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Abraham Lincoln and Modern Healthcare
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> "Contained within Abraham Lincoln's famous "House Divided Speech," delivered to the Republican Convention on April, 16, 1856, is the imperative for data analytics and performance auditing by healthcare providers today. Lincoln said, „If we could first know where we are, and whither we are tending, we could better judge what to do, and how to do it.‟" (Quoted by David Eisenhower in the Foreword to Churchill: *The Prophetic Statesman*, by James C. Humes, Regnery, New York, 2012)
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> "In any human enterprise, if the participants are unwilling to objectively and honestly face where they are, it is improbable that they will ever get to where they want to be, let alone to where they should be."

This was the introduction to a note to SETMA providers which included the daily audit of provider performance. SETMA is committed to improving the quality of healthcare and we believe that quality metrics are one of the keys to that improvement.

History of Quality Measurement

"Records of performance-measurement efforts in health systems can be traced back at least 250 years. More formal arguments for the collection and publication of information on performance were developed more than 100 years ago, when such pioneers in the field as Florence Nightingale and Ernest Codman campaigned for its widespread use in health care. Until recently, professional, practical, and political barriers have prevented these principles from becoming a reality. For example, Nightingale‟s and Codman‟s efforts were frustrated by professional resistance and, until recently, information systems have failed to deliver their promised benefits, in the form of timely, accurate and comprehensive information.

"Over the past 25 years, however, health system performance measurement and reporting have grown substantially, thus helping to secure health system improvement… In many respects, the policy agenda is moving away from discussions of whether performance measurement should be undertaken and what data to collect and is moving towards determining the best ways in which to summarize and present such data and how to integrate it successfully into effective structures for

governance. (“Performance measurement for health system improvement: experiences, challenges and prospects,” Peter C. Smith, Elias Mossialos and Irene Papanicolas World Health Organization 2008)

“The idea of measuring the results of what physicians achieve was…described by Walter McClure in 1990…(when he)…developed a plan for health care cost containment, known as the *Buy Right strategy…* Outcomes assessment is not meant to measure the credentials, knowledge or even competence of health care providers. It is meant to measure performance. The need for this approach is compelling. A physician may be a brilliant theorist and researcher, but lack a compassionate bedside manner, recently-exercised surgical skills, or the judgment needed to select a cost-effective course of treatment.” (Walter McClure, "Health Care Reform: The Buy Right Strategy," Remarks to the NEA Retirement and Benefits Forum, Oct. 20, 1990)

Quality Metrics

No one would argue that quality metrics whether process or outcomes are the only solution to healthcare improvement and cost control. Those who grapple with the design of quality metrics use scientific methodology and a growing body of medical literature on quality metrics to 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.

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.. And, often the standardization of care based on quality metrics will decrease the cost of quality care.

When confronted with the results of quality care audits, physicians will often say, “But, that will take a two-hour visit for each patient.” That would be the case if providers were using paper records. In fact, two hours by paper may not be enough time to accomplish quality care. 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 the time and economic constraints which 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. But, 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 population a 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.

Quality Metrics Philosophy

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.

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 technology alone are not as satisfying as those where trust and technology are properly balanced in healthcare delivery.

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 being 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.

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.

Conclusion

Physician hubris or stubbornness may reject quality metrics for a while, but patient and societal demands will rightly press for change. 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.

Quality metrics tells us where we are and they tell us where we are "tending to go." If tracked, audited, analyzed and publicly reported, quality metrics will help us "judge what to do and how to do it."