

James L. Holly, M.D.

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Demonstrated results on publicly reported performance measures

SETMA's approach to quality metrics and public reporting is driven by these assumptions:

1. Quality metrics are not an end in themselves. Optimal health at optimal cost is the goal of quality care. Quality metrics are simply "sign posts along the way." They give directions to health. And the metrics are like a healthcare "Global Positioning Service": it tells you where you want to be; where you are, and how to get from here to there.
2. The auditing of quality metrics gives providers a coordinate of where they are in the care of a patient or a population of patients.
3. Statistical analytics are like coordinates along the way to the destination of optimal health at optimal cost. Ultimately, the goal will be measured by the well-being of patients, but the guide posts to that destination are given by the analysis of patient and patient-population data.
4. There are different classes of quality metrics. No metric alone provides a granular portrait of the quality of care a patient receives, but all together, multiple sets of metrics can give an indication of whether the patient's care is going in the right direction or not. Some of the categories of quality metrics are: access, outcome, patient experience, process, structure and costs of care.
5. The collection of quality metrics should be incidental to the care patients are receiving and should not be the object of care. Consequently, the design of the data aggregation in the care process must be as non-intrusive as possible. Notwithstanding, the very act of collecting, aggregating and reporting data will tend to create a Hawthorne effect.
6. The power of quality metrics, like the benefit of the GPS, is enhanced if the healthcare provider and the patient are able to know the coordinates while care is being received.
7. Public reporting of quality metrics by provider name must not be a novelty in healthcare but must be the standard. Even with the acknowledgment of the Hawthorne effect, the improvement in healthcare outcomes achieved with public reporting is real.
8. Quality metrics are not static. New research and improved models of care will require updating and modifying metrics.

SETMA currently tracks the following: 34 NCQA HEDIS measures; 14 NCQA Diabetes Recognition Metrics; 35 NQF-endorsed measures; 27 PQRS measures; 9 PCPI measures

related to the physician role in hypertension management; 43 measures of the Bridges to Excellence program for Asthma, Chronic Stable Angina, Congestive Heart Failure, COPD, Diabetes and Hypertension; 10 PCPI related to Diabetes; 6 PCPI for Stages 4 and 5 of Chronic Kidney Disease; 5 PCPI for Chronic Stable Angina; 7 PCPI for Congestive Heart Failure; 20 PCPI Transition of Care measures.

In addition to endorsed-measurement sets, SETMA tracks these self-designed quality measures: 10 measures related to hyperlipidemia; 12 measures related to Chronic Kidney Disease Stages 1-III. Also, in the hospital setting, SETMA has designed an internal study to identify patterns in hospital readmissions, such as lengths of stay, morbidities and co-morbidities, socio-economic status, ethnicity, gender, age, follow-up calls, follow-up visits in clinic, etc.. The purpose is to control cost and increase safety by reducing preventable readmissions to the hospital.

Population Management and Quality Improvement Metrics

SETMA tracks a number of key data points for diabetes, hypertension and hyperlipidemia for its entire patient population. These measures are compared between patients who are controlled against patients who are not controlled. Secondly, the results for the controlled and uncontrolled populations are further analyzed by gender, age, ethnicity, numbers of medications, frequency of visits, frequency of test, income and other measures in an effort of to reduce disparities in patient care across all demographics.

To ensure timely compliance by providers, SETMA has designed functions with its EHR to alert providers to patient conditions which must be reported to local or state agencies for infectious disease control. SETMA reports the results of all of the measures listed [here](#) publicly, by provider name on the organization's website. The results of each of the measures are updated and republished each quarter with the most recently available data.

Gaps in Reporting

Through quality reporting, SETMA has been able to identify deficiencies not only in our work but also in reporting programs endorsed at the national level. For example, SETMA tracks nine different quality metric sets for Diabetes (NQF, NCQA Diabetes Recognition, NCQA HEDIS, PCPI, Joslin, PQRS, BTE, AQA) and each one differs from the next. While the sets are not contradictory, they are not complimentary either.

Harmonization of diabetes measurement sets across the entire quality-metric community would be valuable for population management and comparing of practice outcomes.

In addition to the lack of standardization of diabetes measures, there are two important disease processes that presently lack standardized quality metrics. Those two diseases are Stages 1-3

of Chronic Kidney Disease and Hyperlipidemia. SETMA recommends the adoption of standardized, published quality metrics for these two important disease processes.

