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Clinical Practice Management Issues

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Clinical Practice Management Issues

It is our pleasure to present the first issue of *Advances in Chronic Kidney Disease* for 2008. This issue deals with many of the clinical practice matters that face nephrologists today. The variegated nature of this subject, however, dictates its subdivision into 3 sections: regulatory issues that influence health care, a practical approach to health care, and the contribution of information technology to solutions in health care. These categories are perforce interrelated, albeit interwoven into the fabric of contemporary health care problems and conundra. The process is complex and, regrettably, in many instances bereft of research.

Regulatory Issues

The first section relates to how extrinsic pressures on the health care profession drive quality and the manner by which organizations are responding. Possibly, when reduced to its most simple form, one might conclude that just 1 extrinsic group is exerting this pressure, the public itself! The consumer today is more worldly and informed than ever and, as expectations rise, so do the demands for higher quality and lower costs. Thus, the value as defined by the ratio between quality and cost must rise. Americans are confronted with the sad fact that the cost factor of health care in an automobile manufactured in Detroit is over twice its cost of steel.¹ The many advances and improvements in health care, a life expectancy of 77.9 years,² and an aging America substantially raise the burden of health costs the public must bear. Health care savings can be achieved through better preventive care and the reduction in administrative³ and regulatory costs. Some believe that value-based reimbursement will also reduce health care costs, but many remain skeptical. All agree that health care quality can and should improve and that this will take a national, ambitious commitment.⁴ If quality is functioning at a high level of performance, doing the right thing, the right way, at the right time, the first time, we have a very challenging goal. These challenges to perform better have found their way into corporate America where employers have now determined that incen-

tives and voluntary reporting could help shape provider behavior.

The Leapfrog Group, made up of members of corporate America, has created a database⁵ in an effort to support the notion that value-based reporting is feasible. Furthermore, led by General Electric (Fairfield, CT), an amalgam of industry representatives, providers, and payers created "Bridges to Excellence"⁶ in the hope of enhancing the recognition and rewards of quality performance by providers. To date, Congress and the Executive Office have heard the public's remonstrations for a better health care delivery system.

In August 2006, President Bush issued an executive order to "promote quality and efficient delivery of health care through the use of health information technology, transparency regarding health care quality and price, and better incentives for program beneficiaries, enrollees, and providers."⁷ This set the cornerstones to the Roadmap of the Centers for Medicare and Medicaid Services (CMS). The plan for an incentive-based strategy is presented in this issue of *Advances in Chronic Kidney Disease* by Dr Barry Straube, the chief medical officer of CMS. Notably, the strategy outline includes a voluntary reporting provision, which should assist other payers in shaping their policies regarding this novel change in reimbursement strategy. The downstream advantage of this approach is the reduction in pressure on providers who are caught between cost reduction versus achievement of high-quality care.

Although there will always be healthy debate and rebuttal, our health care system can only move forward by shifting to a culture that expects, promotes, recognizes, and rewards good outcomes, rather than simply rewarding low costs. Yes, all of us remain intimately familiar with the Health Maintenance Organization that negotiates a low rate from a surgeon with minimal vascular access surgical experience

and penalizes the physician and patient for using another surgeon with a greater skill level in this critical area and who would generally achieve superior outcomes. Strangely, the same Health Maintenance Organization does not realize that this cost-preventive strategy represents a tremendous expense when a non-functioning arteriovenous fistula results in the placement of a hemodialysis catheter and, later, a bloodstream infection/sepsis and prolonged hospitalization. Here is but 1 example in which the pursuit of quality reduces cost.

Voluntary health payment and reporting does not come without concerns. It is all too easy to mislead the public if administrative data have not been adjusted for risk, age, and severity of disease. Incorrect data potentially harm patients while castigating providers and further mislead patients who use data to choose their locale and providers of health care. Furthermore, data supporting the concept of "pay for performance" are minimally available. Contrary to reducing costs, pay for performance may raise them, and, presently, this is the truism. Finally, as physicians compete for higher rankings or try to avoid punishment and chastisement by overzealous regulators, there is real concern that "cherry-picking" will affect patient selection. Voluntary reporting at its worst may influence providers to perform less risky procedures or avoid them altogether in sicker patients who could benefit when the pressure to achieve metrics interferes with doing what is "best for the patient."⁸ Who determines what measures reflect quality? If selected on the basis of ease of measurement, they may give a misleading picture of what a physician group is doing and force others, wanting to be impressive, to focus on measures that in reality have no bearing on the health of the patient.

