Performance Improvement
Mark Mosley, MD, MPH
CME sponsored by Wesley Medical Center

ESPA, Wesley Medical Center
550 North Hillside
Wichita, KS 67214
Phone for copies: (316) 962-2313

WESLEY EMERGENCY DEPARTMENT
THE QUEAS-E UPDATE

(**Q**uality, **U**niformity, **E**ducation, **A**ttitude, and **S**ervice - in **E**mergencies)

SPECIAL EDITION "HOW OBAMACARE IS FAILING"

Issue 118 March 2013

ESPA WEBSITE

ESPA stands for **E**mergency **S**ervices, **P**rofessional **A**ssociation. We are a private ER group who has been partnered with Wesley Medical for over 40 years. We have the only pediatric ER in Kansas.

What is "Obamacare"?

Three years ago this month on March 23, 2010 the Patient Protection and Affordable Care Act (PPACA) was signed by President Obama. This is the foundation of "Obamacare". However, for many in medicine, "Obamacare" typifies a governmental approach toward changing physician behavior by using the hospital and Medicare reimbursements – some of which was in the works before Obama was president.

What did "Obamacare" offer?

We all knew the US health care system was (and still is) economically unsustainable. Regardless of who would have become president, the stage was set for inevitable sweeping change. The Republicans offered an uninspired and ill-defined plan. The Democrats with Obama offered a vision that both patients and health professionals could embrace:

1. health coverage for the uninsured poor
2. better safety systems to reduce error
3. electronic health records to decrease error and improve coordination of care
4. standardized quality across different geographic regions and providers
5. health care centered around the patient as a consumer
6. the promise of cost-containment through a focus on prevention and greater efficiency
7. financial incentives for providers and hospitals to change their behaviors

There was more than this, but from an ER perspective, who could argue with such laudable goals? For many, it appeared that trying something would be better than losing Medicare.

How "Obamacare" is failing

Three years into the Affordable Health Act, several failures with Obamacare have become apparent:

1. Health coverage for the uninsured does not translate into better health.
2. Better systems of safety do not translate into less morbidity.
3. Electronic health records do not result in less errors or better transitions of care.
4. Standardized measures of quality do not produce better medical outcomes.
5. Patient satisfaction does not accurately define good health care.

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6. Obamacare does not contain costs – it simply shifts costs away from the government which are paid for by hospitals and providers.
7. Hospitals, corporations and individual providers game the system to get paid which paradoxically dissatisfies medical providers and potentially harms patients.

Health coverage does not translate into better health

Ironically, we learned this from Romney. When Massachusetts had "health coverage for all", it simply increased visits to the ER. Simply having more patients who can see a primary care doctor without having more primary care doctors doesn't really help. And you still have to convince patients to wait and see their primary doctor instead of conveniently going to the ER for free!

And when patients do go to their primary care doctor for routine check-ups, annual check-ups and preventive screening as is envisioned; there is no indication that this improves patients' health. A recent study finds that an annual check-up to your doctor is generally unhelpful.

Better systems of safety have not translated into less morbidity

Yes medicine needs better systems of safety and less errors. Yes medicine can certainly learn from other industries. Yes, medicine can and has shown that doing things like checklists has shown improvement in awareness, knowledge and compliance.

However the complexity of taking care of human beings who rapidly and randomly enter the ER with multiple physical, mental, social and financial problems is so radically different from servicing and flying scheduled commercial airlines that the example of learning from the airline industry has become a safety clique with almost no relevance.

Most importantly one wants all of these safety measures to not just reduce errors but to change outcomes. Greater compliance can not be the measure. Even less errors is not the measure. It is less errors that have meaningful clinical changes for patients that counts. This has not happened.

Electronic health records have not decreased errors or coordinated better care

Electronic health records (EHR) promised legibility. They delivered. They promised more complete records. They delivered. They promised better ability to capture data, collect data and report data. They delivered.

But why was the EHR promoted as necessary? To decrease errors, and coordinate better care that results in better patient outcomes. This hasn't happened. Hospitals are reporting more and more patient safety problems related to EHR with half of them related to wrong input by health professionals. How can this be?

Take the average ER doc who gets interrupted on average about every 15-30 seconds. He or she used to go talk with and touch the patient without writing on a piece of paper or using a computer tablet. After a direct history and physical exam, the physician would circle or speak orders and a nurse or unit clerk would input the orders. It was not an efficient system and ER patients waited longer but the physicians were doing bedside medicine. Today in order to accomplish EHR in a timely manner, mid-level providers are seeing a lion's share of all the patients, scribes are doing all of the documentation for legal and billing purposes, and physicians are inputting the orders. Does this make sense to anyone? Our documentation is more complete but is it really accurate? What will happen in a court of law when a physician claims that the documentation by the scribe is not what he/she did? Or the MLPs history and physical which was "repeated and agreed" was so cursory as to be meaningless. The patients used to say "the doctor came in for about 5 minutes and then left". Now they

say "I'm not sure I was ever seen by a physician". Great efficiency. Great documentation. Great billing. But is this really great medical care?

