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Session: Balancing Measures: Identifying Unintended Consequences of Diabetes Quality Performance Measures

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Molly: And with that, we are at the top of the hour. So I would like to introduce our presenter today. Just one second. So presenting for us today, we have Dr. David Aron. He is the director for the Clinical Program Research and Evaluation at the Louis Stokes Cleveland VA Medical Center and a professor of medicine and epidemiology and biostatistics at the School of Medicine and adjunct professor of organizational behavior at the Weatherhead School of Management at Case Western Reserve University. I’d like to thank him for joining us today and with that, Dr. Aron, I will turn it over to you now.

Dr. David Aron: Well greetings to everyone and all the ships at sea. I am delighted to be presenting this. It turns out it’s incredibly timely because a new consensus guideline came out which pretty much goes exactly against what I’m going to talk about. I’ll get to that later. The topic is Balancing Measures and I’m speaking on behalf of my, not only my colleagues who are listed here but all the folks who have been working on the hypoglycemia safety initiative in the VA for the past few years.

So first a disclaimer. What you’re going to hear are my opinions and plenty of them. You can see my various and sundry disclosures and there is no collusion, no collusion with Big Pharma whatsoever. I just thought you should be aware of that and this particular presentation is rated R for opining and sarcasm which may inadvertently seep in. Be discreet in your viewing but feel free to challenge anything that I say. [David.Aron@va.gov](mailto:David.Aron@va.gov).

So here’s the outline. I’m going to start with a cybernetic model of performance measurement which sounds pretty bizarre on the face of it. Then follow up with the history of some performance measures in diabetes, unintended consequences, balancing measures, homeostasis and some alternatives. I’m an endocrinologist by training so this homeostasis and cybernetic model is just part of my background.

So here’s a cybernetic system. It includes inputs which are sensed oddly enough by a sensor. Some processes take place. There is an effector which results in certain outputs and what’s key to a cybernetic system is that there is feedback. If you think about the beta-cell on the pancreas and since I’m talking about diabetes performance measures, what better to talk about than the beta-cell on the pancreas. There’s a glucose receptor on the beta-cell which is sensed and that signal is then translated into the production of insulin which works on target organs and maintains a certain level of blood glucose which in turn feeds back. So this is a very simple closed-loop system. This is what a normal person would do and this is what we’re trying to achieve in the ideal insulin pumps, a closed loop. Although mostly what we have now is open loop systems. Well if you expand that view, a key point here is the glucose is sensed and that level has to be compared to something. And that’s the set point. And based on the difference between the set point and what the sensor senses determines what happens at the effector level. And this is very similar to what’s going on in your thermostat at home. You set the thermostat for a particular temperature.

You can think about the cybernetic system of a physician responding to performance measurement. Physicians have sensors. We get audited, we get feedback. There are things that we can do with our effectors. Change medication, provide education and so on. And what we do with our effector is dependent upon the difference between what we sense and what the set point is. And you can think about a set point in this particular case as A1c as a measure for glycemic control.

So there are really two key issues here. The first is how effective is the feedback and the second is what about the set point?

So we know that feedback is only modestly effective and this is an example of clinical inertia. We sense that the A1c is too high. Forget about how we determine that or not. We sense that the A1c is high and then we say to the patient, well, let’s try diet for a little longer or something else. But we don’t change medication when medication is really indicated. And this is clinical inertia. And this clinical inertia can last for an awful long time. Now I do want to point out that the date for this particular slide is 2004 which pre-dates most of the diabetes performance measures. But lest you think that all is well in the world, let me show you some much more recent data from the Better Health Partnership which is a Cuyahoga County based initiative here in Cleveland. These are composite measures for diabetes care and that includes an A1c less than 8% in measure. You can see the percent meeting the standard on the Y-axis and the reporting period up through 2016. And while there has been remarkable progress in reducing the disparities, now African Americans and Hispanics are just as bad as Whites, but no worse, with the percent mean standards stubbornly resistant around 50%. So something is getting in the way.

