

Redesigning Care – Reducing Clinical Variation

gmayzell@comcast.net

George Mayzell, MD, MBA

Redesigning Care – Reducing Clinical Variation

It is generally accepted that healthcare is too expensive and costs are increasing at an unsustainable rate. With this in mind, all healthcare systems are trying to control their costs in order to thrive with declining reimbursement. This reimbursement challenge is happening on multiple levels. Payers are decreasing reimbursements and patients are facing higher co-pays and deductibles. Moreover, patients are more focused on cost, value, and convenience with the evolution towards patient directed healthcare plans. New models for reimbursement including pay-for-performance, bundling, and shared savings are becoming commonplace and the terms, “risk” and “capitation” are starting to reemerge.

Most health systems have focused on managing cost through aggressive supply chain management and staffing optimization. There are significant opportunities in supply chain and resource costs utilization, both on the commodity and the physician’s preference items side. While these are certainly important, they can only take a system so far.

As we move towards value-based care and reimbursement that reward outcomes and efficiency, systems are focusing on creating additional value. We define value as outcomes (quality) plus experience, divided by cost (or efficiency). In this challenging environment, the higher value we can provide the more competitive we will be, while maintaining a positive operating margin.

<u>Outcomes (Quality) + Experience</u> Cost or Efficiency
--

Our goal is to achieve the Triple Aim; improve quality by leveraging leading practice, enhance efficiency, and decrease costs.

Coordinating Cost Reeducation

One way to coordinated cost reduction efforts is to look at some of the key diseases that drive cost on the Medicare side. Looking at these key diseases and doing an extensive data analysis by looking where cost lie, one finds that there are some disease specific and physician behavior specific items to each disease, and several items that cut across all disease groups. We must work on the individual disease specific items focusing on evidence-based care and consistency (i.e. decreasing variation) of treatment for each disease. Furthermore, looking across diseases at gaining efficiencies in order sets, pharmacy, lab, radiology, and ambulation. There are of course others, and each hospital will have some nuances that are particular to their market.

The common items that stretch across multiple diseases are sometimes obvious and sometimes not. One thing that I have found is the unique way that order sets are used. Often great time and effort goes into developing order sets that

are disease specific and helps propagate evidence-based care (and cost-efficient care). In many cases, order sets are being used, but not necessarily the correct disease specific order set. Often either a favorite order set or a more generic order set is being used and thus the advantages of a community-based, evidence-based order set is lost. In looking at the use of order sets it is important to measure the disease specific order sets used and not just the fact that the EMR is being used. Additionally, it should be noted that order sets only start the pathway of evidence-based care but are not true care pathways in that they don't take the patient past the first day or so.

There are many items that cut across the delivery system and impact many, if not all, diagnoses groups. These items such as the order sets, early ambulation, lab and radiology usage throughput, and appropriate pharmacy usage are key operational drivers on all diagnoses for operational efficiency.

The next step is to look at disease specific solutions. This requires drilling down in each disease group and looking at cost and utilization patterns by physician, i.e. labs, pharmacy, radiology, etc. Then, setting meetings with the physicians to talk about best practices, and share both individual, and group data. This usually generates a lively discussion of good and bad practices. Usually this will take several meetings with a to-and-fro dialogue about what constitutes "best practices." Research and articles must be produced and shared that document evidence-based care. Some of the things that have come up at these meetings about total joint replacements are: CPM (Continuous Passive Motion) machines, antibiotic infused cement, pre-habilitation, proper use of blood transfusions and cell savers as just a short list of items for orthopedics. Another example in COPD would be the use of a weaning protocol that could be administered by respiratory therapists who are in the hospital 24/7. This will save time in from the to-and-fro physician orders during the workday.

There are many other examples that are specific to each disease process, but the process is still the same.

Pace of the Case – Care Oversight

Another part of the process is to help build care oversight into the ongoing hospital process. The best way to do this is to use care pathways that are overseen by the Case Managers/Care Managers. This may require a reengineering of the entire Case Management/Care Management team. Many of these teams in the current environment focus on utilization review (i.e. getting paid), and discharge planning (i.e. the discharge transition). We must change the focus to looking at the "pace of the case." In this scenario, they are looking at what's should be done each day using care pathways as guidelines and helping to facilitate an efficient evaluation, diagnoses and treatment for each patient. In this scenario, the discharge process is baked in to the care management process. This process must be driven by registered nurses with the assistance and support of ancillary personnel and social workers.

While it is beyond the scope of this article, appropriate physician alignment using clinical co-management and gain sharing or pay-for-performance is critical, a Clinically Integration Network model can also help align the physician with the hospital goals.

One of the most important endeavors here is to collect data and share data about the entire care management process, outcomes and balancing metrics. We not only want to create an efficient care pathway, but also a great patient experience with great outcomes and fewer complications and readmissions.

The Result

This process has no finish line.

It is an ongoing process that requires constant iterations and constant improvements. As the care model shifts from volume-to-value this will become even more critical as more things get financially loaded into the hospital admission. Currently, the hospital is on a case or DRG rate program that only includes hospital services, it is

highly likely in the future that physician services and some portion of the outpatient service will be “bundled” into these types of services. The push toward clinical variation works in the fee-for-service or first curve world but is even more important in the volume base “second curve” world.