SerenaGroup Quality Metrics

measuring what matters

Measuring Quality Metrics that Matter

> "Information is not knowledge."
> -W Edward Deming

Industry leaders, led by pioneers such as W. Edward Deming, embraced quality programs more than 70 years ago. It is only recently that the medical profession has shown interest in quality metrics. It is understandable, therefore, that clinicians misunderstand the purpose of quality improvement initiatives. Measuring quality metrics must improve quality: simply recording healing rates or median time to healing in a wound center does not reflect the center's quality nor does it provide a pathway to improve quality. It was for this reason that Medicare rejected healing rates as a reportable measure of quality.

Recently, a wound center program director proudly exclaimed from the podium that her center had a 97% healing rate and a median time to healing of 30 days. "Do you use hyperbaric oxygen therapy (HBOT)." I asked. "Yes, of course," she answered. "We routinely treat 6 patients per day." "Do you use Cellular and/or Tissue Products (CTPs)?" "At least twice a week," she said. "Then you are committing Medicare fraud," I answered. Her expression implied that she did not understand and did not appreciate my response. I continued, "Medicare requires that patients receive 30 days of standard of care before using advanced therapies such as HBOT or CTPs. If your time to healing is 30 days, then there is no need for these therapies or to have an advanced wound center at all."

Widely publicized rapid healing rates are not supported by the evidence. The converse is true: research from clinical trials and qualified registries report healing rates at 3 months in the range of 30-40%. Easily manipulated healing rates and time to healing are not quality metrics. They merely give the center leadership a false sense that the wound center is providing quality care, which they happily proclaim from podiums and post across social media platforms. More importantly, healing rates do not improve the quality of patient care; if anything, they diminish quality by moving nonhealing patients into a "palliative care" category.

Quality measures, as popularized by Dr. Deming and others, direct leadership to act. If the center is underperforming on a true quality metric, the medical director and center leadership can educate clinicians on the evidence supporting the metric. At SerenaGroup® we measure quality metrics that matter: off-loading diabetic foot ulcers at each visit, compression for venous leg ulcers, nutritional assessment, objective measurement of vascular status and other evidence based measures. We adhere to the continuous quality improvement model often called the Deming cycle (or Plan, Do, Check, Act Cycle). Each year, Dr. Serena and his quality and compliance team develop a plan to follow several evidence-based quality measures. We educate the program managers and clinicians and collect and report the data monthly. Quarterly, the team evaluates each center's benchmarked measures to determine if improvement is needed in any area. If a center is falling behind on a quality metric, the team provides education and support. The continuous process not only improves patient outcomes, it allows for the incorporation of new evidence and technology as it becomes available; for example, SerenaGroup® added antimicrobial stewardship to its list of quality metrics in 2020.

In conclusion, SerenaGroup® advanced wound care centers integrate the science of quality improvement into the measure of quality: We measure what matters.

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