So, the set point. So we can think of the set point as a way to diagnose inadequate glycemic control. Now if the set point is set too low, for example, we want the A1c to be less than six and a half. Then we will over diagnose inadequate glycemic control if you have an A1c of 6.6. And that will lead to overtreatment. If you set the set point too high, then you underdiagnose inadequate glycemic control and you undertreat patients.

So where does this set point come from. So here’s a little history of the A1c less than seven measure for diabetes and this was proposed in 2004 by NCQA and I’m quoting from some of their old material that two comprehensive diabetes measures assess whether members with diabetes have their blood pressure controlled to 135/85 and whether their A1c Levels are controlled to less than 7 percent, the nationally *accepted standard*. I put those in italics because it was not nationally accepted it was just nationally accepted by those they chose to listen to.

And the people they chose to listen to were those primarily coming from the American Diabetes Association and it was noted that this A1c less than seven measure was in line with clinical guidelines established by the American Diabetes Association and I would just to like to point to Qaseem’s paper in the Annals of Internal Medicine which weighted the different guidelines from American Association of Endourologists, American Association of Family Practitioners, American Diabetes Association, American Geriatric Society and a couple from Canada and U.K. and the VA and you can see that the VA’s guidelines were weighted much more highly than the ADA.

Well, there was a national campaign, a national public service announcement campaign sponsored by the Conference of Mayors in partnership with Aim. Believe. Achieve. The Diabetes A1c Initiative, trademark Sanofi Aventis. And this is a screen shot. They’ve taken this website down but thank goodness, I copied it when it was still there. And it was actually Sanofi Aventis that paid for this particular thing and further evidence for that is here’s who actually ran the campaign. It was a very well-known public relations company, Burson-Marstellar, among their clients was Halliburton. You may remember them. And in the second paragraph, Aventis wanted to create an initiative to address the growing epidemic of uncontrolled diabetes. I won’t tell you what Sanofi Aventis was marketing at the time. You can probably figure it out.

So, let’s get back to our cybernetic system here. We’ve got our physician with the sensor and the comparator and effector working with the patient with diabetes to result in outcomes of interest and let’s say A1c is our target here. The set point is influenced not only by professional societies and guidelines and things like that but it’s also influenced by the Quality Measurement Industry, which makes money based on coming up with guidelines. Big Pharma, Patient Advocacy Groups and Payers. Just as an aside, I’ll tell you a story that when I was on the committee that came up with the measures for diabetes for the Better Health Partnership and there was a lot of push, this was a number of years ago, to have an A1c less than seven measure and I fought tooth and nail and interestingly, the biggest push was coming with the members of the committee who were from the insurance companies. Interesting.

So a whole variety of stakeholders come up their idea of what is desired performance that influences what the set point is and with audit and feedback, that affects the physician. And we know that there are unintended consequences of performance measures. One of which in terms of patient care is inappropriate clinical care. Tunnel vision, you focus on one thing at the expense of everything else or you just focus on one measure and make sure you meet that and this is probably, I didn’t make a slide, but this is probably a great time to mention Campbell’s Law. Campbell’s Law comes from Donald T. Campbell, a social scientist. He came up with this in 1976 and it states; the more any quantitative social indicator is used for social decision making, the more subject it will be to corruption pressures and the more apt it will be to distort and corrupt the social processes it is intended to monitor. Think about that.

Well, could that happen? Well, one of the potential issues is if you have a measure where the set point is too low, you can overtreat people. And if you overtreat people with high risk of hypoglycemia, you’re more likely to get hypoglycemia. You diagnose undertreatment when the A1c is 7.1, you do something to lower the A1c, never mind that the coefficient of variance of A1c, conversion of variation of A1c is somewhere between 2 and 6 percent so an A1c of 7 could be anything from about 6.7 to 7.3 plus or minus. But putting that aside, you might overtreat and lead to hypoglycemia.

