ACKD Advances in Chronic Kidney Disease
A Journal of the National Kidney Foundation®
Vol 23, No 1, January 2016

EDITORIAL

Geriatric CKD: Value-Based Nephrology

Each nephrologist in the United States is now participating in a value-based purchasing (VBP) plan. Nephrology patients, particularly geriatric individuals with advanced CKD or ESRD represent the bulk of our current and future VBP-based decision-making. Therefore, nephrologists must become more adept at value-based decision-making, and these decisions must align with the values of patients.

The "Medicare Hospital Spending by Claim" Web page details comparative average hospital spending during a specified interval of performance for a Medicare Spending Per Beneficiary (MSPB) episode.[1] The episode includes Medicare Parts A and B claims paid for the period beginning 3 days before a hospitalization and up to 30 days post-discharge. More specifically, a hospital's MSPB amount is determined by dividing the hospital's average MSPB by the national median MSPB amount for the nearly 3000 participating US hospitals. A hospital's MSPB amount represents its average price-standardized, risk-adjusted spending for an MSPB episode. The price-standardization normalizes payments by removing the effects of geographic differences in payments and add-on payments for indirect medical education and disproportionate share hospitals. There is variation in the "spend" per hospital, which is measured by diagnoses-related group reimbursement, and part of the variation is attributable to size (and therefore risk) of the CKD and ESRD populations cared for by a particular institution. Risk stratification and adjustment for age uses the hierarchical condition categories and ESRD status. Since an MSPB episode is a patient-level event, adjustments are essentially case-mix adjusted and are not included for all episodes collectively.

Because the MSPB measure is part of a VBP program, it is evaluated based on results, not goals.[2] Namely, achievement and improvement points are earned to offset the 1.75% standard penalty fee imposed by the VBP program within the fabric of the Centers for Medicare and Medicaid Services (CMS). Established in 2010 by the Affordable Care Act, the VBP program was applied to payments beginning in fiscal year 2013; incentive payments to participating hospitals are based on performance on each measure and improvement on measures compared to baseline status. The approved measures and dimensions are grouped by specific domains of quality (Tables 1-3).[2] Although ESRD is case-mix adjusted, there are no explicit clinical processes of care measures for ESRD. Arguably, the clinical process of care domain and patient experience of care domain encompass what is important to the ESRD patient (Table 1). One may argue that the nephrologist and the patient should determine what is most important to the patient. However, there is no performance measure or quality metric for decision-making. Consequently, there should be some latitude regarding ESRD metrics such as mortality ratios because patient choice may be in direct opposition to metric performance. One example would be an incident maintenance hemodialysis patient with a hemodialysis catheter older than 90 days who chooses not to undergo vascular access surgery and subsequently develops a fatal central line-associated bloodstream infection. The death negatively impacts the standardized mortality ratio of the hemodialysis unit. In this case, patient self-determinism abridges CMS' call for an abolition of dialysis catheters, and the value-based hospital is penalized for it. CMS would argue that the outcome domain for mortality of ESRD patients remains exceedingly high. This patient's catheter-related death would be simply considered a failure on the nephrologist's part by CMS. Notably, there have been impressive reductions in first- and second-year death rates of, respectively, 14% and 16%, between 2003 and 2009.[3] These improvements were driven by reduced mortality from infections and cardiovascular disease. Hemodialysis catheter rates increased during this period, following implementation of the Fistula First Breakthrough Initiative.[4] ESRD-related death from infections has decreased remarkably over the last 2 decades, but mortality attributable to other causes has worsened since 1999. Moreover, disturbingly high rates of all-cause mortality persist in the early months of renal replacement therapy (RRT) in the ESRD population, particularly among the elderly. Succinctly, death in the dialyzed is 10-fold greater than for similarly aged Medicare patients sans CKD. The worry is that invoking

© 2016 by the National Kidney Foundation, Inc. All rights reserved.
1548-5595/$36.00
http://dx.doi.org/10.1053/j.ackd.2015.11.001

Table 1. Applicable Domains, Fiscal Year (FY) 2013 to 2015

FY	Applicable Domains
2013	Clinical process of care Patient experience of care
2014	Clinical process of care Patient experience of care Outcome
2015	Clinical process of care Patient experience of care OutcomeEfficiency

Reproduced with permission from Department of Health and Human Services, Centers for Medicare & Medicaid Services (2014, November).[2]

patient-centeredness may affect value-based purchasing in a perverse and negative way. On a population basis in a value-based environment, one would argue that dialysis of the elderly represents an unfavorably very high cost per patient.

