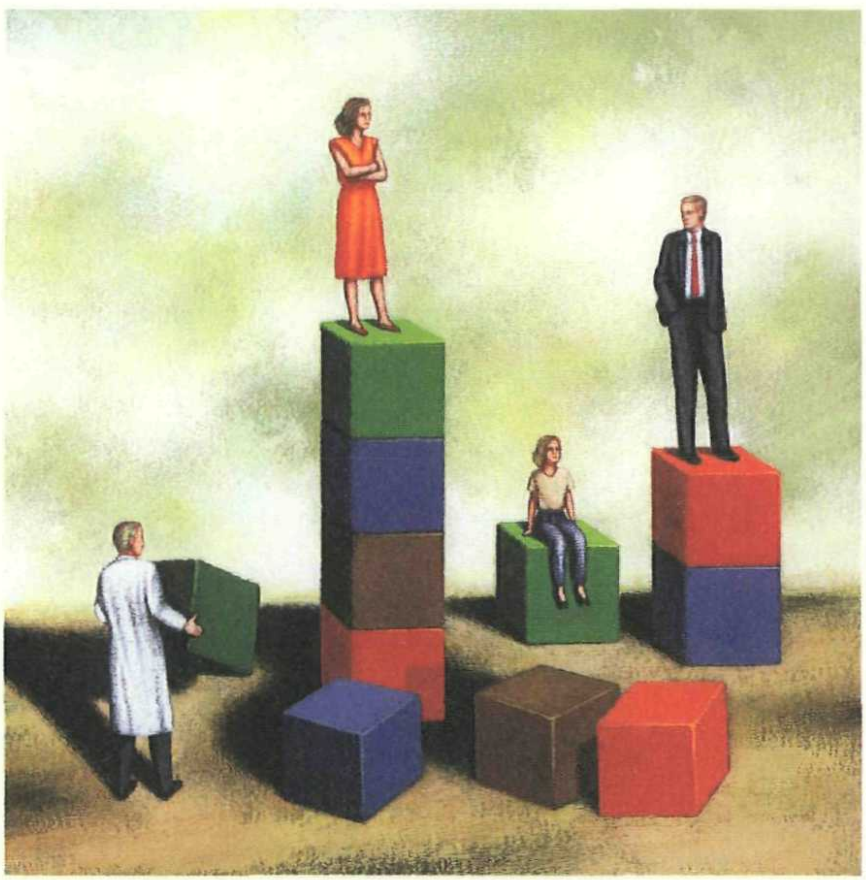
Allocating Resources Wisely

Providers Tackle the Tough Decisions

Resource utilization is a complex problem that requires a complex response. The experiences of others may help you tackle the issue in your own institution.



Tomek Olbinski

SPECIAL SECTION

A DIALOGUE ON STEWARDSHIP

A Multiunit Organization Commits to Improving Utilization Of Scarce Resources

BY RONALD L. MEAD, DOUGLAS D. FRENCH, & MICHAEL A. SLUBOWSKI

Summary To initiate a dialogue and begin addressing the issues of appropriateness of patient care and resource utilization, since 1988 leaders within the East Central Region of the Daughters of Charity National Health System (DCNHS-EC) have conducted a series of workshops involving managers, physicians, ethicists, attorneys, and others. The dialogue initiated in these workshops, along with the results of a 1991 survey of the region's local health ministries, has provided DCNHS-EC with baseline information on how each of the region's institutions supports care givers in making ethical decisions at the bedside level.

The first workshop focused on the ethical dimensions of providing high-quality care with reduced reimbursement, local initiatives for ensuring quality while containing costs, and steps DCNHS-EC hospitals could take to promote effective use of scarce medical resources. Subsequent workshops provided opportunities for further exploration of these issues. Another workshop is being planned for late 1993 or early 1994.

DCNHS-EC health ministries are taking a number of concrete steps to improve appropriateness of care and resource utilization. The support of local management, governance, and physician leaders is critical to these efforts.

As healthcare costs continue to escalate, Americans have increased their scrutiny of how medical resources are used. Likewise, over the past five years, leaders at the East Central Region of the Daughters of Charity National Health System (DCNHS-EC) and its nine local health ministries have become increasingly aware of the need to address the appropriateness of patient care and the ethical use of limited medical resources.