This is exactly what happened. Hypoglycemia is a common side effect especially with insulin and sulfonylureas and in high-risk groups and it leads to increases in hospitalizations. This graph shows data from Budnitz et al. on emergency hospitalizations for adverse drug events and you will see that insulin and warfarin are at the top and among all agents, all hypoglycemics and a couple of others are bad actors and in data by Lipska et al. on national trends in hospital admissions for hyperglycemia and hypoglycemia, more people are getting hospitalized for hypoglycemia nowadays than for ketoacidosis which was totally the opposite when I was a resident many moons ago.

Well with this increased frequency of hypoglycemia following promotion of intensive glycemic control, and that measure was A1c less than seven for everyone aged 18-74. No exclusions. Was it a black swan? The answer is no. It should not have been a black swan. It should have been completely anticipated. Now in response to a paper that Len Pogach and I wrote. Greg Pawlson who was the head of the scientific committee for NCQA and Tom Lee wrote it is important to note that the National Committee for Quality Assurance includes a strong advisory that 100% performance is not the goal and that clinical judgment should be used in applying a measure. It sounds like they’ve actually never worked for a healthcare system. Certainly not the VA or where anything less than a hundred is failure. To imply that clinicians would knowingly put patients in harm so they could perform marginally better than other physicians in a clinical performance measure, provides a rather dim view of medical practice. Anyone who is a doctor probably has a dimmer view of medical practice at mass.

So what we decided to do was assess what is it? Let’s ask the question, who are the people who are at particularly high risk for over treatment? Particularly high risk for hypoglycemia where overtreatment would be a serious problem. And we focused on the rather well-known risk factors for hypoglycemia.

Number one, taking insulin. Number two, taking sulfonylureas. Number three, taking both insulin and sulfonylureas. Number four, age greater than 75. Number five, chronic kidney disease and various other potential risk factors. And we looked at the amount of over treatment and it was rather extraordinary. Patients who met these criteria. Okay, and remember, they are all on insulin and/or sulfonylureas. Half of them had A1c’s less than 70. Now if you’re over age 75 and you’re on insulin and a sulfonylurea with an A1c less than six, and about 10% of people had A1c’s less than six, you’re at real risk for falling, fracturing a hip and so on. So this was really common. Overtreatment, potential overtreatment is really common. And I want to emphasize, these are people on insulin and sulfonylureas. We’re not talking about metformin, we’re not talking about dive control diabetes. This is the kind of variation we see in the VA. These are facilities with greater than a hundred patients with diabetes who met those criteria. You can see the networks. You can see in the darkest of the blue, the percent of patients with A1c’s less than six percent. I mean there’s in network B, there are a couple of facilities where 20% of the patients had A1c’s less than six. Pretty incredible. The A, B and C there show facilities which had relatively low levels of overtreatment that were significantly different than the rest of their facilities in the networks. So potential positive deviance.

Well what happened to the A1c less than seven measure? Those data by the way were 2009 data. Well it was piloted in 2005, then it was initiated in 2006 and then the ACCORD trial was stopped prematurely because of increased mortality in the intensive treated group. And in 2008 NCQA discontinued its measure of A1c less than seven for all patients with diabetes aged 18-74 and limited it to patients less than 65 with other exclusions in younger patients. Coronary artery disease and dementia. But A1c less than seven is still marketed widely by others. This is something I pulled off the internet in September and yesterday I got a copy or maybe the day before, of the American Association of Clinical Endocrinologists who recommended an A1c less than six and a half percent, with everybody saying that was optimal, of course if it could be done safely and in an affordable fashion. You might find it interesting to see what the Big Pharma connections are to the members of the consensus committee that came up with those.

