Does what’s measured improve care?  

BY ANDREW TELLIJOHN

When Mayo Clinic learned that its baseline surgical site infection rates related to gynecologic cancer surgeries were in the bottom 10 percent of the country between 2010 and 2012, the organization implemented a bundle of interventions aimed at improving those results.

Changes included requiring staff glove changes for fascia and skin closure, dressing removal at one to two days following the procedure and a follow-up nursing phone call after discharge.

Within a year, Mayo had gone from the bottom 10 percent in national rankings to the top 20 percent. At 18 months, it reached the top 10 percent in the country.

“This is a good example of how following outcomes can identify areas for improvement,” says Sean Dowdy, MD, division chair of Gynecologic Oncology at Mayo Clinic. “These outcomes can improve if you have the will, the resources and surgeons who are willing to face up to their shortcomings and change old habits.”

More recently, Mayo Clinic was facing challenges with higher-than-average infection rates related to clostridium difficile and surgical site infections after colorectal surgery. After quality measurement readings in 2018, Mayo performed a root cause analysis to determine why the rates were high, then put in motion a series of interventions aimed at reducing those incidents.

“Both interventions have been successful and our rates are now at or below average nationally,” says Dowdy, who also is the Midwest vice-chair of Quality and Affordability.

NOT ALWAYS THE RIGHT MEASUREMENTS

When the health care system became more intentional and organized in measuring quality over quantity more than a decade ago, many stakeholders celebrated the

“I learned that no one really knew what the previous quality people did,” she says. “At Southside, it was always behind the scenes.”

Which doesn’t mean that performance on quality measures wasn’t being logged and reported—as a Federally Qualified Health Center, Southside is required to report quality measures each year to the Health Resources Services Administration and to MN Community Measurement. It was just that people within the health care organization didn’t necessarily know how Southside was doing.

“As I was learning, it was natural for me to go, ‘Gosh, I need to see where we’re at,’” says Palmer. “We don’t know what we don’t know, if we’re not looking at these numbers.”

She started with screening for colorectal cancer. Southside reported that 47 percent of its patients were being screened. “I think a lot of people look at quality metrics and think of them as something we have to do, and they look at 47 percent and it’s a little bit of a beat down, we’re not doing

WHY MEASURE QUALITY?

To improve patients’ lives

When Alyssa Palmer took on the quality measurement job at Southside Community Health Services in Minneapolis two years ago, she asked her new colleagues what they expected.
Among the less useful metrics, Dowdy says, are measuring “discharge to home” and treatment of sepsis. With sepsis, many interventions are tracked to determine whether the patient received appropriate care, but multiple studies have shown that such measures do not necessarily correlate with better outcomes. “We are, nevertheless, evaluated on whether or not we perform them. In some instances, performing all the required interventions would not be in the patient’s best interest.”

Measurement organizations, Dowdy says, also often inappropriately penalize care providers for discharging patients to somewhere besides their homes.

“The discharge to home metric assumes that if a person is admitted to the hospital from home, but is discharged to a skilled nursing facility, that some lapse in care occurred during the hospitalization,” he says. “In fact, discharge to a skilled nursing facility in the vast majority of instances is a marker for high-quality and safe care to assure optimal functional recovery.”

Dowdy says in many cases elderly patients are living alone inappropriately.

Once the patient is admitted to the hospital, their family, together with caregivers, may jointly decide the patient is not safe at home and would benefit from supervi-

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well,” she says. “Whereas I look at it and go, ‘Gosh, 47 percent, that means half of our patients are missing this opportunity to be screened. What can we do to make it better?’”

Palmer shared the numbers with staff. They discovered that it wasn’t a matter of clinicians not ordering colorectal cancer screens, but of patients not returning their kits. With a few relatively small changes to the system, Southside increased colorectal screening to 61 percent of its patients by the end of the year.

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“That was the perfect door to being able to show our staff and our clinicians that this is what we can do, this is why we get those numbers,” Palmer says. She shares quality measurements with staff every month, “but I tell them that these numbers are for me to worry about, as the quality director. You guys just need to worry about taking care of patients. If I notice a trend in the wrong direction, then I’m going to come to you guys and we look at the system and where we need to tweak.”

