

Rational Numbers

Let's start measuring quality metrics that matter

■ **By Peter Valenzuela, M.D., M.B.A.**

A few years ago, I sat in a quality meeting reviewing our groups' performance measures. Our presenter said, "I have good news and bad news. The good news is our quality metric for cervical cancer screening is at the 90th percentile in the nation. The bad news is our quality metric for cervical cancer *over-screening* is terrible." (Over-screening occurs when intervals between screenings are shorter than recommended guidelines.) Physicians are pressured to provide more screening tests to address the increasing number of quality metric requirements but penalized if done too often. At that moment, I thought to myself, we're damned if we do and damned if we don't.

Done well, measuring quality can be a good thing. However, we've gone a bit overboard. The Centers for Medicare and Medicaid Services (CMS) has approximately 1,700 measures for providers within different practice settings.¹

An Excerpt from
*Doc-Related: A
Physician's Guide
to Fixing Our Ailing
Health Care System*

Combine that with over 80 Healthcare Effectiveness Data and Information Set (HEDIS) measures used to score health insurance plans, along with another 57 measures the Joint Commission uses to gauge the quality of inpatient care for hospitals, and you get an insurmountable number of metrics.²

To complicate matters, the metrics are not universal across all entities. For example, the 2018 CMS' Shared Savings Program metric for poor diabetes control was a hemoglobin A1c level at or above 8%, but most health plans use the HEDIS standard of at or above 9%.³ The same applies to blood pressure control in elderly patients. Depending on the organization, systolic blood pressure targets for patients over 65 range from less than 130 mm Hg to less than 150 mm Hg.⁴ In fact, a study



istock.com/kteel23/PeopleImages

of 23 health insurers found they used 546 quality measures, and few of them matched across all insurers.⁵

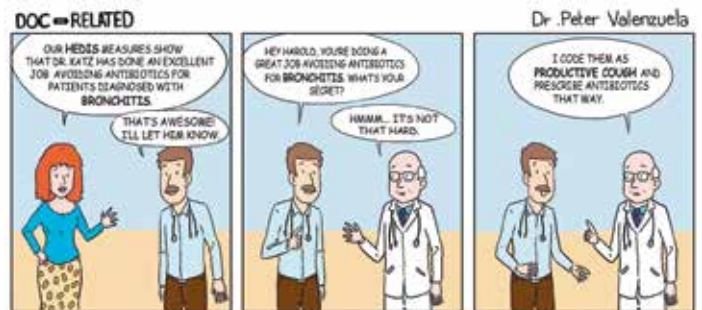
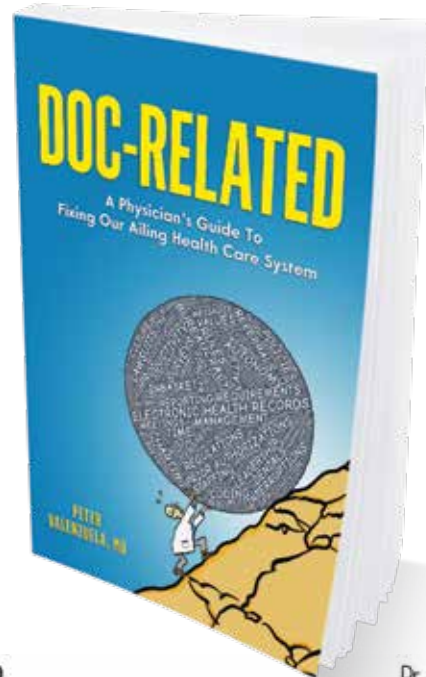
In addition, reporting and collecting data is time-consuming and cumbersome. Even though most physicians use electronic health records (EHRs), EHRs automate only a portion of quality metrics. This forces physicians and staff to manually track measure specifications, collect and enter data, and transmit the data.

One study of four common specialties (general internists, family physicians, cardiologists, and orthopedists) showed that physicians and staff spent 15.1 hours per physician per week dealing with quality measures, with 2.6 of those hours per week by the physicians.⁶ Time spent by physicians and staff translates to an average cost to a practice of \$40,069 per physician per year. Primary care practices spent \$50,468, compared to \$34,924 for cardiology practices and \$31,471 for orthopedics practices.⁷ They based this estimate on actual cost without considering the opportunity cost of what doctors and other personnel might have done with the time they spent capturing and inputting data.

