

Thinking Out Loud... Questions of Quality, Cost, and Unintended Consequences

*“We lost a significant amount of money last year.
It was because we wanted to do the right thing.”*

—Paul Kurtin, MD (*Modern Healthcare*, May 2003)¹

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This is an article about questions, observations, and unintended results. It was prompted by the current healthcare landscape, which provokes questions such as, “Who is the beneficiary, who is the payor, and who is the payee?” Interesting questions for a renal community faced with many issues, namely:

- ◆ An ESRD patient population that is growing by 7% per year and which doubled between 1992 and 2001.
- ◆ Medicare reimbursement for outpatient dialysis that has increased by approximately 10% between 1992 and 2001.
- ◆ Patients, private organizations, and the federal government demands for improved ESRD outcomes.
- ◆ A Medicare program that plans to control the ESRD budget while at the same time improving the quality of care through innovative approaches.

Addressing these questions is a matter of necessity if patients and caregivers are to survive the issues. As a result, unlike any other time in the past, there is the potential for deep-seated, significant change

within the healthcare industry and specifically within the renal community, change that may result in some unintended consequences. Consider the following...

October 30, 2002

The Institute of Medicine (IOM) published its report, “Leadership by Example: Coordinating Government Roles in Improving Health Care Quality.” The IOM urged the federal government to exert its immense purchasing power in healthcare and assume a leadership role in promoting its quality.

May 12, 2003

Modern Healthcare published an article—“The Best Route”—in its May 12th edition. It is a saga of the Children’s Hospital and Health Center in San Diego, CA, a pediatric hospital that has generated outstanding clinical outcomes as a result of its 92% adherence to its 62 current pathways. The results?

- ◆ The facility **reduced treatment costs** from its clinical operations by \$5.2 million over six years.
- ◆ It **increased market share** of its

14-year-old-and-under patient population from 46% (pre-pathway) to 70% (post-pathway).

- ◆ Children’s Hospital **absorbed a 46% increase in market share with fewer staff** than it would otherwise have needed because, according to the article, their pathways provided them the discipline to lay the foundation for increased clinical efficiency and effectiveness, to put procedures in place for efficient care coordination, and to improve communication between physicians and nurses. Importantly, it created a highly energized care team who could see and prove the excellence of their outcomes.
- ◆ It **lowered the average length of stay** per hospital admission.
- ◆ Emergency Room (ER) physicians in 2002 treated more than 75,000 patients in a facility designed for 25,000 patient-visits per year with **no new construction required**.

Children’s Hospital, however, experienced an unintended consequence—a \$19.1 million operating loss in 2002 (compared to a \$12.4 million

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operating loss in 2001 and \$2.6 million in 2000) because payors typically reimburse pediatric hospitals on a per diem basis. As stated by Paul Kurtin, MD, vice president of clinical innovations at the hospital and a nephrologist, “We lost a significant amount of money last year. It was because we wanted to do the right thing....”¹

June 4, 2003

The Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS) publicly released, in the *Federal Register*, a request for proposals pertaining to an ESRD disease management demonstration, a follow-up to the original End-Stage Renal Disease Managed Care Demonstration Project. It unambiguously states that “The quality and cost of the care generally can be improved through **better integration of the delivery system.**” CMS and HHS expect the participating organizations to implement clinical protocols and to state their clinical objectives.

To ensure that quality and cost are appropriately aligned, CMS will reimburse participating organizations only 95% of their defined bundle of services deemed necessary to coordinate the patient’s care—inpatient, outpatient, and home—across specialties, disciplines, and healthcare entities without allowing a break in the patient’s care, especially in the areas of cardiovascular disease, hypertension, and diabetes. CMS will set aside

the remainder of the payment, the 5%, as “quality incentive payments” and will award them based on the criteria in the ESRD Clinical Performance Measures (CPM).

This said, the demonstration project must cost the government no more than it would have cost them for the same bundle of services were they provided outside the demonstration project. The cost to the government must be “budget neutral.”



After reading the above-mentioned documents, questions popped up and vectored sharply with one another:

- ◆ How should organizations that participate in the demonstration project avoid causing unintended, downstream consequences to other participants in the healthcare process? Should they even try to avoid doing so? Is there an evolving Darwinism emerging within the healthcare industry? Who pays whom?
- ◆ How should we morph the covenant between the caregiver and the patient into a hybrid agreement, a contract if you will, so that each has measurable duties and is responsible in some way to the other? How should we handle infractions by either participant?
- ◆ Is the demonstration project laying the cornerstones of a single-payor system within what will become a

system of universal healthcare? Will the cornerstones represent consolidation, coordination of care, outcome measurement, and cost control? Who will ultimately be the payor? Who is the beneficiary?

- ◆ To what degree should information technology embed clinical pathways and protocols within the care process? Should they act as advisories, or should they become enforcers?
- ◆ How should we harmonize what now are two separate investment decisions—one in clinical quality and the other in information technology? Should these decisions become interdependent? Can the one exist without the other?
- ◆ What is healthcare becoming as cost squeezes everyone’s sensitivities and as the patient in each of us yearns for good, old-fashioned doctoring and nursing, the glue that holds everything together?

Quality pays for itself. I am as convinced of this as I am of information technology’s pivotal role to achieve it. The questions are, “How much should we reserve as a quality-incentive payment to do so, and to whom should it be paid?” I believe we want to do the right thing.

Reference

1. John Morrissey. “The Best Route.” *Modern Healthcare* May 12, 2003. **D&T**