Palmer understands why the idea of measurement can feel like a burden to clinicians, but she’s very nearly a cheerleader for it. “From a clinician’s viewpoint, they really just want to take care of their patients, and then all of a sudden, there are all of these checkboxes being thrown at them,” she says. “When we feel like we’re being told what to do with every single patient, we replace intent with fear, we worry about payment, we worry about those measures not being where they need to be. We get so caught up in the idea that we have to do this, or that someone else is telling us we have to do this, that we forget our own stories about why we’re doing it.”

In 2018, Southside needed to improve by at least 5 percent on three specific quality measures—depression screening, controlled hypertension and uncontrolled diabetes (where a lower score is desired) as part of the Federally Qualified Health Network in the metro area. Palmer put together three focus groups that included representative staff from physicians to front desk staff. “It was my way of being able to share with people who were not historically familiar with quality measures—some of them didn’t even know what we were measuring—and for them to get involved and engaged.”

The focus groups looked at the numbers, and then brainstormed ways to improve not only the way they did things but, most important, patients’ health.

The result: Southside met or exceeded the 5 percent improvement goal on all three measures—and attained an HRSA gold-level Health Center Quality Leader status for its clinical quality improvement in 2018. That means that of roughly 1,400 community health centers in the nation, Southside is in the top 10 percent. —LINDA PICONE
on us on a quarterly, semi-annual or annual basis and we have to try to keep up,” Peterson says. “We’ve got systems in place to deal with those changes, but this quality reporting does cost a lot of money and none of it is reimbursed.”

St. Luke’s has had to add staff in its quality and patient safety, patient experience and information technology areas and also spent significantly on more sophisticated IT systems, Helgeson-Britton says.

The investments have resulted in the ability to get consistent measurements on how the group’s performance lies in comparison with other health care organizations. And St. Luke’s values the purpose of the measurement. “We believe in the need for transparency for how we perform for our patients,” Helgeson-Britton says.

The low volume of patients and small staff at Cook County North Shore Hospital and Care Center in Grand Marais, presents unique challenges for quality measures.

Kimber Wraalstad, CEO and administrator, says the organization has about 150 employees. Four of them handle collecting and submitting data, although none of them do it full-time. In fact, the department manager who is predominantly responsible for data might spend only about one-eighth of her time on it.

“Could it be more? Yes,” Wraalstad says. “I think she sometimes feels overwhelmed, particularly when somebody says ‘here’s another piece of data to gather.’”

The organization, which acts as hospital, nursing home, home care agency and ambulance service for Cook County, struggles at times to interpret what data is being sought and the degree to which a small number of misses can affect its own scores. She cited flu shots as an example of a measure where goals are high, but numbers skew quickly when just a few patients don’t get the treatment.

“As a small rural organization, we sometimes don’t have the volume with which to look at some of the measures,” she says.

But, she says, the organization is committed to using data to better itself. “That’s how you learn. We all want to get better. We all want to do it because we care about the people we are taking care of.”

**MN COMMUNITY MEASUREMENT**

Julie Sonier, president of MN Community Measurement (MNCM), says there are outlets of communication in place that health care providers can use if they want to add, alter or change a measure. Doing so requires input from multiple perspectives, including providers, health plans, employers and consumers.

MNCM is an independent nonprofit that collects and publishes measures of health care quality and cost, focused primarily on clinic and medical group performance.

“Much of the feedback that we receive about measurement from health care providers is more general, rather than being about specific measures, and it is about the overall burden of measurement and the need for greater alignment of measures being collected by different entities,” she says. “We’ve been working hard on these pain points.”

She acknowledges that measures change over time, both as clinical evidence changes and in response to feedback from users. Depression measures, for example, have changed to allow for a longer window of measuring whether follow-up care is being provided. Feedback from providers also helped identify problems with a national measure for colorectal screening.

“MNCM was able to successfully advocate with the national measure steward for changes that address this problem,” Sonier says.

In the last two years, MNCM has launched an effort to make data on quality timelier and more actionable while reducing the collection burden. Work also is underway on an effort involving health plans and providers that will standardize and streamline data flows “in ways that will make data less fragmented and more actionable, and set Minnesota up for success in value-based care.”