Well meanwhile back at the ranch, Choosing Wisely was initiated by the American Board of Internal Medicine. And among its lists of five things that we could stop doing, American Geriatric Society came up with one that said avoid using medications to achieve Hemoglobin A1c less than 7.5%. In most adults aged 65 and older moderate control is usually better and reasonable targets would be seven to seven and a half percent in healthy older adults with long life expectancy and higher targets depending on life expectancy. If someone’s not going to live for six more months, whether they live, whether those six months are with a normal A1c or not is probably not particularly important. Coincidence with this was a national action plan to reduce adverse drug events sponsored by HHS, FDA, CMS, NIH, CDC, VA and among the drugs that was focused on, and the top two were warfarin and drug induced hypoglycemia.

So let’s just take a look at the evidence. We have ADVANCE, ACCORD and VADT showed serious hypoglycemia strongly associated with mortality. Although the association was strongest in the control arms and I don’t want to give anyone the impression that it is not just the A1c level but it’s also how you get there. The VA, in contrast to American Diabetes Association, has had stratified targets for A1c based upon comorbidities and presence of complications. If someone is already blind from retinopathy, keeping their A1c at an optimal level is not going to prevent further blindness and you can see the American Diabetes and the American Geriatrics recommendations below.

So there is some disagreement here and people can look at the same evidence and come up with different views. There’s nothing wrong with that as long as we agree on what the actual evidence is. Well in response to this, the VA launched the Choosing Wisely/Hypoglycemia Safety Initiative in 2014. A voluntary program and what was made available to all facilities and individual practitioners were lists of patients at high risk for hypoglycemia. A1c less than seven and on insulin and sulfonylureas who were aged 75 or greater or had renal damage with a creatinine greater than two, and those at high risk who were demented and any VISN site, or any VISN or any facility or any individual doc could receive a variety of support materials which were available on the internet. Still are, I looked.

So the data that I’m going to show you were funded by HSR&D QUERI and if you’re interested, this is really a sub-study that I’m going to talk about, but if you’re interested in the grant itself, the actual grant and the critiques, and I mean the real critiques of the initial submission, the concept paper, the revision, everything and all the critiques, you can find them all in supplementary files in this article in Implementation Science. It makes for a rather amusing reading. Once it was funded, it was a lot more amusing.

So the two objectives were to determine the impact of the VA’s initiative on overtreatment rates and also to determine if there was an unintended consequence of an increase in undertreatment rates. So, was focusing on overtreatment going to lead to less of an interest in undertreatment? So this is pre-test/post-test using cross-sectional VHA data from calendar years 2013 and 2016. The patients met the same criteria that I’ve already discussed and in 2013 there were 172 thousand patients roughly and in 2016, 167 thousand patients roughly that met those criteria.

Our outcome measures, the primary outcome was a rate of overtreatment defined as the proportions of patients in this group with A1c less than seven percent. So it was consistent with American Geriatrics Association where the Choosing Wisely Initiative is actually a little less stringent. And we also looked at secondary outcome measures, rates of A1c less than six percent and as a measure of inadequate treatment, A1c greater than nine percent, which has been a standard measure for many years. And here are the data. I have highlighted in red and now I’ve just remembered after I’ve gone through almost all my slides that I can use the pointer. But if we just look at A1c less than seven, 40% of these high-risk patients had A1c’s less than seven which dropped modestly in 2016. Nine percent had A1c’s less than six which also dropped a tad and with paired t tests, these are all significant at a fairly high level but that’s not difficult to do when you’ve got 170 thousand patients. A1c great than nine percent actually rose a little bit. And you can see that they’re very wide facility ranges, very wide.

We then looked at the correlation between overtreatment and undertreatment and it was an inverse correlation. So, the more people who were undertreated, the higher the overtreated. And we also looked at the percent changes, sorry, the absolute changes which were also inversely correlated and highly statistically significant and because there were considerable baseline differences, we looked at the relative year to year changes and those were also highly correlated. So, this is what it looks like. And I’ve made rather elaborate X and Y-axis titles so basically you want to be in the green, green area which is here. This is lower overtreatment and lower undertreatment. This is lower undertreatment and higher overtreatment. This is higher undertreatment and higher overtreatment. You really don’t want to be here. And this is lower overtreatment and higher undertreatment.