Changing Quality Metrics

Diabetes is a target of quality measures for several reasons:

- Process Quality Measures, i.e., was a hemoglobin A1c (HbA1c) done, and Outcomes Quality Measures, i.e., what was the HbA1c value, are easy to determine and to report.
- The treatment goals for the elements of diabetes are generally known and accepted.
- Standardization of methods for laboratory testing is generally accepted.
- These three make diabetes a model for the idea of "precision medicine" presented in *The Innovator's Prescription: A Disruptive Solution for Health Care*. Precision medicine, exists "Only when diseases are diagnosed precisely...therapy that is predictably effective ...be developed and standardized. We term this domain *precision medicine*." The care of diabetes calls for little intuitive judgment or guess work.
- Diabetes is a devastating disease but evidence-based medicine demonstrates that aggressive and successful treatment dramatically changes the outcome of the disease.
- Diabetes is a major public health problem in that the increasing prevalence of diabetes is almost on the scale of a pandemic.
- The cost of caring for diabetes and its complications is enormous making the potential benefit of treating the illness large for both the individual and the society.

While the above points are true, new research is suggesting that if a patient has had diabetes for more than twenty years, and if the patient does not have certain complications, it is probable that the patient may develop those complications. Therefore, research will modify our understanding of quality metrics and their value. New research will not eliminate the use of quality metrics, but it will make us stay "up to date" in our understanding of how to apply quality metrics.

Additionally, quality metrics groups published by different organizations can have different goals. Some of the greatest points of leverage for improving outcomes come from the examination of complex processes which are not easily reduced to simple process metrics. Diabetes metrics illustrate this point. Because excellence in diabetes care requires a team, it is possible to identify complex quality metrics to assess the functioning of the team. These complex-process metrics are often not easily audited. For instance, if a primary care provider is caring for a patient with diabetes, it is possible to establish a standard that if after a pre-determined interval the patient is not progressing toward the treatment goal, the patient should be referred to an endocrinologist. Business Intelligence software solutions can measure this process, audit it and report it. Without the auditing of this metric, a significant opportunity for improving care can be missed.

These complexities of quality metrics are in mind as SETMA is reading the National Quality Forums 171-page "Measures Under Consideration for Calendar Year 2012." It is for these

reasons that quality metrics, even ones which are quantifiable, must always be being reviewed and re-evaluated.

The Limitations of Quality Metrics

The New York Times Magazine of May 2, 2010, published an article entitled, "The Data-Driven Life," which asked the question, "Technology has made it feasible not only to measure our most basic habits but also to evaluate them. Does measuring what we eat or how much we sleep or how often we do the dishes change how we think about ourselves?" Further, the article asked, "What happens when technology can calculate and analyze every quotidian thing that happened to you today?" Does this remind you of Einstein's admonition, "**Not everything that can be counted counts, and not everything that counts can be counted?**"

Technology must never blind us to the human. Bioethicist, Onora O'Neill, commented about our technological obsession with measuring things. In doing so, she echoes the Einstein dictum that not everything that is counted counts. She said, "*In theory again the new culture of accountability and audit makes professionals and institutions more accountable for good performance. This is manifest in the rhetoric of improvement and rising standards, of efficiency gains and best practices, of respect for patients and pupils and employees. But beneath this admirable rhetoric the real focus is on performance indicators chosen for ease of measurement and control rather than because they measure accurately what the quality of performance is.*"

Technology Can Deal with Disease but Cannot Produce Health

In our quest for excellence, we must not be seduced by technology with its numbers and tables. This is particularly the case in healthcare. In the future of medicine, the tension - not a conflict but a dynamic balance - must be properly maintained between humanity and technology. Technology can contribute to the solving of many of our disease problems but ultimately cannot solve the "health problems" we face. The entire focus and energy of "health home" is to rediscover the trusting bond between patient and provider. In the "health home," technology becomes a tool to be used and not an end to be pursued. The outcomes of pure technology alone are not as satisfying as those where trust and technology are properly balanced in healthcare delivery.

As we move deeper into the 21st Century, we do so knowing that the technological advances are astounding. Our grandchildren's generation will experience healthcare methods and possibilities which seem like science fiction to us today. Yet, that technology risks decreasing the value of our lives, if we do not in the midst of technology retain our humanity. As we celebrate science, we must not fail to embrace the minister, the ethicist, the humanist, the theologian, indeed the ones who remind us that being the bionic man or women will not make us more human, but it seriously risks causing us to be dehumanized. And in doing so, we

may just find the right balance between technology and trust and thereby find the solution to the cost of healthcare.

Conclusion

It is in this context that SETMA whole-heartedly embraces technology and science, while retaining the sense of person in our daily responsibilities of caring for persons. Quality metrics have made us better healthcare providers. The public reporting of our performance of those metrics has made us better clinician/scientist. But what makes us better healthcare providers is our caring for people.

The following pages summarize SETMA's performance on over 200 quality metrics. By provider name, provider performance is measured. Each year, we add new metrics to measure and each year, we make sure that our denominators and numerators are properly defined and that the benchmarks against which we measure ourselves are valid, but the "real benchmark" against which we measure ourselves is our prior performance. Like Mikhail Baryshnikov, "we never try to dance better than someone else, we try to dance better than ourselves."