# Editorial

## Quality Measures: Do They Really Measure Quality?

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The Health Reform Bill passed by the Senate has directed attention to the importance of measuring quality and value in medicine. The public demand for greater accountability and public reporting of quality data has increased, and corporate America has joined the push for quality measurement. The big question is will the push really be for better quality or simply for cost containment?

In the absence of high-quality published evidence that quality measurement itself improves patient outcomes, some have questioned if the resources spent on quality reporting would be better spent on actual delivery of healthcare. It is impossible to deny that the tide has shifted. Quality measurement and assessment of cost effectiveness is here to stay and the push for objective measures of quality will only continue to grow. The challenge is how we will respond as a specialty. Are we willing to be marginalized, or will we remain active participants in the house of medicine?

We can expect an increased emphasis on the measurement of quality, patient satisfaction, and outcomes in our practices, but serious questions remain regarding what constitutes appropriate quality measurement. Many of the "quality" measures put forward by payers have really been measures of cost efficiency rather than quality of care. Measures of cost efficiency are notoriously problematic with regard to risk adjustment. Physicians who are willing to care for the sickest patients can appear to be the least cost efficient. Similarly, changing disease prevalence can drive utilization. Dermatologists should not be blamed for rising rates of skin cancer or for providing care to patients with the most complex tumors. As the incidence of skin cancer increases, utilization of advanced surgical techniques will follow, which should be taken into account. We need data demonstrating the increasing prevalence of skin cancer as well as the proportion of complicated tumors. Hard data are best to counter attempts to cap payments because of increased utilization.

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Critics are quick to point out that quality measurement itself has yet to be scrutinized with a rigorous evidence-based approach. Certainly the science of validation of quality measures remains in its infancy, and the standards of evidence accepted often are weak compared to what we would require as level of evidence in support of medical therapy. Nonetheless the push for quality measurement shows no sign of abating. As a specialty, it is advantageous to remain part of mainstream medicine. Many payers are beginning to tier physicians based on quality or measures of cost, and there is a growing demand for some form of public reporting to allow informed consumers to choose between physicians.

Physicians are likely to find that it is to their benefit to report quality measures to qualify for top-tier payments and to avoid higher co-pays for their patients. As maintenance of certification and maintenance of licensure requirements begin to affect more of our members, we will see increasing requirements for quality reporting from all sides. The challenge for the American Academy of Dermatology is to create a broad array of evidence-based guidelines and quality measures that members can voluntarily use to improve patient outcomes and participate in voluntary quality-reporting programs.[1] If we do not have nationally accepted quality measures for dermatology, members will be subject to a dizzying array of measures created by payers. One can easily see a dermatologist who participates in 10 insurance plans being held to 10 different quality measurement standards, each with its own burden of reporting. It is to our benefit to have a single set of measures accepted by all plans. The standards for such measures are continually being raised and the menu of measures has to encompass all aspects of dermatologic practice so all members can choose relevant measures if they wish to report.

Poorly crafted quality measures create perverse incentive to avoid sicker patients and cherry-pick those patients more likely to experience good outcomes.[2] Payers are quick to defend their practices and explain that they risk adjust to account for differences in case mix, but risk adjustment is prone to error and the methods of risk adjustment

should be disclosed and transparent.[3] Physicians should not be afraid to question the methods used for risk adjustment. In general, payers should be held to the same standards of transparency and public disclosure to which physicians are held. The American College of Surgeons has adopted standards for risk adjustment that have been successfully used in their National Surgical Quality Improvement Program.[4]

Measurement of patient access is a particularly touchy subject for dermatologists. Rewarding physicians for offering appointments within 30 days can have the perverse effect of causing patients beyond the 30-day mark to be abandoned in favor of a patient who could still be seen within the required 30 days. Measurements of improvement in access are better than set targets.

When done correctly, measurement provides a stimulus to improve patient safety and outcomes. The first step in designing an appropriate and effective quality measure is to determine where there is the greatest opportunity for improvement.[5] Measures receive the broadest acceptance when they are based on current, vetted, evidence-based best practice guidelines that have been validated and shown to improve patient outcomes. Best practice bundles are groups of steps that would all take place in optimal patient care. It can be valuable to measure how often each one of those steps is performed as well as how often all steps in the bundle are performed. Organizations such as Geisinger Health System have demonstrated that improved consistency in patient care can translate to better patient outcomes.[6,7]

While measurement of outcomes often is promoted as the gold standard in performance measurement, it also has the greatest risk for creating perverse incentive for physicians to abandon needier patients or take unnecessary risks. For example, incentive payments for better control of psoriasis could encourage the use of more expensive or riskier therapy. Process measures encourage best practices with less potential for perverse incentive but do not necessarily translate to improved outcomes. Structural measures often are the focus of performance improvement plans for dermatologic practices. Structural measures include creating standardized procedures to ensure that all surgical assistants follow aseptic technique, setting up a tracking system for biopsy specimens, or setting up a standard system to ensure accurate specimen labeling.

Improvements in patient safety benefit both the patient and the physician. The patient safety issues most relevant to dermatology include labeling and tracking of biopsy specimens, as well as avoiding delayed diagnosis of malignancy, adverse drug reactions, and surgical complications. Dermatologic surgery enjoys an exceptionally low complication rate, so demonstration of statistical improvement in outcomes can be a challenge. The "low-hanging fruit" for quality in most dermatologic practices is biopsy accountability. Many errors relate to inadequate documentation of the exact site of the biopsy and mislabeling of specimens. Switched specimens are much more common than lost specimens but can have equally devastating effects. Failure to receive or act on reports also can result in patient injury.[8] Dermatologists can improve patient safety in their practices by targeting any of these areas. It is important to measure outcomes to determine if the changes enacted are really accomplishing their goals.

Although most quality measures focus on the physician or members of the office staff, those measures that may have the greatest potential for improved outcomes are patient centered. Therapeutic failure often relates to poor patient compliance rather than an inadequate treatment plan. Efforts to promote greater patient compliance can have far-reaching benefits.[9,10]

Most dermatologists practice in small or solo practices and are just starting to adopt electronic prescribing and electronic health records. Whenever possible, the burden of data collection and reporting should be minimized by the use of technology and there should be government incentives to offset the cost of adopting the technology.

We cannot afford to leave development of quality measures to payers. Rather, appropriate measures of quality should be developed by physicians to benefit our patients. We are the ones who understand our field and can develop measures with real potential to improve the quality of care. To be nationally accepted, the measures need to be based on current vetted evidence-based guidelines of care and must address documented gaps in care. We are a smart group and will rise to the occasion. Anyone who has ideas for quality measures appropriate for dermatology should contact Samantha Sheridan (ssheridan@aad.org) or Alison Shippy (ashippy@aad.org) at the American Academy of Dermatology.

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