But what you see is this correlation which is statistically significant and here’s looking at the relative change, it’s equally significant. In other words, the more you overtreat, the more you undertreat. So, what’s going on? Well, promotion of undertreatment, overtreatment reduction may be associated with an increase in undertreatment in patients with diabetes. And this is, in a way, a simplified double-cybernetic model where if you focus on one, focus on overtreatment, you ignore undertreatment which leads to increased undertreatment which then you may find you’re getting beaten on to focus on undertreatment and then ignore overtreatment and so on.

Now for the limitations. The VA, of course, is a single health care system albeit a particularly large one. Pre-test/post-test design is susceptible to changes in secular trends and all the forces affecting over and undertreatment rates in the VA could differ from those in the private sector. And the magnitude of the changes is modest and the statistical significance may exceed the clinical significance. Now this idea of balancing measures is nothing new. This is what homeostasis is all about and if we go back to the pancreas, we not only have beta-cells which respond to high glucose, we have alpha-cells which make glucagon that respond to low glucose to maintain glucose level within a range.

So these are, homeostasis is a tendency towards a relatively stable equilibrium between interdependence elements. So this is perfectly nice. So balancing measures is something to think about. An alternative measure is to think about keeping an A1c within a range. So think about anticoagulation. Ideally, we want the INR to be within a particular range. We don’t want it to be too low where the patient has an increased risk of clotting. We don’t want it too high where the patient has an increased risk of bleeding. You want it to be, you know, just right.

So, Len Pogach and the rest of us came up with this In Range and Out of Range measure. The In Range would be between seven and a half and eight and a half, and Out of Range would be a combination of less than seven and greater than nine, and remember these various measures are going to apply to particular people. If we’ve got a newly diagnosed, young type I diabetic with a long life ahead of her, we want to keep her, we want her to maintain an A1c that is, that’s basically as close to normal as it can be safely done. And if we ever get to closed loop systems, we might be able to keep it absolutely normal. So we proposed this as well. It has not taken off to say the least. And as I end here, being in my advancing years, this has been quite a long quest for Len Pogach and me to try to bring some reason to the use of performance measures. And we talked about balancing measures eight years ago now and have been sailing against the wind for a long time. But it has definitely been quite an interesting quest.

So in summary, actions have consequences. Both intended and unintended and parenthetically, the unintended consequences are not always bad. They may actually be good. I just present an example of one that was bad. The implementation of an improvement initiative or a performance measure are actions. When adverse unintended consequences can be anticipated, and I think these could have been, it is incumbent upon systems to include mitigating actions such as counterbalancing measures to ensure that unintended harms are avoided.

And I cannot help but tell a little story about when I met the person who was, I believe he was a scientific director at NCQA at the time. This was before Greg Pawlson and I was at a meeting and the A1c less than seven measure had been out for maybe six months or so by then and I went up to him and I asked him, have there been any problems with patients getting hypoglycemic? And he said, no, no problems at all. I said that is fantastic. How are you measuring it? Oh, we’re not. Okay, well you know if you don’t look for it, you’re certainly not going to find it. I don’t think this was a black swan. I’ll leave the slide for those who like to download slides to show all the various ways that the value of performance measurement can just leak away. And we do this really well in the VA, I must say. But the bottom line, it is easy to dodge our responsibilities but we cannot dodge the consequence of dodging our responsibilities. Thank you very much.

Molly: Thank you very much, Dr. Aron.

Dr. David Aron: By now, it should be Dave, don’t you think?