Still, Sonier cites statistics in several key areas as proof that measuring quality is working. In 2004, for example, only 12 percent of diabetic patients in Minnesota were receiving optimal care, compared with 45 percent now. The percentage of adolescents who receive mental health screenings at well-check visits has increased from 40 percent to 86 percent since MNCM introduced its measure in 2015. Follow-up assessments at 12 months with patients who have depression have increased from 17 percent to 30 percent.

“We know that measuring and reporting on health care quality makes a difference,” she says. “Health care providers tell us they use our data extensively to understand how they compare to others and where they have the biggest opportunities for improvement. And we know that data drives change.”

**CONSULTANTS OFFER OBSERVATIONS**

Daniel K. Zismer, PhD, professor emeritus at the University of Minnesota’s School of Public Health and current co-chair and CEO of Associated Eye Care Partners, says those who establish quality measurements could take years and years attempting to find consensus on where to start in order to satisfy every stakeholder, or they could pick some, start measuring and adjust as feedback arrives.

“You have to start somewhere,” he says. “There have been decades worth of argument on what is quality. And that argument really doesn’t get anybody anywhere.”

He hears frequently about small organizations struggling to keep up in a market becoming increasingly dominated by well-capitalized, large health care organizations. Those larger organizations spend the money to make sure their systems communicate, which he says means better care for patients.

“The care for individuals is becoming less fragmented over time, which really has had an extraordinary effect on quality,” Zismer says. “If you want to swim upstream against that, you have the perfect right to do so, but if you are going to remain relevant and included in certain markets you’ve got to be prepared to play at a very high level or take the consequences.”
At this point, says Arnold Milstein, MD, MPH, a professor of medicine at Stanford University and director of its Clinical Excellence Research Center, the quality movement is making progress. “Though the direction is positive,” he says, “its yield could be higher if performance measures better addressed the main reason people subject their checkbooks and bodies to health care—whether they function better physically, mentally or emotionally after treatment.”

Health care providers themselves, if they strongly disagree with the currently established data sets, could take matters into their own hands by collecting before, during and after treatment surveys from patients on the improvement—or lack of improvement—in their ability to function. The data could be collected in person or via smart phone. But so far, Milstein says, it’s been hard to make “patient-reported outcome measurement” routine in the United States, despite early success in some Scandinavian countries.

**WHAT’S GOOD, WHAT’S NEXT?**

Organizations are asked to collect and collect some more. Then what? “We have more data than we know what to do with,” Bergeson says. “There’s tons of data on individual clinicians and hospitals and different groups. The question is how do we use it in meaningful ways? There is still the need to make data actually meaningful rather than just data, something that can actually be used to improve things.”

He agrees that collecting data for measuring quality has been a good first step, and says the next step is to engage and work collaboratively with clinicians to decide on the initiatives to improve care. If it is diabetes, then clinicians will be needed to develop new standards for diabetes care. Eventually, algorithms will be created for best practices for advancing medications and standards for staff to order necessary lab according to a protocol. With these algorithms, improvement becomes hard-wired; it’s easy to do the right thing.

Bergeson says he’s eager to see how quality measurement evolves and he hopes it starts moving away from collecting hundreds of data points and more toward interventions when necessary.

For instance, patients with diabetes need to have access to the right food. “If diet is part of getting diabetes under control and you don’t know if they have trouble getting enough food, then that’s something you should know,” he says.

What Bergeson would like to see is care providers finding ways to take existing data and then adding information about patients who face some kind of disadvantage due to their employment, family or other situations so their care can be improved. That, he says, would help take measuring quality to the next level.

“What we’re all struggling with right now is how we get information into our systems that would show us our patients at highest risk,” he says. “So, it’s not just who are our patients that are in poor diabetic control, but who are our patients in poor diabetic control who don’t have the resources or tools to help themselves.”

**MMA VISION COMING SOON**

Doug Wood, MD, medical director for the Center for Innovation at Mayo Clinic, where he also is a consultant in cardiovascular diseases, is the immediate past president of the Minnesota Medical Association. During his tenure, the MMA’s board convened a work group to look at where quality measurement might go next.

“When quality improvement methods began to be adopted in medicine, there was a good deal of emphasis on how we measure processes and outcomes,” he says. “That was appropriate and important because it was necessary to get medicine to think about how it could more consistently perform, especially when we saw evidence that certain processes were not consistent and needed to be better.”

