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Are Quality Metrics a Good Part of the Future of Healthcare?
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A "perspective piece' appeared in the *New England Journal of Medicine* (*NEJM* 363:7) on August 12, 2010. It concluded with the following:

> "If the goal of providing reports to individual physicians is to help them improve their care, it's critical to understand the baseline assumption about doctors' performance. Are most doctors doing a reasonable job? If so, then our analytics should aim to weed out the few who are inept. Or are most doctors mediocre, with shoddy clinical skills that put patients at risk? If so, then our data-driven system must prod doctors as a group to up their game. There isn't a simple formula for distinguishing good doctors from second-rate ones, nor will there ever be. At least some evidence suggests that when doctors deviate from quality measures, they nearly always have medically. valid reasons for doing so"

This piece started with the author declaring that her "quality report care" had been poor two years ago, a year ago and this year, and that it would probably be poor in the future. As I read this "perspective piece," I felt the angst of the physician whose clinical support and treatment resources are limited. I was not concerned that the physician's quality metrics were not good, none of us can claim not to have been surprised with the objective evidence that we are not doing as well as we hoped and as we wanted in the treatment of our patients. The disturbing thing about the "perspective" is that with the quality outcomes not improving from year to year, the physician expressed no alarm, and apparently rather than looking for ways to improve, chose to attack the quality-metric process. The poor "report card" which the physician received is not nearly as important as the fact that treatable disease processes continue to ravage her patients without any expressed plans by the physician to improve her performance, and thereby improve her patients' health.

Treatment Inertia

Treatment, or clinical inertia is well documented in the medical literature. Practice administrations struggle with methods for overcoming this barrier to effective care. The tendency of physicians not to change a treatment plan when a patient is not moving toward or reaching a treatment goal is a problem for large medical organizations, for healthcare centers and for small group or solo practicing physicians. Nevertheless, the audacious declaration by this physician that her documented, continuing poor treatment outcomes only makes this physician

hold those who design quality measures in contempt is a new twist in treatment inertia, a twist for which there is no obvious solution.

Healthcare delivery in America must change and the attitude reflected in this perspective is one illustration of why that change may have to come from political pressure, if the medical profession does not effect real change internally. When I started my medical career in 1969, there was no effective way of measuring quality other than by tedious chart reviews which were expensive and time consuming. Now, due to technology, we can measure performance in real time. To ignore that measurement is not an acceptable alternative.

Quality Metrics

No one would argue that quality metrics are the only solution to healthcare improvement. Those who grapple with the design of quality metrics do not sit around thinking up new ways to aggravate healthcare providers. Using scientific methodology and a growing body of medical literature on quality metrics, these pioneers look for leverage points in identifying potential for real change in healthcare-delivery processes, which will reflect real change in the quality of patient health. Unfortunately, quality metrics are not static such that once you identify one metric that it will have permanent relevance to quality improvement. Once processes are in place, such that the outcomes are virtually totally dependent upon the process, rather than healthcare provider performance, new metrics must be found to move the system further toward excellence.

A single quality metric for a complex disease process will have little if any impact upon patient safety and health. And, all quality metrics of value should point to treatment change which will improve patient health. Though a single metric is of extremely limited value, a "cluster," or a "galaxy" of quality metrics can effect real change in healthcare quality and in patient health. A "cluster" is defined as a group of quality metrics (seven or more) which define quality treatment standards in both process and outcomes for a single disease process. "Comprehensive quality measures" for diabetes are a good illustration. Unfortunately, PCPI, NQA, NCQA Diabetes Recognition, AQA, PQRS, HEDIS and Joslin Diabetes Center, all have comprehensive quality measures for diabetes; and, they are all different.

A "galaxy" of quality measures is a group of "clusters" which relate to the health of a single patient. When "comprehensive quality measures" for diabetes, hypertension, dyslipidemia, CHF, Chronic Stable Angina, Cardiometabolic Risk Syndrome, Chronic Renal Disease Stage 1-III and then Stages IV-ESRD are identified and measured for a single patient, the successful meeting of those metrics, which may exceed 50 in number, ***WILL*** reflect quality treatment and ***WILL*** result in improved health.. Quickly, physicians will say, "But, that will take a two-hour visit for each patient." That would be the case if we were using paper records; if fact, two hours by paper may not be enough time to accomplish all of this. However, with electronic patient management via a well-designed electronic patient record, and with a well-trained and highly functioning healthcare team, this "galaxy" of metrics can be met within in the time and economic constraints currently existent in healthcare in the United States.

How Can Quality Metrics Effect Quality Care?

While quality metrics will always reflect quality, they will not always effect quality unless they are transparent to the healthcare provider at the time and point of a patient encounter. A "report card" delivered retrospectively, six months to two years after the care event which was

measured, will have absolutely no impact on provider behavior. The collecting of provider performance data will only improve healthcare outcomes if they are audited and that auditing must be contemporaneous with patient care. This seems to be the piece which is missing from many quality metrics. Any auditing that is done is often delayed and is thus of little benefit in changing provider and patient behavior. If the provider is able to "see" his/her performance at the time of the patient encounter, behavior will begin to change. And, if the panel or populationa single provider manages, or participates in managing, has data aggregated daily, monthly, quarterly and annually, treatment inertia can be overcome. And, finally, when that provider's performance is publicly published by provider name, treatment inertia will disappear.

