Reviewer's report

Title: Using a summary measure for multiple quality indicators in primary care: the Summary Quality Index (SQUID)

Version: Date: 4 December 2006

Reviewer: Robbie Foy

Reviewer's report:

General

This review is mainly written from the perspective of a UK family physician and implementation researcher. Hence my comments will focus on clinical utility and implications for quality improvement evaluation.

This manuscript describes an algorithm used to produce a summary measure for the quality of primary care. The algorithm was applied to an electronic medical record system used in 89 ambulatory care practices. The authors assessed and found acceptable the reliability, internal consistency, responsiveness to change and face validity of the summary measure.

This manuscript is well written. The criteria used in the summary measure are clinically relevant and evidence-based and the algorithm methods appear transparent. My feedback therefore mainly concerns discretionary issues.

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Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

None

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Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

None

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Discretionary Revisions (which the author can choose to ignore)

1. A brief description of the active QI components of A-TRIP (e.g. whether it used audit and feedback) in a couple of sentences would be helpful to readers not familiar with this programme.

2. I wasn’t certain if there was a clear rationale for combining process and outcome measures – and whether this is routinely done in other quality measures. The achievement of clinical outcome measures may be partly determined by population characteristics. So, wouldn’t process measures used alone represent a more sensitive indicator of performance? Outcome measures themselves are of interest but possibly are measuring something different unless adjusted for confounders. Please clarify in either manuscript text or accompanying correspondence.

3. How comprehensively do the summary measures capture the relevant patient populations? In other words, are there any risks of over- or under-playing performance based on patients being excluded deliberately or by default from the denominator? For example, were the estimated prevalences broadly in line with those predicted by literature? I’m not sure if this feature is mainly determined by the comprehensiveness of the PPRNet electronic medical record system rather than the algorithm itself.

4. How were the comments fed back to assess face validity selected – so as to avoid selection bias? Were there any negative results? How many of those asked for comments provided feedback?

5. One of the limitations of using summarised performance measures in assessing quality of care is that they might help detect general problems, but condition-specific indicators might be more useful to target quality improvement efforts at conditions where need is greatest.
6. That said, I thought that the most interesting feature of this algorithm is its use in measuring equity, i.e. levels of use by or access to recommended treatments by those in need of them. This issue can be marginalised in quality improvement efforts, where efficiency is usually implicitly more important than equity. In this case, were there any (probably predictable) characteristics of patients who received inappropriate care?

What next?: Accept after discretionary revisions

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: Yes, but I do not feel adequately qualified to assess the statistics.