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Speed Limits on the Highway to Clinical Quality and Efficiency

By Jim Reynolds and Dan Roble

In aiming to achieve patient safety goals, the experts now seem to agree that clinical practice guidelines that reflect the effective and efficient use of resources across the care continuum should form the basis of a prospective payment system that rewards better clinical outcomes.

Buttressing this policy prescription is the related proposition that improvements in clinical outcomes also bring improvements in case costs.

Researchers such as John E. Wennberg, MD, MPH at Dartmouth, demonstrated that better clinical outcomes for cases at equivalent levels of severity of illness tend to be correlated with lower resource consumption and higher revenue margins when case rates are the payment methodology. This makes sense because when hospitals and their medical staffs redesign a particular clinical process around best practices, which should also include reduction of average length of stay and related efficiencies in serving patients, they are often able to identify key changes that significantly improve clinical and financial results.

Even though the ultimate goals have been fairly clearly stated and steps toward permanent solutions are being taken, it is still likely that another eight to 10 years of development will be needed to put in place real-time clinical information systems that incorporate computerized standing order sets for specific patient conditions that will embody best clinical practices, document physician compliance and produce improvements in clinical and financial outcomes.

In the meantime, it is quite possible that the health care quality and cost problems that now seem so ominous will be compounded by increasingly unaffordable health insurance premiums and increasingly unprofitable hospital service delivery to trigger an economic catastrophe – unless a way is found to accelerate progress in achieving better clinical outcomes at lower costs.

Movement to date

Using retrospective clinical information systems, some hospitals have already designed and implemented innovative approaches for measuring, comparing and improving clinical and financial outcomes that have paid off in terms of better clinical outcomes and greater financial stability. For example:

- The Greenville Hospital System in South Carolina has reduced the mortality and complication rates for its cardiac surgery patients by more than 20 percent.
- Physicians at the Doylestown Hospital in Bucks County, Pennsylvania have cut cost per case for specific kinds of cardiovascular patients by more than 25 percent.

Pay 4 Performance demonstrations sponsored by purchasers are expected to create economic incentives for physicians and hospitals to do the right thing – that is, improve quality.

P4P demonstrations with physicians in their offices have to-date focused primarily on disease management of chronic conditions that provide incentives for physicians to document that they are doing the screening, tests and interventions that will minimize the frequency and severity of acute episodes and reduce demand for specialty physician and hospital inpatient services.

The only major P4P demonstration with hospitals to-date has been led by CMS, working with Premier Perspective Online, to reward hospitals for reporting on the rates at which patients in each of nine clinical conditions/DRGs receive certain kinds of tests and therapies that are considered to be best practices. This voluntary demonstration is now becoming mandatory for all hospitals that want to collect the full measure of Medicare revenue due them under current reimbursement policies.

Both of these kinds of demonstrations, while representing positive steps in the right direction, do not directly focus on improving clinical and financial outcomes, which should be the focus of efforts to measure, compare and take steps to improve the results of care.

Legally permissible gain sharing arrangements offer the prospect of aligning the financial incentives of hospitals and physicians by sharing in any cost savings produced by efforts to improve the cost-effectiveness of patient care. A narrowly defined program to gain share on reductions in the cost of surgical supplies for cardiovascular patients has recently received a favorable, but qualified, opinion from the Office of the Inspector General (OIG).

The opinion stated that while the program as designed might violate prohibitions on limiting service levels and inducing physicians to refer additional patients, enough safeguards are offered to avoid sanctions. The OIG did not opine on the issue of fair market valuation for the payments to participating physicians or on compliance with the Stark laws.

Nevertheless, the gain sharing concept is gaining momentum. Medpac has recommended that U.S. Health and Human Services approve gain sharing arrangements that do not dilute the quality of clinical outcomes and Congress passed the Deficit Reduction Act of 2005 that authorizes six gain sharing demonstrations to be funded this year.

These early results suggest that:

- High quality, cost-effective, care is possible right now.
- If the purchasers and providers of health care could find ways to share equitably in the cost savings associated with more effective and efficient healthcare delivery then health care premiums could be made more affordable and providers could become more profitable by reducing their cost per case.

