On Patient Safety

Quality: A Process or an Outcome? It's not what you may think...

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No one likes to pay taxes. But regardless of which side of the political fence you sit on, whether you consider yourself left-leaning or right-leaning, whether you believe in small government or big

government, whether you drink Coke® or Pepsi®, most agree that—at least at some level—taxes play an important role in our society. Taxes pay for the roads and infrastructure we all use. Taxes support important community services that everyone relies on, like the police and fire departments. Taxes fund the military. Most people are on board with at least these concepts.

Beyond these points, though, we often see disagreement. The very mention of the topic triggers vitriol on cable news stations and rallies in the streets. While we can agree a minimum is needed in terms of taxation for basic government services and infrastructure, anything more results in debate or worse.

Quality metrics in healthcare are a lot like taxes. Most agree that process-based quality metrics make sense (Were antibiotics given preoperatively? Were they discontinued within 24 hours after surgery? Was DVT prophylaxis used appropriately?). Tracking these seems fair; when we know the right thing to do, it is reasonable to ensure we are doing it. Reporting results publicly will also drive quality—lower-performing institutions will respond to the pressure, and patients will benefit. In general, quality metrics that measure the practice of medicine are fair. There is a standard of

care, and we, as health care providers, should adhere to that standard.

But quality metrics now go far beyond that process. Outcome-based or complication-based quality metrics take things to new levels. Under these rubrics, the occurrence of a complication, rather than the failure to adhere to an accepted process, will result in decreased reimbursements to the medical center. By linking complications to decreased reimbursements, the thought process is that medical centers will take all possible measures to avoid those complications, thus improving the quality of care. This thesis is untested, unproven, and may have unintended consequences. How did we get here?

In 2001 Dr. Ken Kizer, CEO of the National Quality Forum (NQF), introduced the idea of “never events” [1]. Originally, these really were meant to be as the name implies: serious process failures that just should not have occurred. Wrong-patient surgery, wrong-site surgery, and wrong-procedure surgery were some of the initial “never events,” as were an infant discharged to the wrong person, sexual assault, abduction, patient death from contaminated products, and incorrectly used equipment. “Never” sounds about right for these.

On October 1, 2008 the Centers for Medicare & Medicaid Services (CMS)

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came out with its own list of “never events,” potentially avoidable events or hospital-acquired conditions [2]. CMS announced that it would no longer reimburse for the care of certain hospital-acquired complications, including retained foreign bodies from surgery, administration of incompatible blood, injuries resulting from in-hospital falls or trauma, surgical-site infections after certain orthopaedic procedures, and deep venous thrombosis (DVT) or pulmonary embolism (PE) after total knee and hip arthroplasties.

Technically, CMS now does not equate a retained foreign body to a surgical site infection or DVT... technically. The former is a “never event,” and the latter is a “potentially avoidable event.” CMS recognizes a distinction, in principle, between the kinds of events that should never happen, like retained foreign bodies, and those that have improved odds with better processes but may still happen despite everyone’s best efforts, such as DVT.

But actions speak louder than words. Though CMS classifies a retained foreign body differently than a DVT or surgical-site infection, CMS treats them similarly from a reimbursement standpoint. There is no due process after a postoperative DVT or surgical-site infection to determine whether process-

based quality standards were met. CMS makes no distinction between infections that arose when all precautions were taken and those that happened in patients who, say, did not receive pre-operative antibiotics. The reimbursement is cut for the care of the patient who developed an infection in either instance.

As if they didn’t before, medical centers now have additional financial incentives to minimize complications. Here is where the unintended consequences come in. Ideally, we would like to see hard steps taken to improve the quality of care. But we have already seen that, despite the best efforts taken, there really will be no avoiding reductions in reimbursements. Hospitals may find playing the odds—finding less risky patients to treat—a good way to soften the blow. “Less risky” may mean healthier or better insured patients, and it may mean patients whose surgical problems are simpler. Regardless, the fallout may reduce access to care for patients who need it the most.

Risk adjustment might help, but this is a complicated business: So complicated, in fact, that it is hard to see it being put into play, and, indeed, it hasn’t been, at least not to any great degree. Moreover, some risks just can’t be accounted for, even in the best models; for example, there is abundant evidence that poverty and ill health are

linked. There is no easy way to factor that into this conversation, so, again, one fears the unintended consequences (discrimination) if the current, unsophisticated approach is not modified.

These pressures may drive other undesirable behaviors, as well. A colleague recently called me about an obese patient who returned after discharge from a two-level fusion with a draining wound. My colleague’s hospital encouraged him to wash out the wound at an ambulatory center rather than in the operating room of the hospital where the index procedure was done, to avoid readmission and reoperation at the same facility. It seems clear to me that hospitals should not have to provide expensive care for free if all process-based standards were met. It is also clear to me that hospitals will take steps to try not to provide such free care. In this instance, had my colleague not thrown a flag, a patient who belonged in the hospital would have undergone a procedure at the surgicenter.

We need to track outcomes. It is possible that even if process-based standards are followed, there will be outliers, perhaps severe outliers; these call for inquiries. Such inquiries may reveal any number of things, perhaps including defective equipment, fraud, or, most helpfully, the need for refined and improved processes. But linking

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reimbursements to outcome-based metrics is just too fraught with problems, including unintended consequences affecting the neediest of patients, to be considered a good approach.

References

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