And why are we doing this? For safety? All the data on EHRs so far are consistent in that some errors may be decreased but others are increased – and overall there is no change in error rates or safety. And coordination of care is neither better at the bedside or between institutions. Instead of one physician talking directly to the patient, we now collect electronic fragments from the nurses electronic documentation, the MLPs electronic documentation, the scribes electronic documentation, and our own electronic documentation without looking at the patient in order to text the MLP who is working for the hospitalist who sees the primary care doctor's patients of whom he has never met but has reviewed their last electronic record when they were admitted by someone else. The electronic documentation has replaced the cornerstone of medical care – knowing the patient and listening to how they tell their story.

Standardized measures of CMS "Quality" have NOT produced better clinical outcomes

Acute myocardial infarction, community acquired pneumonia (CAP) and congestive heart failure – these are common diagnoses related with significant morbidity and mortality with a fair amount of good quality scientific evidence concerning management.

Unfortunately, CMS used measures particularly with regard to community acquired pneumonia that had poor or no scientific evidence (eg 4 hours to get antibiotics on board). Even when there was excellent scientific data such as aspirin for an ST elevation myocardial, the marked improvement of the process did not show improved cardiac mortality.

This seems impossible since the 1988 ISIS trial showed that 162mg of aspirin could reduce mortality up to 25%. There are at least two major errors in Obamacare/CMS thinking:

1. Measuring a process or behavior change (foaming in, not putting in a foley, giving an aspirin, seeing a doctor in 15 minutes, asking about smoking cessation, etc) DOES NOT necessarily translate into improved clinical outcomes.
2. The adage "If it's not documented, it didn't happen" may be a correct legal or financial statement but it is not a true medical statement. Maybe we were giving aspirin to everyone; we simply weren't documenting it well. Therefore the improvement in documentation alone did not affect a real change in patient outcome.

We now have an abundance of data that shows that better "quality report cards" and hospitals with "better quality measures" (according to CMS) do not translate into better quality medical outcomes. CMS "quality" does not equal patient care quality.

So while our local hospitals continue to advertise "top 5% quality" and "100% quality benchmarks", let's be very clear what we are saying. This has nothing to do with the quality of patient care outcomes. This is not about their physicians. It's not about their nurses. It's not about their technology. And sadly, it is not about their patients. This means the hospital has spent a lot of money and energy to document better to make money. Document better for business and advertising. And the government and hospital administrations know this. This is why they shrug their shoulders when physicians yell that medical science and data do not validate these ideas. It is possible they may not know this but chances are they may find us naïve. Because while many of us still consider medicine to be a sacred profession, we are told daily "medicine is a business". So who cares what the scientific data says, it is the bottom line that guides a hospital's behavior.

Patient satisfaction does NOT accurately define good health

If a person was in legal trouble would anyone consider it good law for the person to define and direct their own legal care? No, because they don't know law. If a person needed to electrically re-wire their house, would anyone consider it smart to direct their own electrical needs? No, because they are not a licensed electrician.

Why then has the government bought in to "the patient is always right" model for medical care because after all patients are not licensed physicians neither do they know medicine (and cable and the internet have not helped them).

While the idea of including the patient in decision-making is certainly paramount; it is altogether a different animal to choose not to pay a physician when the patients do not give high enough "patient satisfaction scores" in which anything other than "always" is a negative score.

People ask "why not rate your doctor or hospital? Why not grade them the way you grade a restaurant?" The answer is that restaurants can't typically kill you by giving you larger portions or the wrong entrée – hospitals and physicians can. Physicians are often persuaded (and sometimes paid) to do tests that make people happy (from strep throat to CT to c-section to discectomy, etc). 66% of physicians surveyed are paid based upon patient satisfaction scores. While patients may be happier, the data show that the most satisfied patients may have a higher mortality rate. Wanting higher patient satisfaction scores can definitely feed the "more is better" fallacy. And more tests and procedures are often dangerous.

"Obamacare" does NOT contain costs – it simply shifts the costs

Imagine the cost of a new IT department in every major hospital, the IT servicing, and the addition of a "scribe" (a person hired simply to document like a court reporter) for each physician in an emergency department. All of this done and paid for by the hospital (or an individual physician) in order to get proper electronic documentation in a timely manner. (The electronic health record has not improved efficiency. Every study done to date shows the electronic health records slow down the normal processes that take place in an ER. If you are lucky after two-three months you may come close to the efficiency you had before. Most in the ER have not been able to do this well without hiring an additional person [a scribe] to do most of the physician's documentation.) The electronic health record, even if completely necessary, has exploded costs. The only value the EHR currently manifests consistently is that it supplies data to the federal government that allows them to deny payments to hospitals and providers. Electronic health records have helped contain costs for the feds, but no one else.

