcomes is challenging. The paucity of relevant evidence is a factor; these populations are often excluded from the randomized clinical trials, which are the basis of clinical evidence and high-quality guidelines. However, the main issue for people with multiple conditions, who often also have personal care and social needs, is knowing where to start. That is why we need a quality dashboard focusing on health care priorities for this population.

Chang et al used a rigorous process grounded in evidence and shaped by input from stakeholders, including military veterans, to identify a parsimonious set of process measures to improve Veterans Health Administration (VHA) primary care for veterans at high risk of adverse outcomes such as hospitalization or death. This work is important because it avoids the disease-specific focus of other sets of primary care measures and highlights social needs and facilitation of transitions of care (eg, from the emergency department or hospital); however, it does not address assessment of patient values and individualized care plans aligned with patient goals. The authors note the study panel’s concerns about the burden of data collection, the ability to create meaningful measures, and system vs clinic-level accountability for these measures.

The dashboard suggested by Chang et al offers a pragmatic approach to answer a driving question for the VHA: what measures can help reduce the risk of hospitalizations among patients receiving intensive case treatment? The approach of anchoring ratings to feasibility constrains innovation and fails to address the bigger question of how to prompt more veteran-centered outcomes beyond acute care utilization. What should guide construction of a quality dashboard for people with complex needs?

First, a dashboard highlighting key aspects of care for people with complex needs should address person-centered care. Person-centeredness has long been recognized as a fundamental component of health care quality, particularly for people with complex needs. Because evidence to support clinical care may be limited or conflicting for this population, what matters most to the individual should be the “north star” that guides care. Frameworks for people with complex needs consistently note the need to prioritize the goals and preferences of individuals and families in care. Finding out what matters and using that information to align care plans with patients’ priorities can lead to reduced patient-reported treatment burden and lower use of priority-discordant medications and diagnostic tests. There are survey tools that assess care experiences with communication, goals, and care planning, but they may be cumbersome, although not impossible, to include in a dashboard. There are also promising new measures for documenting and measuring progress toward personalized goals aligned with the clinical process of eliciting and addressing goals of care plans.

Second, a dashboard should accommodate the heterogeneity of the population with complex needs and incorporate approaches that encourage personalized care. Choosing to track a single social need or screen for a single mental health need may signal a perceived lack of importance of other factors. This is of particular concern for the VHA, where substance use, posttraumatic stress disorder, and military sexual trauma affect many patients. Dashboards could show the most prevalent needs and whether reporting social needs results in follow-up. The same is true for quality measures for mental health and substance use that address both screening and follow-up.
Technology could reduce the burden of needs assessment and monitoring, such as through interactive voice response, computerized adaptive testing, and text- or web-based data collection. Digital data collection presented in a dashboard may facilitate clinical management by supporting better data visualization and clinical decision support.

Third, a dashboard should highlight equity. We cannot change what we cannot see. In the US, we are awakening to how political and social structures grounded in racism have created and sustained widespread inequities in health and health care. The VHA has been a leader in recognizing equity concerns, focusing on race and ethnicity as well as on care for women and for veterans in rural areas. Dashboards could highlight groups that experience inequities in care and guide specific actions to increase equity and improve quality.

Fourth, a dashboard for managing care of patients with complex needs should consider how different parts of the health care system can promote high-quality care. Improving care requires aligning services across the health care system. Dashboards help keep “eyes on the prize” for practitioners and leaders. For patients with complex needs, a dashboard should include measures for which efforts require collective action, such as addressing social needs and coordinating care across settings. In the comprehensive VHA, these measures may be considered reasonable, but they would likely be discarded in less integrated settings. Further enhancements of the dashboard could include personalized engagement and joint decision-making for individuals and their care teams.

We commend Chang et al for development of a dashboard of primary care measures to concentrate energy and align purposes across all VHA system practitioners. Their efforts may promote meaningful steps toward improving care for people with complex needs and may reduce the risk of unnecessary and unwanted care. To take this effort to the next level, VHA investigators and others working to improve care for people with complex needs should integrate cocreation with individuals, their families, and their care teams (as has been shown in cystic fibrosis care). Cocreation is a promising approach to making person-centered, clinically relevant dashboards; it requires the freedom to innovate and iterate to address priorities, rather than constraining choices to existing tools and data.

ARTICLE INFORMATION
Published: August 2, 2022. doi:10.1001/jamanetworkopen.2022.24945
Open Access: This is an open access article distributed under the terms of the CC-BY License. © 2022 Scholle SH et al. JAMA Network Open.
Corresponding Author: Sarah Hudson Scholle, MPH, DrPH, National Committee for Quality Assurance, 1100 13th St NW, 3rd Floor, Washington, DC 20005 (scholle@ncqa.org).
Author Affiliations: National Committee for Quality Assurance, Washington, DC (Scholle); School of Public Health, University of Texas Health Science Center at Houston (UTHealth Houston) (Naik); Michael E. DeBakey VA Medical Center, Houston, Texas (Naik).
Conflict of Interest Disclosures: Dr Naik reported being supported in part by the Houston VA Health Services Research and Development Center for Innovations in Quality, Effectiveness, and Safety (CIN 13-413) and serving as the Nancy P and Vincent F Guinee, MD Distinguished Chair of the UTHealth Houston Consortium on Aging.
REFERENCES