Although the metrics may be well-intended, they don't always follow the real world of practicing medicine. Let's take the asthma medication ratio (AMR) metric.⁸ We categorize medications for asthma into long-term "controller" (steroid) medications used to maintain control of persistent asthma and short-term "rescue" (albuterol) medications used to treat acute symptoms. Appropriate ratios for these medications might prevent asthma-related hospitalizations, emergency room visits, missed work, and school days. The goal is not to overly prescribe rescue inhalers alone.

Here's the problem: patients rarely have only one rescue inhaler. Some of my best-controlled asthmatics—who will never need controller medication—keep a rescue inhaler at home, in the car, at school, and at work. This metric would penalize me for not prescribing a controller inhaler. Even if appropriately prescribing the correct ratio of rescue and controller medications, they base this metric on claims data, which is what the insurance paid. As a physician, if I prescribe a patient one rescue inhaler and one controller to use each month, the claims data may show that within six months, the patient filled the rescue medication six times and the controller medication only twice. This makes the AMR equal to 0.25 (2 controllers divided by 2 controllers plus 6 rescue inhalers).

The same holds true when doctors order labs or screening tests on patients who do not follow through with the orders. If the metric being tracked by the patient's insurer is claim-based, doctors will not receive credit for their efforts. Physicians are inherently competitive and hate to score lower than their colleagues in any category, especially quality. In addition, more and more physicians are being financially incentivized to achieve quality goals, so missing targets negatively affect their income.

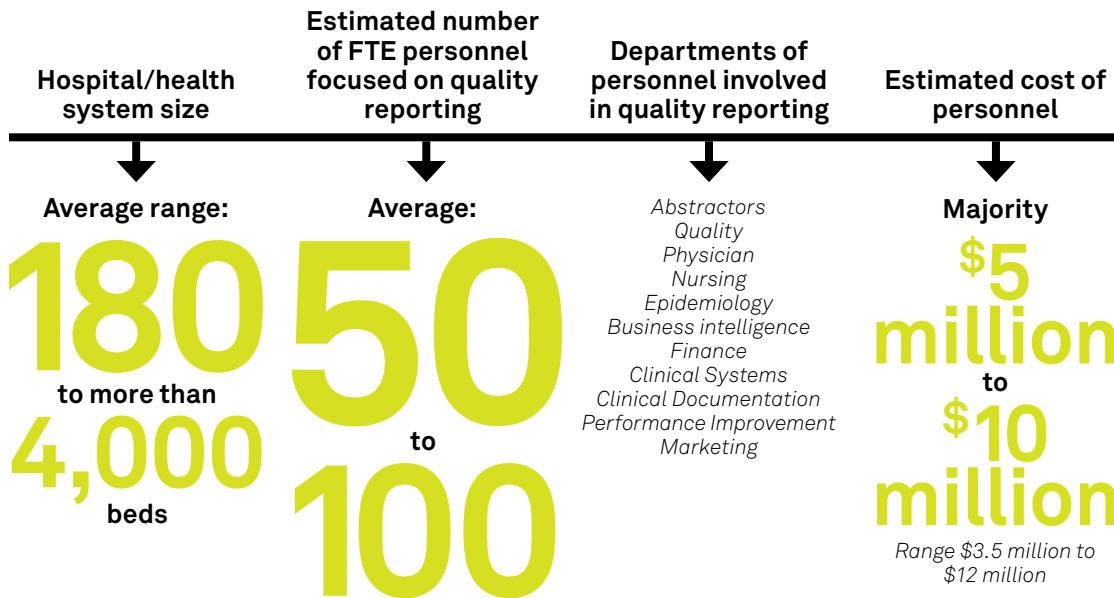


Doc-Related

Dr. Valenzuela's new book, *Doc-Related: A Physician's Guide to Fixing Our Ailing Health Care System*, takes us behind the clinic doors of today's ailing U.S. healthcare system. A medley of anecdotes, comics, and data-backed musings, *Doc-Related's* "truth-tellers" turn out to be a half-dozen characters you will surely recognize. The author has created them from his 20-year experience as a practicing family physician and health system executive. Whether you're one of the 16 million Americans who work in the U.S. healthcare industry or simply someone who has tried to navigate its bureaucratic maze of insurance plans or electronic record systems, *Doc-Related* will help you see these challenges in a new light. Available on [amazon.com](https://www.amazon.com).

