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Part II Four categories defined by MIPS Correlate with
Four Strategies SETMA Defined in 2000-2005
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Quality Metrics Philosophy

The potential problem with MIPS is suggested by a review of SETMA's approach to quality metrics and public reporting which 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.
2. 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.
3. The auditing of quality metrics gives providers a coordinate of where they are in the care of a patient or a population of patients.
4. 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.
5. 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.
6. 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.
7. 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.
8. 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.

9. 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.

How Can MACRA and MIPS Be Improved?

MIPS could be improved by the establishment of an absolute standard against which providers and practices will be measured, rather than a comparison with others. Competiveness among providers can improve performance on objective standards but if the idea is to improve the quality of care, an established standard which everyone can meet would be better than the current design of MIPS. Please review the first part of this article for further explanation of this concept.

Additionally, the artificial assumption that performance on nine, or six, or any number of isolated, unconnected, arbitrarily metrics chosen by a practice, often on the basis of how easy it is to perform the requirements of the metric, is not going to change the quality element of practice. This was always the flaw of PQRI and subsequently PQRS, although "comprehensive metric sets" for a particular condition were an option in both programs. The design flaw was that the comprehensive metric sets were not required. Now the same mistake is being made in MIPS.

An alternative is that just as National Committee Quality Assurance (NCQA0 recognition as a Level 2 Patient-Centered Medical Home meets the MIPS' Clinical Practice Improvement Activities, so a practice or provider meeting NCQA standards for Diabetes Recognition and for Heart/Stroke Recognition could be given credit for the metric side of the Quality Category of the MIPS Scoring System.

In addition to a recognized and established standard which represents excellence in complex, chronic care settings, the data base generated by this change to MIPS would allow for statistical analysis of the kinds of practices which are meeting standards of excellence which would allow for further public policy observations about how to improved population health. Other accreditation agencies for quality healthcare performance can also be included in this option, such as the Accreditation Association for Ambulatory Healthcare, URAC and the Joint Commission.

Ultimately, the real flaw of MACRA and MIPS is that like any standard it was created to be measurable when what it needs to be is scalable and elastic to support healthcare delivery transformation rather than at best a system which promote compliance without necessarily improving care quality. This is the very nature of reform.