The Dawn of Metric (Driven) Medicine for Heart Failure Care

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CURRENT QUALITY PARADIGM

The readmission reduction program (RRP) is intended as a cost saving measure to optimize the healthcare delivery system. It presumes that a punitive philosophy will lead to a change in healthcare delivery and, ultimately, to value-driven quality of care in medicine. While these presumptions seem farfetched, what is obvious is that the immediate intent of the program is to save money for the country's healthcare system—or more specifically, for the government payer. There is no doubt that cost saving is necessary, but the RRP puts undue pressure on hospitals while ignoring the obvious disparate incentives of all the parties that constitute the healthcare system: the hospitals who are being penalized, the practitioners who make money on any kind of admissions, and patients who might rather be admitted for thoroughness (rather than be turned away from an emergency room). The RRP has forced the institutions to hold their quality officers and administrators responsible for meeting the metric of 30-day readmission rate. However, the complexities of chronic disease states like heart failure are beyond simple quality paradigms, so this responsibility is inevitably shared by physicians caring for heart failure patients. Depending on the hospital, such physician engagement could range from internists to general cardiologists to advanced heart failure cardiologists. The fact that heart failure is cared for a broad spectrum of physician specialties almost makes it necessary to engage a multi-specialty and even a multidisciplinary team. Irrespective of their expertise and qualifications, are they ready to take the helm of such a responsibility?

RESPONSIBILITY OF THE CLINICIAN REPRESENTATIVES

More than ever, physicians are becoming involved in their institutions' efforts to create solutions to improve care for heart failure patients. Despite the fact that readmission rate has no bearing on any meaningful clinical outcome for individual patients, reducing readmission rates has suddenly become a responsibility of the physicians to save money for Medicare. The cost-saving atmosphere has extended to efforts in optimizing length of stay an hence another important metric to assess heart failure quality programs. The conundrum for today's physicians is to create systems that expedite care and enhance and sustain recovery while remediating all issues (medical, social, behavioral, personal and financial) that may lead to readmission.

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Although a focus on economic metrics is essential for long-term sustainability of Medicare and the entire health system, making it the primary focus could distract from building the best quality paradigm to assure cost-effective care from the perspective of all relevant parties. This distraction and misdirection is obvious when looking at Medicare's priorities: Whereas Medicare has implemented a RRP requiring strict reporting of readmission rates, the system does not mandate reporting compliance to life-saving, guideline-directed medical therapy. Moreover, meaningful quality programs like "Get With The Guidelines" that provide process measures specific to evidence-based medicine remain voluntary for hospitals, with no special incentive to drive them to sign up. While many hospitals track in-hospital mortality, out-of-hospital mortality is not tracked in a timely manner for quality programs to ensure that patients are not dying when sent home. It becomes incumbent on modern physicians to recognize such disconnects in the quality metrics so that changes in delivery of care are made in a sustainable, patient-centered manner focusing on an entire spectrum of metrics—not just one. This is not to minimize the importance of fiscal responsibility, but to avoid unintended consequences that could harm our patients.[1]

PICKING THE YARDSTICKS TO MEASURE HEART FAILURE CARE

With punitive dollars associated with the 30-day readmission rate, this metric has become a focus for many institutions; thus, efforts over the last several years have led to a reduction in 30-day readmission across the nation.[2] Although initiatives like observation units and diverting patients who re-present within 30 days from emergency rooms to urgent care clinics or observation units can reduce the readmission rate, it is

imperative for us to acknowledge that keeping people out of the hospital is not equal to keeping them healthy at home. On the contrary, it is possible that we are inappropriately avoiding admission of patients who may be sick—a sobering possibility reflected in the 30-day mortality rate that is rising even as the readmission rate is falling.[1]

BALANCING PATIENT CENTEREDNESS AND A METRIC FOCUS

In general, patients do not want to be admitted to the hospital, but in the pure sense of patient-oriented care, there is no evidence to suggest that a 30-day readmission is harmful or not preferred by patients. On the contrary, when a recently hospitalized individual seeks medical care by making an effort to return to the hospital, it only makes sense for that individual to be thoroughly evaluated and, if necessary, admitted to treat the condition. A more patient-centered effort would be to make avoiding hospital admission a quality metric for outpatient practices, incentivizing them to prevent their heart failure patients from decompensating.

Although the current metric focus is relevant to the long-term financial viability of the healthcare system, metric-driven medicine can easily take the focus away from the individual patient. Constantly admonishing practitioners to reduce length of stay and avoid readmission can play a subconscious role in their decision-making, potentially leading to premature discharge or inappropriate avoidance of a readmission. That kind of metric-based decision-making could lead physicians to inadvertently deviate from their oath, “primum non nocere.”

The quality measures driving today’s heart failure care have been implemented without a thorough understanding of their unintended consequences. While the nation is experimenting with perfecting the paradigms of cost-effective healthcare delivery, it is incumbent upon all practitioners to get involved in orchestrating the quality programs at their institutions to assure adoption of appropriate measures that are not too focused on a single metric; we must implement “responsible quality.” At the same time, administrators and quality departments need to acknowledge the complexity of chronic diseases like heart failure and not get carried away implementing regulatory metrics in a hasty, reactionary manner that loses sight of our patients. The constructs of quality healthcare are most powerful when used conscientiously and appropriately by individuals who deliver care by keeping all aspects of the disease and the individual patient in mind. Medicare’s recent example of implementing quality framework for heart failure should make us realize that we need to practice responsible quality care and avoid defaulting to metric-driven medicine.

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Conflict of Interest Disclosure:
Ryan Chang is an intern at the *Methodist DeBakey Cardiovascular Journal.*

REFERENCES

1. Gupta A, Allen LA, Bhatt DL, et al. Association of the Hospital Readmissions Reduction Program Implementation With Readmission and Mortality Outcomes in Heart Failure. JAMA Cardiol. 2018 Jan 1;3(1):44-53.

2. Bergethon KE, Ju C, DeVore AD, et al. Trends in 30-Day Readmission Rates for Patients Hospitalized With Heart Failure: Findings From the Get With The Guidelines-Heart Failure Registry. Circ Heart Fail. 2016 Jun;9(6). pii: e002594