Desirable Attributes of HEDIS® Measures

(Updated and revised January 1998)

Important Notes: This list of desirable attributes of measures was included in NCQA’s Public Call for Measures for HEDIS 3.0, which was distributed to over 2,000 organizations (and posted on the Web) in December 1995. NCQA’s Measurement Advisory Panels (MAPs) continue to use these attributes as they assess measures for future versions of HEDIS.

These attributes were designed to assess measures for comparison between health care systems, not measures for quality improvement (although some may also be valid for the assessment of quality improvement measures). A “health care system” may be a managed care organization, a physician group practice, a hospital or other institutional setting that provides acute and/or nonacute care etc.

NCQA staff and MAP members recognize that no measure will be perfect with respect to each of these attributes, and not all attributes will be equally important for all measures. For example, if a measure requires information that is not currently available in plans’ information systems, it may still be considered for inclusion in HEDIS if it has other desirable attributes, captures meaningful information on quality of care delivered, and if it will stimulate the improvement of information systems. Similarly, measures relating to access, satisfaction, and informed health care choices may require consideration of criteria in addition to those listed below.

1. **Relevance.** The measure should address features of health care systems that are relevant to purchasers and/or consumers for making choices between systems, that are useful in negotiating with systems, or that will stimulate internal effort at quality improvement by systems.

   A. **Meaningful.** The measure should be meaningful to at least one of the audiences for HEDIS: individual consumers, purchasers, or health care systems. Decision-makers should be able to understand the clinical and economic significance of differences in how well systems perform on the measure. The meaningfulness of a measure is enhanced if benchmarks and targets are available.

   B. **Health importance.** The measure should capture as much of the health care system’s activities relating to quality as possible. Factors to be considered in evaluating the health importance of a measure include the type of measure (e.g., outcome vs. process), the prevalence of the medical conditions to which the measure applies, and the seriousness of the health outcomes affected.

   C. **Financial importance.** The measure should be related to activities that have high financial costs to health care systems, or purchasers or consumers of health care.

   D. **Cost-effectiveness.** The measure should encourage the use of cost-effectiveness activities and/or discourage the use of activities that have low cost-effectiveness.
E. **Strategically important.** The measure should encourage activities that deserve high priority in terms of using resources most efficiently to maximize the health of their members. In general, measures that have high clinical importance, high financial importance, and are cost-effective will also be of high priority.

F. **Controllability.** There should be actions that health care systems can take to improve their performance on a measure. If the measure is an outcome measure, there should exist one or more processes that can be controlled by the system that have important effects on the outcome. If the measure is a process measure, the process should be substantially under the control of the system, and there should be a strong link between the process and desired outcomes. If the measure is a structural measure, the structural feature should be open to modification by the system, and there should be a strong link between the structure and desired outcomes. The measure’s time period should capture the events that have impact on clinical outcomes and reflect the time horizon over which the health care system had control.

G. **Variance among systems.** If the primary purpose of the measure is to differentiate among health care systems, then there should be potentially wide variations across systems with respect to the measure.

H. **Potential for improvement.** If the primary purpose of the measure is to support negotiations between health care systems and purchasers, or to stimulate self-improvement by health care systems, there should be substantial room for systems to improve their performance with respect to the measure.

2. **Scientific Soundness**

A. **Clinical Evidence.** There should be evidence documenting the links between the interventions, clinical processes, and/or outcomes addressed by the measure.

B. **Reproducible.** The measure should produce the same results when repeated in the same population and setting.

C. **Valid.** The measure should have face validity, i.e., it should make sense logically, clinically, and, if it focuses on a financially important aspect of care, financially. It should correlate well with other measures of the same aspects of care (construct validity), and capture meaningful aspects of this care (content validity).

D. **Accurate.** The measure should accurately measure what is actually happening.

E. **Case-mix Adjustment/Risk Adjustment.** Either the measure should not be appreciably affected by any variables that are beyond the health care system’s control (“covariates”), or any extraneous factors should be known and measurable. If case-mix and/or risk adjustment is required, there should be well-described methods for either controlling through risk stratification or for using validated models for calculating an adjusted result that corrects for the effects of covariates. (In
Some cases, risk stratification may be preferable to risk adjustment because it will identify quality issues of importance to different subgroups.

F. **Comparability of data sources.** The accuracy, reproducibility, risk-adjusted and validity of the measure should not be affected if different systems have to use different data sources for the measure. We recognize that strict comparability may be difficult to obtain with current information systems; however, we hope to minimize any potential bias that might be introduced by different data sets, and to stimulate continuous improvement in information systems.

3. **Feasibility**

   A. **Precisely specified.** The measure should have clear operational definitions, specifications for data sources and methods for data collection and reporting.

   B. **Reasonable cost.** The measure should not impose an inappropriate burden on health care systems. Either the measure should be inexpensive to produce, or the cost of data collection and reporting should be justified by improvements in outcomes that result from the act of measurements.

   C. **Confidential.** The collection of data for the measures should not violate any accepted standards of member confidentiality.

   D. **Logistically feasible.** The data required for the measure should be available to the health care system during the time period allowed for data collection. The measure should not be susceptible to cultural or other barriers that might make data collection infeasible. (e.g. in patient or physician surveys, there may be cultural or personal barriers that lead to biased responses; these would need to be addressed).

   E. **Auditable.** The measure should be auditable, i.e., it should not be susceptible to manipulation or “gaming” that would be undetectable in an audit. Methods to verify retrospectively that reported results accurately portray delivered care should be suggested.