In this issue, Blaser and Kliger argue that there must be alignment of incentives and outcomes and that the definition of quality must be relevant. As mentioned by Blaser and Kliger, the saga regarding erythropoiesis-stimulating agents may conclude with the passage of far-reaching legislation that revises health payment, with consequent payment reform. Concurrently, the Kidney Care Partners group has outlined a platform to meet the monetary needs of the nephrology profession

because budgetary pressures force less government spending on health care. In addition, this group is also helping to present quality measures that may be more meaningful for use in a value-based reporting system. It is incumbent on our profession to select and define quality, lest it be done by others who have a very marginal understanding of what we do.

Practice Management

The second section of this issue deals with practice management. Drs Rastogi, Linden, and Nissenson outline the scope of disease management in kidney disease. In this article, they identify several barriers that lead to sub-optimal clinical outcomes and high costs. In offering alternative options, they define and outline the basic principles of disease management, listing key components to a successful chronic kidney disease program. They propose applying organizing principles of care coordination to manage kidney disease with the objectives of improving clinical outcomes while constraining cost. This thread is picked up by Dr Spry who overviews methodologies that assist providers in promotion of patient education and disease management such as facile utilization of nurse practitioners and physician assistants. Spry shows the scalability of CKD clinical care by identifying 3 clinical models.

Information Technology

This issue concludes with discussions of health information technology. The importance of this third section is espoused by the Institute of Medicine and reiterated in this issue by Straube. The success (or failure) of health care hinges on its successful integration and its reliance on information technology. Four decades ago, several bankers united and created the credit card industry we "rely" on today.⁹ Secure, interoperable, and standardized data systems rapidly and transparently move monetary information. Imagine the hassles of long-distance purchasing without it; yet, we have failed to do the same with patient information, despite that interoperable health care is 1 of the 4 cornerstones of the CMS Roadmap. The success of this

cornerstone is dependent on the creation of first class technology and the willingness of payers and vendors to share information. However, all of this comes with a tremendous cost, and this monetary barrier represents a tremendous stumbling block to lesser capitalized health care organizations. The cost of an inability to break through this barrier is borne by providers and, worse yet, by patients.

Akin to the scenario regarding vascular access, the overall startup costs of health information technology to pharmacies, health plans, patients, and the public are less than the future losses that will be incurred by the nonimplementation of standardized health information technology. Currently, legislation is being reviewed in Congress that should help alleviate some of the cost burdens to physicians.¹⁰ The American Association of Kidney Patients is trying to resolve this issue through the creation of a personal health record (PHR) in which the patient lists laboratory information, medications, and a record of doctor visits. This concept has been examined at several levels including the government, provider groups, and health informatics organizations. Because standards for interoperability and data transfer evolve within the health care system, patients will be empowered more and more by these types of systems. The PHR concept involves patient empowerment through involvement in the health information process and via built-in education initiatives. Buettner and Fadem discuss not only the PHR but also patient-education issues and resources. Patient education must be considered in the context of the Internet, which is a massive, unregulated, and freely accessible body of knowledge. Although it is not controllable, providers can take precaution to make sure that the information their patients review is authentic and reliable.

Even if the PHR becomes widespread, the challenges and barriers to the physician practice will be experienced by the absence of a standardized health care vocabulary. Drs. Maddux and Maddux outline the obstacles to a practice wishing to obtain a health care system and highlight the value, particularly with respect to quality care, and advance catalyst efforts that can stimulate the adoption of health information technology by physicians.

Health care systems, regardless of their level of sophistication, must be designed to meet human needs, and there must be a workable interface between the software, the hardware, and the lifeware or user.¹¹ The template, as discussed in this issue of *Advances in Chronic Kidney Disease* by Rosenthal and Spiegel, helps reduce events and merits success in preventing errors when it can conform and adapt to an individual's work style and still maintain its structure. The use of a computer system is a balance between standardization and uniformity and autonomy and customization. The design of a computer system must follow the natural order that work is done. Enhancing safety and helping our profession engineer itself to the level of acceptable risk that other industries, such as the aviation industry, expect from us is a necessary goal in which computers can play a key role.

Soman and Yee have outlined 1 expert system aimed at best practice implementation in chronic kidney disease. Computer templates enable a physician to modify the system to his/her particular needs while still keeping the standards needed for data reporting. With respect to the latter, Wintz, Rosenthal, and Fadem outline how integrated technology can be used to construct algorithms based on The Physician Quality Reporting Initiative.¹² The creation of 2 software programs, one that collects data from the dialysis unit and organizes it for reporting and the other that generates G codes via customized template, facilitates reporting to CMS (all in the background). Because this initiative does not use claims data, it represents a first step toward reporting pure data.

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