Figure 1

Estimated Personnel and Cost Associated with Quality Metric Reporting



Source: National Academy of Medicine/Observations from the Field: Reporting Quality Metrics in Health Care

Are We Measuring What Matters?

With quality metrics, we only measure things we can track, not necessarily what matters to the physicians treating patients or to the patients themselves. Most of the metrics tracked, such as annual screening tests, are primary care focused. Many are SMART metrics—specific, measurable, achievable, relevant, and timely. Unfortunately, finding SMART metrics for each specialty can be challenging. This can leave some specialists tracking metrics with minimal significance to the care they provide.

Another challenge with tracking quality metrics is assessing whether they truly affect overall health. Despite being a \$3.6 trillion annual expense, healthcare delivery drives only 10–20% of health outcomes.⁹ Behavioral and social determinants of health—like having a job, eating right, not over-consuming alcohol, avoiding drugs, and hazardous behavior—play a much bigger role in overall health and longevity. However, they are not actively tracked.

Unintended Consequences

Although quality metrics are meant to improve patient care, reporting them can lead to negative behavior. The HEDIS measure for “avoidance of antibiotic treatment in adults with acute bronchitis” is determined by whether physicians prescribed antibiotics for seven ICD-10 diagnosis codes showing acute bronchitis (J20.3, J20.4, J20.5, J20.6, J20.7, J20.8, and J20.9).¹⁰ The way physicians get around this is by prescribing antibiotics using different ICD-10 codes that describe bronchitis symptoms, like cough (R05). Similar concepts apply to

two other HEDIS metrics related to avoiding antibiotic prescribing for upper respiratory infections and ear infections.

Quality metrics and report cards can also lead to “cherry-picking” patients more likely to follow clinical recommendations. Because physicians value their reputation, they may be “risk averse” and avoid operating on patients with multiple chronic conditions who might be high-risk. Many of those patients will never undergo needed treatments. Physicians may refer some to other care centers who will then be responsible for the quality metrics.

Ways to Fix Metrics

The easiest way to improve quality metric reporting is to cut down on the number of metrics. One of my biggest healthcare idols is Dr. Don Berwick. He’s a pediatrician, former Administrator of the CMS, and former CEO of the Institute for Healthcare Improvement. Berwick believes we need to stop excessive measurement and reduce all metrics by 50%. He’s not the only expert who supports this concept. A study by the National Academy of Medicine outlined key themes we should use to improve our reporting system.¹¹ Below are a few of those themes:

- ▶ We should target improvements that impact how we care for patients in the present. Most of what we measure has a one- to two-year time delay. This time delay limits the benefit of performance feedback in making improvements and changing physician behavior.
- ▶ We need to get all the entities requesting quality metrics to align and standardize their definitions. We should have one

standard for each metric, not variances depending on the accrediting organization or insurance company. By definition, we should all be following the best practice for each condition.

- ▶ We should design EHRs to more easily collect and report metrics. Instead of putting the burden of data collection on healthcare providers, we should mandate that all certified EHRs abstract reporting data. Taking it one step further, we need to push for more interoperability, so the EHRs talk to each other. This will allow us to track metrics performed outside of individual care centers and decrease redundant testing.
- ▶ We should move away from quality metrics derived from billing and administrative systems. We should not penalize physicians and clinicians for doing the right thing, only to have the patient not follow recommendations.

Besides the recommendations above, we need to develop quality metrics that are specialty specific. All physicians should have the ability to develop quality metrics that matter to them. “Choosing Wisely” is an initiative of the American Board of Internal Medicine (ABIM) Foundation that promotes patient-physician conversations about unnecessary medical tests and procedures. The program launched in 2012 and includes 54 specialty societies and 17 consumer groups.¹² Choosing Wisely now has over 550 recommendations developed by clinicians for clinicians. A few examples include not performing MRIs of the peripheral joints to routinely monitor inflammatory arthritis in rheumatology and avoiding opioids

for migraines, except as a last resort in neurology.