A dialysis patient who is aged 65 years or older has twice the mortality than a general population patient who has either diabetes, cancer, congestive heart failure, stroke, or acute myocardial infarction. Why are only 51% of dialysis patients and 82% of those undergoing preemptive kidney transplantation alive just 3 years after the initiation of ESRD therapy? The answer has been hiding in the open. Since 2005, the 3 most cited papers of "Advances in Chronic Kidney Disease" in order are "The prevalence of symptoms in end-stage renal disease: a systematic review" by Murtagh, and colleagues in 2005,[5] "Progression in chronic kidney disease" by Eddy in 2005,[6] and "Cognitive impairment in the aging dialysis and chronic kidney disease populations: an occult burden" by Murray and colleagues in 2008.[7] A re-reading of these articles along with "Cardiorenal syndrome in critical care: the acute cardiorenal and renocardiac syndromes" by Cruz in 2013[8] serves as a backdrop of this issue of Geriatric Nephrology by Guest Editor, Samir Patel. In this issue, a theme emerges: those with progressive CKD often have subtle symptoms, including cognitive dysfunction and depression, unrecognized by many health-care providers. Acute kidney injury compounds this scenario in which elderly patients with advanced CKD or who already are on maintenance dialysis treatments become increasingly and perilously frail, especially those with evolving cardiac dysfunction: systolic, diastolic, and/or arrhythmogenic.

Another reason for premature death during RRT is found in Pareto's principle, the so-called "80–20 rule," where 80% of a problem results from just 20% of the mediators of the problem. In ESRD, the probability density function is not exactly 80 to 20, but mortality is greater than it should be simply because nephrologists and/or patients have chosen the "dialysis option" instead of the "no dialysis option" for a variety of reasons.[9] Some examples include the following: (1) the patient has a serious disease, particularly in the critical care setting, and, if the patient is dialyzed, the patient will "pull through"; (2) the patient is offered a menu of options for pre-end-of-life-care that includes dialysis, but the patient and/or family are not informed that dialysis is likely

Table 2. Clinical Process of Care Measures, Fiscal Year (FY) 2013 to 2015

Measure ID	Measure Description
AMI-7a	Fibrinolytic therapy received within 30 min of hospital arrival
AMI-8a	Primary PCI received within 90 min of hospital arrival
HF-1	Discharge instructions
PN-3b	Blood cultures performed in the emergency department before initial antibiotic received in hospital
PN-6	Initial antibiotic selection for community-acquired pneumonia in immunocompetent patients
SCIP-Inf-1	Prophylactic antibiotic received within 1 h before surgical incision
SCIP-Inf-2	Prophylactic antibiotic selection for surgical patients
SCIP-Inf-3	Prophylactic antibiotics discontinued within 24 h after surgery end time
SCIP-Inf-4	Cardiac surgery patients with controlled 6:00 a.m. postoperative serum glucose
SCIP-Inf-9 (for FY 2014 – 2015 only)	Urinary catheter removal on postoperative day 1 or postoperative day 2
SCIP-Card-2	Surgery patients on a beta-blocker before arrival who received a beta-blocker during the perioperative period
SCIP-VTE-1 (for FY 2013-2014 only)	Surgery patients with recommended venous thromboembolism prophylaxis ordered
SCIP-VTE-2	Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 h before surgery to 24 h after surgery

Abbreviations: AMI, acute myocardial infarction; HF, heart failure; PCI, percutaneous coronary intervention; PN, pneumonia; SCIP, Surgical Care Improvement Project; VTE, venous thromboembolism.
Reproduced with permission from Department of Health and Human Services, Centers for Medicare & Medicaid Services (2014, November).[2]

permanent; (3) the patient and/or family will "never give up hope"; (4) the nephrologist is discomforted by being the last care provider to "pull the plug"; (5) familial, social, and/or religious reasons; and (6) financial reasons (possibly immoral). Any of these 6 reasons may obscure more important discussions that better reflect patients' wishes, including symptoms, quality-of-life, and end-of-life preparation.

Regardless of the reason, our value-based imperative is that we must do better. Otherwise, health-care costs from ESRD will continue to escalate from their presently disproportionate level of 7% of the greater than half-billion dollars of total Medicare expenditures. Overall, the goal is delivery of value-based care, that equates with care of value to the patient. The financial reward is the corollary of the delivery of such care, not the driver.

Renal physicians must play a role in finding solutions to this financially unsustainable model of care by doing less

Download English Version:

https://daneshyari.com/en/article/3846260

Download Persian Version:

https://daneshyari.com/article/3846260

Daneshyari.com