In some situations, it has resulted in improvements. Measures, for example, have improved the treatment of hypertension and diabetes by making sure people are getting examined and taking medications. That said, Wood adds, there’s a need for change going forward. The Government Accountability Office in September issued a report indicating that the Centers for Medicare & Medicaid Services have not done a good job of tracking program funding or whether quality measures meet goals.

Additionally, despite a focus on measurement, there has not been improvement in areas like life expectancy, obesity, disparities on several socioeconomic factors and the overall health of those in the United States, Wood says.

Wood says the MMA has closely examined a 2015 National Academy of Medicine report, “Vital Signs: Core Metrics for Health and Health Care Progress.” The report challenged the effectiveness of current measurement efforts, noting that measurement “as a whole is limited by a lack of organizing focus, interrelationship and parsimony in the service of truly meaningful accountability and assessment for the health system.” The report further recommends concentrating on 15 “core” measures that would focus on decreasing the burden of collecting metrics while improving outcomes.

“The thing we are missing is a way to look at health as an outcome and all the factors that are important to it,” Wood says. “Medical practice affects only a portion of the outcome of health. To expect, then, that we should spend lot of time and money and effort measuring, especially, processes that might not produce results means it’s time to think about a different way of examining how you achieve health and what measures you use.”

That might include shifting the focus from processes to achieving outcomes. With diabetes, for example, the focus so far has been on diabetes care, ignoring proven methods for preventing diabetes in the first place. “They haven’t really been used because payment has not been aimed at prevention,” Wood says.

The working group will issue its recommendations to the board in November.

“What we’re thinking about is how we advance the important task of measurement in a way that will help us make sure Minnesotans are among the healthiest people in the country,” Wood says.

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DATA-DRIVEN APPROACH AT RCHC PAYING DIVIDENDS NOW AND IN THE FUTURE

RC Hospital and Clinics (RCHC) has a partnership with PrimeWest Health, the Medicaid provider for Renville County as part of the Accountable Rural Community Health (ARCH) program that has helped improve care quality and reduce health care costs in rural Minnesota.

RCHC had screening measures to meet in five different areas: mammograms, A1C blood tests, human papillomavirus, asthma and a post-discharge medication reconciliation review.

“When we initially started the program, we were surprised our numbers were not where we want them to be,” says Jennifer Kramer, RN, lead nursing care coordinator on the RCHC’s Population Health Team.

By having care coordinators reaching out individually to Medicaid patients who weren’t getting screened, RCHC was able to change some of its processes and get more of those who need screening to show up. “Last year we successfully met all those quality measures for them,” Kramer says.

Although the initial efforts were focused on Medicaid patients, Kramer says that after studying the processes that worked and those that didn’t, the organization was able to roll changes out to the entire organization.

More recently, says Carly Kubesh, RN, quality improvement specialist on the Population Health Team, the system implemented a change that has diabetic educators looking at patients with A1C blood test results above an 8 and automatically referring them for a consultation.

The organization, Kramer says, likely would have made the changes eventually, but using the measures to do so allowed for a better approach.

RCHC has a number of quality-related projects taking place at any given time and, in a smaller organization, it can be tough having enough resources to spread across them all. “We don’t have a lot of staff, so a lot of us wear multiple hats,” Kubesh says.

The organization also can be challenged by regular changes to Epic, the electronic medical record program it uses, or by having patients that go to other care facilities that are on different versions of that program or different programs altogether that don’t communicate, says Michelle Erikson, Epic optimizer on the Population Health Team. She works with care providers to ensure that those records are entered the proper way to save time and add a layer of efficiency to the collection process.

The organization takes a “care team” approach, with a multidisciplinary group of people including doctors, clinic nurses, health coordinators, scheduling and hospice representatives and others as appropriate, meeting monthly with the Population Health Team to discuss data, approaches that are working or not working and how they can collaborate, Kramer says.

Rob Kemp, MD, family practice physician, says there is a “long game” at play with a lot of the data-driven changes at RCHC. Much of the approach is preventative care and preventative medicine that, for instance, will prevent diabetes patients from having strokes or experiencing kidney failure. Those results don’t always show up right away.

“There’s not always immediate gratification where we do this and we see a few days later that all of a sudden, things have improved dramatically,” he says. “We’re in this for the long haul.” — ANDREW TELLIJOHN