Financial incentives to change physician behavior have failed

The federal government and CMS thought their "quality measures" were failing because there was not enough physician "buy-in". So they attempted financial incentive programs called "pay-for-performance" (including "value-based purchasing"). These incentive programs have failed for many reasons:

1. The outcome data comes from billing data rather than clinical patient records. (only a politician or a business major could either not understand this or fail to care how obvious an error this is)
2. The payment incentives were comparatively very small for individual physicians.
3. The complexity of obtaining reimbursement was confusing, laborious and unpredictable.

The pay-for-performance programs have been inaccurate and unsuccessful.

Corporations, hospitals and providers "game" the system which harms and dissatisfies everyone

Attend the myriad of daily meetings of your local hospital and you will find that almost all of the meetings about the "quality" of medicine being provided are really meetings about the hospital claiming money for CMS "quality metrics".

Look down the hallways at who is at the bedside taking care of your relatives, friends and neighbors. Most of the nurses even in the ICU settings are mostly new graduates or just within the first few years of their training. Where are the veteran nurses with ten to twenty years of experience? If they are still in the hospital at all, there is a good chance they have become a data collector and metric measurer. We have created an entire business tier of data collectors and reporters who used to be at the bedside as our best most seasoned nurses. Considering all the novel job positions, time in meetings, energy, attention and opportunity cost taken away from direct bedside care is almost incalculable.

This is not unique to nursing. Physicians are expensive – and many of them in response to all of the government game-playing are retiring early. So mid-level providers are the inexpensive and readily available fix to offset cost and efficiency. The physician, much like the Wizard of Oz, now goes behind a curtain (or computer screen) while mid-level providers do all of the bedside work. Many of these mid-level providers may be no more than a few years in school and new to the workplace compared to the prolonged training of a medical student, resident and physician. Both in nursing and medicine, our least seasoned professionals are at the bedside while the veterans are inputting data.

Physicians are told to play the game of CMS metrics electronic documentation and speed or you won't be in our hospital. And to try and reduce non-compliant physicians, the newest approach is to just make them salaried employees of the hospital so that their voice is help captive by their paycheck. If any of this actually resulted in safer and better clinical outcomes in patients it would be easier to board the Obamacare bus. However, after all of the "new" hospital guidelines, "you-fell-out-buddy" letters, government disincentives, and dashboards of "quality" measurements, Obamacare has failed to find decrease in inpatient mor-

bidity or mortality with regard to these changes.

Furthermore, one can definitely argue that while a patient's record of their hospital stay was certainly more legible, more billable, timely and met all of the CMS quality metrics, and rated high on HCAHPS scores – that the actual medicine done was fragmented, frighteningly rushed, poorly monitored, with both under-treatment and overtreatment being done more based on no other reason than not having time to see the patient or trusting electronic information input by someone possibly very young in their training. To a large degree, Obamacare is responsible for these corporate responses to game the system.

Conclusion

Obamacare however well-intentioned, has not accomplished any of the intended goals outlined in this paper. Corporations and hospitals in order to get paid by the government are leveraging massive resources in order to game the system. The result of failed Obamacare goals and corporate gaming has been worse patient care. To add salt to these wounds, these government changes and corporate adjustments are not containing costs in medicine – they are simply shifting costs out of the pockets of medical providers and into the pockets of the federal government and those in medical business who have learned to game the system.

* Addendum

If you want to "write-off" this essay of some doctor who went mad, I will be the first to agree with you. But please don't let my belligerent tone dissuade you from looking at all of the scientific evidence which supports the positions of the paper.

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QUEAS-E
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1. Health coverage for the uninsured has shown to improve health outcomes. T or F
2. Better safety measures in the hospital have proven to result in less morbidity. T or F
3. Electronic health records (EHR) have resulted in less errors and better transition of care. T or F
4. Better CMS metrics and quality measures produce better clinical outcomes. T or F
5. Patient satisfaction is an accurate measure of good medical care. T or F
6. Obamacare has shown to contain medical costs through efficiency and focus on prevention. T or F
7. Financial incentives have helped physicians and hospitals to improve behaviors that help patients. T or F
8. Obamacare has encouraged veteran physicians and nurses to return to the bedside with direct communication with patients. T or F

Circle the one correct answer.

To complete this educational activity, please check your test for accuracy. The correct answers can be found on the evaluation.

(Evaluation following)

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   A great deal 5 4 3 2 1 Little

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