Molly: Sounds good. We do have time for some Q&A with the audience. For those of you that joined us after the top of the hour, to submit your questions or comments, just go to the GoToWebinar control panel on the righthand side of your screen and click the arrow next to the, next to the word questions and that will open up the dialogue box for you and then you can submit your questions or comments there. And the one person wrote in, I’d like the references to this, thank you, and that actually is included the slide. That gets the last slide after this one so you can go ahead and download a copy of today’s slides and you will find all the references there. Another person wrote in do we have access to the slides to this presentation? Once again, yes you do have access to that. David, we can still see your screen actually. If you can [unintelligible crosstalk 39:54] hold off on that until the end, thank you.

Dr. David Aron: That’s there just so you see the feedback I’m getting.

Molly: Excellent.

Dr. David Aron: It doesn’t hurt that I was his attending when he was an intern.

Molly: Oh wow. Well I mean that’s not the funniest thing we’ve had pop up on the screen so you’ve got that. I’m sorry. One of our attendees wrote in saying do we have access to the slide presentations? Yes we do. You can download those. There is a link in your reminder email that you received this morning and also you can, you can also wait for the follow up email that will show up two days from now and that will have a linked recording as well as to the slides. We do have several people writing\_

Dr. David Aron: \_I should mention\_

Molly: Go ahead.

Dr. David Aron: Excuse me, I should mention that the Hypoglycemia Safety Initiative materials which are available to be downloaded can be found on the VA’s Quality Safety and Value website and it’s on the internet so it’s open to everybody and you’ll see there materials that are directed towards clinicians and materials directed towards patients as well.

Molly: Thank you. We have several people that wrote in saying that they very much appreciate this presentation as well as the sense of humor you were able to bring to it. So thank you for that.

Dr. David Aron: Just remember that life is much too long not to have fun. Because if you’re not having fun, you’re not having it for a long time.

Molly: That’s a good one. I’m going to keep that one. The first question that came in. One other unintended consequence are medical groups that are treating Veterans, Medicare patients, privately insured patients and others who are being quote graded on meeting multiple metrics on DM control. How do we manage that chaos?

Dr. David Aron: Yeah, that is both a great and a really tough question. We have found that, at least in the patients here in Cleveland. So, we identify patients who are at high risk and try to do something about it. The ones in whom it’s very very difficult to do anything about it are those who have another provider outside the system. And it may be the metrics but it may also be that doctors have been brought up to believe that tight control is everything. So I wouldn’t solely blame the measures. I think the measures are certainly contributing. It’s extremely difficult. Fundamentally it comes down to shared decision making and spending time with a patient. And empowering the patient to go back to their primary care outside the VA and tell them they don’t really want to have risk of falling down and breaking their hips. But it’s very, very difficult. If there were a simple solution to that, word would have gotten around by now.

Molly: Thank you for that reply. The next question. Dave, why were insurance companies so keen on more aggressive A1c targets?

Dr. David Aron: Well, I tried to find out why and I didn’t, apart from the fact that they believed it. And these were both docs who were working for the insurance companies. My guess is that insurance companies wanted to be able to demonstrate their value to the payers. And by having a more stringent measure, they could beat on the docs more effectively. That’s my guess but it is only a guess. If anyone has a better explanation, I’d really like to hear it.

Molly: Thank you. How is clinical significance of difference in percentages estimated compared to statistical significance?

Dr. David Aron: How is clinical significance. Well that’s a good question.

Molly: Yea, how\_

Dr. David Aron: So that’s a very, very general question. So, there are a couple of issues here and the first is a measurement issue. So, let’s say is there a statistically significant difference between a hundred thousand patients who have an A1c of 7.3 and a hundred thousand patients who have an A1c of 7.1, okay? Let’s assume just for the sake of argument there’s a statistical difference. Is point two A1c a clinically significant difference? Well point two A1c is within the measurement error for most A1c lab tests. So part of the way of determining clinical significance is based on the coefficient variation and how much difference it is relative to the coefficient of variation. A lot more is based on clinical judgment, quite frankly, as much as anything else.