There is no doubt that it is possible to question the validity quality metrics. The science of the development of these metrics is beyond this brief review, but we know that they must be formulated on the results of evidence-based medicine. That said, it must be admitted that evidenced-based medicine is almost in its infancy. And, there is little information on whether it is possible to translate evidence-based medicine's results which were produced with extensive ancillary personnel support and extensive grant financial support. Whether evidenced-based medicine works in the "real world" of medicine is still open to question.

Additionally, some healthcare processes which are imperative for producing excellent outcomes are very complex and are not easy to measure with quantifiable metrics. These processes are part of healthcare which are still in the "intuitive" stage of process and outcomes development. However, no matter how much healthcare providers may object or be threatened, significant areas of healthcare delivery have moved into the arena of "precise" medicine which are easily and validly subject to quality metric design. It is probable that medicine will increasingly become more and more "precise" in its performance nature, making healthcare provider performance increasingly easier to measure by quality metrics.

One of the most interesting aspects of quality metrics design is the need to find metrics where the provider performance is a factor in the process or the outcomes measures. One of the means of this is to find such measures where there are significant disparities in provide performance. When the outcomes of provider performance are all the same, then it is arguable that the provider participation in the process to produce that good outcome is not relevant thus indicating that a quality metric defined in that case would not change the quality of care.

Limitations of Quality Metrics

Even as we want to talk about 'precision medicine' and even as we want to measure quality using quantifiable processes and outcomes, we still have to admit that there are limitations to quality metrics. Because healthcare does not deal with machines but with people, there will always be subjective, poorly quantifiable elements to quality in healthcare. This question of the balance between technology and humanity was the subject of an articles published, May 6, 2010. It can me read at www.jameslhollymd.com under Your Life Your Health.

There are several critical steps which can help bridge the gap between quality metrics and true quality in healthcare. These were discussed in the April 22, 2010, Your Life Your Health. Part of that discussion addressed the place of patient-centered medial home, Medicare Advantage health plans, and Evidenced-based medicine. At the foundation of quality healthcare, there is an emotional bond - a trust bond -between the healthcare provider and the patient. It is possible to

fulfill all quality metrics without this bond; it is not possible to provide quality healthcare without it. That is why the patient-centered medical home (PC-MH), coupled with the fulfilling of quality metrics is the solution to the need for quality healthcare.

The genius of PC-MH is to discover the true implications of SETMA's motto which was adopted in August, 1995, which is, 'Healthcare Where Your Health is the Only Care'" It is to put the patient and their needs first. And, it is to include the patient as a member of the healthcare team. There are 8,760 hours in a year. If responsibility for a patient's healthcare is seen as a 'baton,' the patient carries that 'baton' for over 8,700 hours a year. PC-MH promotes methods for effectively 'passing the baton' to the patient so that the patient's healthcare does not suffer under the patient's own supervision. SETMA has placed the patient's healthcare at the center of our healthcare delivery in many ways. One way is that we developed The SETMA Foundation, through which we help provide funding for the care of our patients who cannot afford it. Our resources are meager in comparison with the need, but it is a start.

The following is one example of how PC-MH and the SETMA Foundation have worked together to produce quality healthcare. A patient came to the clinic angry, hostile and bitter and was found not to be a bad person but to be depressed because he could not work, could not afford his medication and was losing his eye sight. He left the clinic with The Foundation paying for his medications, giving him a gas card to get to our ADA certified DSME program, waiving the fees for the classes, helping him apply for disability, and getting him an appointment to an experimental program for preserving his eyesight. He returned in six weeks with something we could not prescribe. He had hope and joy. By the way, his diabetes was treated to goal for the first time in years. This is PC-MH; it is caring and it is humanitarianism.

As the Patient-Centered Medical Home is restoring the personal aspect of healthcare, the Medicare Advantage (MA) program and/or the Accountability of Care Organizations (ACO) are modifying the 'piece' payment system of healthcare. While the President has been convinced that Medicare Advantage is the problem; it is the solution. The supposed increase in the cost of Medicare Advantage is because it is being compared to traditional Medicare costs where the administrative cost of Medicare is not calculated in the formulae. There are bright examples of success with Medicare Advantage, success marked by quality outcomes and high patient satisfaction. That success also is marked by a dramatic change in the trajectory of health care cost while maintaining its quality.

The third piece to true healthcare transformation is including quality process and quality outcomes in the payment formula. There are fledgling programs such as the Physician Quality Reporting System (PQRS) where healthcare providers are being paid for the demonstration of quality outcomes rather than just for piece work. The accountability of the pubic reporting of provider performance on quality measures completes this picture. This is why SETMA has begun quarterly reporting on our website of our providers' performance on multiple quality metrics. Included in that reporting is the examination of whether disparities of care in ethnic and socio-economic groups have been eliminated.

Quality healthcare is a complex problem. Measureable processes and outcomes are only one part of that complexity. Communication, collaboration and collegiality between healthcare provider

and patient, between healthcare provider and healthcare provider, between healthcare providers and other healthcare organizations are important aspects of that complexity also. Data and information sharing within the constraints of confidentiality add another layer of complexity. All of these aspects of healthcare quality can be addressed by technology but only when that technology is balanced by humanitarianism. .

The good news is that the right questions are being asked and historically in that setting .the right answers have been found.

Conclusion

Physician hubris or stubbornness may reject quality metrics for a while, but patient and societal demands will rightly press for change. I am confident that the author of the attached perspective piece is a "good doctor" and cares about her patients. Unfortunately, caring in the 21st Century will no longer be measured by personality or friendliness, it will be measured by competence which will increasingly be an objective measurement. To reject that reality is to prepare oneself for obsolescence when that is not necessary.