In addition, we need to incorporate metrics that matter to patients and impact overall health. The greatest way is by addressing social determinants, which make up from 80% to 90% of a person’s overall health.¹³ Examples include opportunities and resources in homes, neighborhoods, and communities, along with the quality of our schooling, the safety of our workplaces, and the cleanliness of our water, food, and air. By shifting the roughly \$15 billion physicians spend reporting metrics annually to target social determinants, we can institute programs that matter.¹⁴

Last, there are more than 318,000 health apps available today, with more than 200 apps being added each day.¹⁵ We should require EHR vendors to allow third-party technologies to help clinicians better understand patient behavior. These technologies will also help patients take control of their overall health and well-being.

By reducing the number of metrics we track, eliminating variation in metrics, and making it easier to gather data by leveraging technology, we can save billions of dollars to be used for more meaningful programs that better serve our patients. By developing metrics that truly make a difference, we can improve overall health and outcomes. **GRU**

Peter Valenzuela, M.D., M.B.A., is a nationally recognized physician leader, cartoonist, and educator. He specializes in family medicine and is chief medical officer at Mercy Medical Group in Sacramento, California.

References

1. D. Blumenthal, E. Malphrus, and J.M. McGinnis. 2015. *Vital Signs: Core Metrics for Health and Health Care Progress*. Washington, DC: National Academies Press.
2. N.E. Dunlap, D.J. Ballard, R.A. Cherry, et al. 2016. Observations from the Field: Reporting Quality Metrics in Health Care. NAM Perspectives Discussion Paper. Washington, DC: National Academy of Medicine.
3. A. Higgins, G. Veselovskiy, and L. McKown. 2013. Provider Performance Measures in Private and Public Programs: Achieving Meaningful Alignment With Flexibility to Innovate. *Health Affairs*, 32(8). Accessed December 20, 2021 at [healthaffairs.org/doi/10.1377/hlthaff.2013.0007](https://doi.org/10.1377/hlthaff.2013.0007).
4. A. Agarwala, A. Anurag Mehta, E. Yang, and B. Parapid. 2020. Older Adults and Hypertension: Beyond the 2017 Guideline for Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults. *American College of Cardiology*, February 26, 2020. Accessed December 20, 2021 at acc.org/latest-in-cardiology/articles/2020/02/26/06/24/older-adults-and-hypertension
5. A. Higgins, G. Veselovskiy, and L. McKown. 2013. Op cit.
6. L.P. Casalino, D. Gans, R. Weber, et al. 2016. US Physician Practices Spend More than \$15.4 Billion Annually to Report Quality Measures. *Health Affairs*, 35(3). Accessed December 20, 2021 at healthaffairs.org/doi/full/10.1377/hlthaff.2015.1258.
7. Ibid.
8. National Committee for Quality Assurance. 2021. Medication Management for People with Asthma and Asthma Medication Ratio (MMA, AMR). Accessed December 20, 2021 at ncqa.org/hedis/measures/medication-management-for-people-with-asthma-and-asthma-medication-ratio.
9. Centers for Medicare and Medicaid Services. 2019. CMS Office of the Actuary Releases 2018 National Health Expenditures. Press Release, December 5, 2019. Accessed December 20, 2021 at cms.gov/newsroom/press-releases/cms-office-actuary-releases-2018-national-health-expenditures.
10. Centers for Medicare and Medicaid Services. 2019. Quality ID #116 (NQF 0058): Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis. Accessed December 20, 2021 at app.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2019-Measure_116_MIPSCQM.pdf.
11. N.E. Dunlap, D.J. Ballard, R.A. Cherry, et al. 2016. Observations from the Field: Reporting Quality Metrics in Health Care. Discussion Paper, National Academy of Medicine, July 25, 2016. Accessed December 20, 2021 at doi.org/10.31478/201607e.
12. Choosing Wisely. 2021. All data and guidelines referenced about Choosing Wisely is located on their website at choosingwisely.org.
13. S. Magnan. 2017. Social Determinants of Health 101 for Health Care: Five Plus Five. Discussion Paper, National Academy of Medicine, October 9, 2017. Accessed December 20, 2021 at nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five.
14. L.P. Casalino, D. Gans, R. Weber, et al. 2016. Op cit.
15. IQVIA Institute. 2017. The Growing Value of Digital Health. Accessed December 20, 2021 at iqvia.com/insights/the-iqvia-institute/reports/the-growing-value-of-digital-health.