Molly: Thank you. The next question. What are your concerns with all the different DM medications available now?

Dr. David Aron: Well you know I remember when I was a medical student. We were taught always use the newest medications before they have had a chance to have any side effects. So, I am a bit old-fashioned. I would like to see that drugs have been safe over some long term before I am willing to adopt them routinely. I am very hopeful that some of these newer agents which have a very low risk of hypoglycemia which is great, will turn out to be very safe. I am hopeful. But I’m still waiting for the evidence. We don’t have 10 years of experience with many of these drugs.

Molly: Thank you.

Dr. David Aron: Another issue that we don’t really talk about much is you know, we talk about diabetes as if that’s the only thing the patient has. That’s usually one of three or four or five things that the patient has. So, it’s not only the diabetes medications we have to think of. We have to think of the interactions between those medications and the other medications they’re taking as well as issues related to adherence, especially with polypharmacy and medication error. As a general rule, the less medications that I can use, the happier I am.

Molly: Thank you. Dave, is VA more or less tunnel vision about performance measure than private sector healthcare organizations?

Dr. David Aron: Oh, yeah. I mean they all are to some degree. I guess it’s what is the light at the end of the tunnel? At our university affiliates, the light at the end of the tunnel is RVUs. But the VA, I think, tends to have more tunnel vision that is politically inspired.

Molly: Thank you. [unintelligible crosstalk 48:53]

Dr. David Aron: In fact, let me just. I think one of the reasons why the Choosing Wisely Initiative in the VA had so little impact is because of Phoenix, and everyone is focused on access and that’s the only thing that we talk about. And it’s not that access is bad but access is only one thing.

Molly: Thank you. What would be the most practical clinical solution for frontline providers to balance the risk for over and under treatment? A reminder in the EMR or would this be ignored?

Dr. David Aron: Well I can tell you that the experience in Network 12 starting out at Tomah. So this actually started by one primary care doc in Tomah who was really unhappy overtreating patients. He really came up with this initiative and developed a clinical reminder that included stratified targets, lists of patients who met criteria for overtreatment and so on. And it was used. And there have been a number of networks and these tools are available. And there have been a number of networks that have chosen to use those. Would they be ignored? Probably depends on how many other clinical reminders. You know, the death by a thousand clicks, kind of thing.

Molly: How do we get away from one size fits all metrics? Your shared decision making cannot be quantitated by computers.

Dr. David Aron: Well, that is only partly true. One measure that might be reasonable and this is actually built into the clinical reminder, is that the patient has an agreed upon A1c target. So the quality is based on the degree to which you achieve that target.

Molly: Thank you. Thank you for the great talk\_

Dr. David Aron: I should also mention that there are, the VA has had stratified targets since 2000 which have been, I think, systematically ignored by everybody outside the VA and to a large extent inside the VA. And those targets could probably be operationalized but does everything have to be assessed by computer? Is that what we’ve come to?

Molly: Thank you. Thanks for a great talk. How do you stratify performance measures based on age and comorbidities in VA so that primary care providers don’t get penalized?

Dr. David Aron: Before I answer that, I want to mention the name of the internist who started all this stuff and his name is Mark McConnell and he works at, now he’s at Iron Mountain VA. He is my hero. So let’s get to how can you address the issues of comorbidities? There’s some pretty good guidelines within the VA’s guidelines of how to do that. It takes time to operationalize those but I don’t think it’s beyond the realm of possibility to do that. I think it’s probably more practical to focus on the extremes. So basically A1c greater than nine is not good for anyone. That’s a pretty good measure. That’s very reasonable. Because you couldn’t even be symptomatic. So even if you have a short life expectancy, getting up at night to urinate because of hyperglycemia is probably not a great thing. Then we could pick out individual populations. I think we have to be much more sophisticated about how we use performance measures instead of this one size fits all which has been a problem. That is the easy solution but H.L. Menken was misquoted actually, or it’s a misattribution, but he said there’s a simple answer to every complex problem and it’s wrong. Well most simple answers turn out to be wrong when you have a complex problem like this one.