Going in the right direction

Some initiatives currently under way by legislators, regulators, purchasers, accrediting bodies and IT vendors are expected to make significant breakthroughs within the next year or two with respect to quality improvement to secure better clinical outcomes:

- NQF recently endorsed 21 consensus standards for cardiac surgery that will facilitate better clinical outcomes
- Mortality rates are being more widely and meaningfully reported to support informed patient choice in selecting their physicians and hospitals
- JCAHO is in the process of adding ICU measures
- P4P contracts that create financial incentives to follow best practices
- The initial voluntary CMS quality reporting demonstration, which focuses mainly on process standards, will be mandated for those hospitals that want to maximize their Medicare revenue
- The Senate's Grassley-Baucus bill is calling for Medicare payments to be conditioned on hospitals' reporting of severity-adjusted clinical outcomes data
- The Leapfrog Group is launching a hospital rewards program that seeks to motivate improvements in effectiveness and efficiency
- The House Ways and Means Health Subcommittee is drafting legislation that would increase the use of health information technology
- A Senate bill is seeking to help finance IT investments
- Efforts are underway to standardize IT connectivity
- Medpac's recommendations and the provisions of several of the pieces of legislation now under consideration suggest that a broader approach to gain sharing arrangements that focuses on proactively improving clinical outcomes while cutting unit costs is likely to enter the mainstream.

Rocks in the road

Concerted progress on these fronts has been slow and uneven because the interdependent, but misaligned interests of health care purchasers, physicians, hospital managers and IT vendors create situations in which positive outcomes for all are hard to come by.

Many commercial insurers, who generally pay for hospital services at per-diem or discounted fee-for-service rates, would like to keep virtually all of the cost savings that might be produced if hospital and physicians worked together to reduce resource consumption and hospital stays while improving clinical outcomes.

Most hospital managers, whose services comprise 2/3 of the more than $1.6 trillion spent in 2003 for health care, are reluctant to invest in IT systems and redesign clinical care processes because of the investment cost and the fear that their service volumes and revenues will dwindle as case costs are reduced and the savings accrue to purchasers.

Most physicians, who see their incomes threatened by Medicare's tightening payment policies, are reluctant to take time away from their practices to help redesign hospital-based care processes when they do not receive any compensation for a great deal of hard work.

IT vendors want hospitals to build infrastructure and install real-time applications geared to CPOEs and EMRs that will require additional years of effort before they are capable of incorporating the real-time computerized standing order sets that are expected to improve clinical and financial outcomes.

And since most quality advocates are focusing in the near term on assuring that providers will become able to report on clinical process variables, little attention is being paid to clinical outcomes.

Put the pedal to the metal

Actually, it is fairly easy, even at this early stage of development, to use clinical and financial data retrospectively to measure, severity-adjust, analyze and compare the clinical quality and efficiency of patient outcomes. As a consequence, it is also possible to:

- Reward physicians for their efforts to simultaneously improve the quality of clinical outcomes and use hospital resources more efficiently.
- Accomplish these objectives within the constraints of existing laws and regulations.

Such an approach to gain sharing can serve as a bridge technology that would make positive changes in clinical and financial results in the near term.

More interestingly, if clinically focused gain sharing arrangements could be combined with an approach to P4P that pays participating hospitals at a case rates that are lower than the current levels, but higher than the levels attainable under the clinical gain sharing arrangement, the participants could produce win-win-win results in terms of affordability for purchasers and patients and profitability at lower case costs for hospitals and physicians.

Such a combination of P4P and clinical gain sharing offers the potential to realign the incentives for all of the players in ways that:

- Motivate physicians to participate in clinical process redesign and compliance activities that begin to increase quality and reduce cost per case in hospitals, without waiting for real-time applications.
- Provide the tools needed, with nominal investments of time and funds, to measure and compare clinical and financial outcomes in hospitals and then prioritize efforts to improve both by starting with clinical areas that can provide immediate and significant success, and which will extend to more complex continuums of care.
- Improve hospitals' bottom lines immediately for those payer contracts that are already case-based, and then using these funds to help finance the investments in real time IT applications that are needed right now.
- Provide a means, through P4P demonstrations that are based on hospital case rates, to reassure hospital managers that the inevitable consequence of their efforts to improve clinical outcomes and cost per case does not have to be a full offset of the revenues they are receiving now for unneeded services.
- Offer financial inducements for insurers, hospitals and physicians to pursue innovative P4P arrangements for hospital and physician services that can make healthcare more affordable and profitable for all of the players by improving efficiency.

In this way, participating hospitals and physicians would have incentives right now to create paper-based clinical pathways that produce cost-effective clinical outcomes. Those clinical protocols would, when the IT infrastructure is ready to support their development, serve as the launching pads for creating computerized standing order sets that would further improve compliance and clinical outcomes.

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