Molly: Thank you. As follow-up, they ask how can a PCP not get penalized when they leave a percentage of their panel list with an A1c over eight percent?

Dr. David Aron: Well, you know right now in the VA, there really is only one measure. There’s only one official measure and that’s A1c great than nine. I know that individual facilities choose to use other things like A1c less than seven, or A1c less than eight, but I don’t believe that there’s an official measure for that. Maybe something has happened recently and I’m wrong. So this is a facility issue and I am very mindful of these facility issues. So this goes way back to the beginning of performance measurement. For hypertension, we’re going to put in a clinical reminder for blood pressure less than 140/90. Okay, not bad. That’s actually what the measure was. But a primary care person wanted it to be 130/80 because if it was 130/90 and people were a little bit above they’d ignore it. Never mind whether 130/80 was appropriate or not or was overtreatment or not. So facilities do, people in facilities do interesting things and it’s basically a political fight as much as it is a fight about evidence.

Molly: Thank you. Two pending questions. I am a diabetes educator. At my VA I have a very difficult time finding documentation of the Veteran’s target A1c. How can we better share this information?

Dr. David Aron: Well what we do here in Cleveland is we have a diabetes note template where that’s part of it. So that’s probably the easiest way to do it although docs have to want to do it. I mean, all these things take time and in an era where time is limited, let’s just say any era, and there’s pressure on access, time spent with one patient is time not spent with making oneself available to another. But I think using a note template is probably the easiest way to do it. And god bless diabetes educators. We would be nowhere here in Cleveland without them. They are absolutely, absolutely essential. I think we have 26 people who have gone to get certified diabetes educator status. They aren’t all doing diabetes education but it’s really important.

Molly: Thank you. One person wrote in in response, in every consult that I provide, we quote individualized goal for that particular patient and that helps the PCP a great deal. Thank you to that commenter. And\_

Dr. David Aron: \_Couldn’t support that more.

Molly: The final question. Is the VA considering that quality measures as external motivators may actually be decreasing intrinsic motivation of clinicians to provide the best care?

Dr. David Aron: God forbid. I’m laughing when I say that. I think there’s pretty good evidence that these extrinsic motivators are damaging intrinsic motivation and I certainly worry about it a lot. Do I think those at the top worry about it? Who knows. I’m nowhere near the top.

Molly: Thank you\_

Dr. David Aron: You know sometimes it’s really good to be old. [laughs]

Molly: That is the final pending question. Do you have any concluding comments or takeaway message you’d like to leave our audience with?

Dr. David Aron: Yes. I am going to quote, so in my clinic I have three rules. They’re in Latin, so bear with me. Primum non nocere, first do no harm. Secundo cognustrua, second, learn. And third, tertium habera fun, third is have fun. If we do those three things, we will be able to sustain ourselves as healthcare professionals and I recognize that it ain’t easy but don’t lose focus of that, of those three.

Molly: Well thank you so much for coming on and lending your expertise to the field and thank you to Cristine Kowalsky and Nick Bowersox for organizing this and all of our QUERI Cyberseminars which generally take place on the first Thursday of every month at noon Eastern so keep an eye out in your email. Thank you to all of our attendees for joining us today. I am going to close out the session now and for our attendees, please wait just a second while the feedback survey populates on your screen and take just a moment to answer those few questions. We do look closely at your responses and it helps us to continuously improve our presentations as well as the program as a whole. Once again\_

Dr. David Aron: And I would like to say that if you have any suggestions to me about how I can make this presentation better the next time I do something like this, my email should be on the screen. Please send them to me. I take quality improvement very personally.

Molly: Wonderful, well thank you again, Dave and everybody have a great rest of the day. Bye Bye.

[ END OF AUDIO ]