The East Central region is one of four regional organizations that make up the Daughters of Charity National Health System. DCNHS-EC comprises 19 facilities in six states, with a total of about 5,300 beds. The region's local and regional executives have made a long-term commitment to work with physicians and other care givers to enhance the ethical use of resources while maintaining high-quality patient care.

DCNHS-EC is beginning to link these efforts to its local and regional strategic planning and priority-setting process. The region's Performance Enhancement Steering Committee, composed of a senior operating executive from each location and chaired by the regional vice president of strategic planning and analysis, facilitates comparison of financial and clinical information for selected high-volume case types.

Now, after years of education and analysis involving physicians, managers, ethicists, attorneys, and others, DCNHS-EC's local health institutions have defined objectives (as part of their operating and capital budgets) designed to improve the appropriateness of care they provide. In addition, the region now has baseline informa-



Mr. Mead is vice president, strategic planning and analysis, Daughters of Charity National Health System–East Central Region, Evansville, IN; Mr. French is president and chief executive officer, St. Mary's Medical Center, Evansville, IN; and Mr. Slubowski is executive vice president and chief operating officer, Providence Hospital, Southfield, MI.

tion on how each of its local healthcare institutions supports its care givers in making ethical decisions at the bedside level.

Workshops

Since 1988, DCNHS-EC has conducted a series of workshops on improving appropriateness of care and resource utilization. Each has reflected the region's progress in grasping the key factors relevant to these issues.

Workshop I One impetus for the first workshop was a 1988 clinical performance improvement effort at St. Thomas Hospital in Nashville. Using five physician task forces, St. Thomas identified several ways to lower costs and improve outcomes. The hospital was able to achieve cost reductions only because physicians were willing to change some of their traditional practice patterns in such areas as critical care use of ancillary services.

The one-day workshop was an opportunity for regionwide dialogue among DCNHS-EC medical and administrative leaders. It allowed participants to:

- Discuss the ethical dimensions of delivering high-quality care with reduced reimbursement
- Discuss local initiatives for ensuring quality while containing or reducing costs
- Identify steps hospitals could take to promote stewardship and effective use of scarce medical resources

One major focus of the workshop was on the ethical implications of providing aggressive, costly treatment to patients who would likely receive little or no benefit from it. The keynote speaker, Rev. John Paris, SJ, challenged participants to consider the purpose of intensive care units (ICUs) and the ethics of admitting to ICUs patients whose health probably would not improve as a result. When physicians countered that the U.S. medical and legal system encourages such treatment in spite of the negligible results, Fr. Paris replied that hospitals must work with physicians to:

- Emphasize appropriate treatments likely to yield some benefit to the patient
- Develop policies and protocols that support ethical decisions by physicians and relieve them from the pressure to use every high-tech intervention that could possibly delay a patient's death

In addition to involving a significant number of physicians and senior managers in a discussion on appropriate and ethical use of medical resources, the workshop produced the following results:

- It led local DCNHS-EC healthcare institutions to examine how they could use their case-mix information system (maintained by all the region's ministries) to work with physicians to investigate clinical resource utilization patterns.
- It prompted the region's Performance Enhancement Steering Committee to grapple with the issue of sharing data related to various diagnosis-related groups and to begin developing comparative analyses of the methods and systems DCNHS-EC hospitals use for selected treatments (e.g., cesarean sections, cardiac catheterizations).
- It encouraged several hospitals to invite Fr. Paris to meet with their medical staff to discuss the ethical use of medical resources.

Workshop II A second workshop, held in 1989, built on this dialogue with physicians. It expanded the focus to consider organizational, operational, and clinical strategies to conserve resources and contain costs while ensuring high-quality patient care.

One presenter identified a need to begin developing protocols to guide medical care practice. His suggestion was based on an analysis of a 1988 Rand Corporation study of the appropriateness of coronary artery bypass surgery and a review of such surgery at several large DCNHS-EC hospitals. A representative from Providence Hospital, Southfield, MI, demonstrated how the hospital used its case-mix information system to reduce variations in practice patterns and improve resource utilization.

In another session, J. Philip Lathrop of Booz, Allen & Hamilton explained how the healthcare industry's fragmented approach to care creates inherent structural "idle/ready for action" time (see "Patient-focused Delivery Promises to Reshape Hospitals," *Health Progress*, May 1992, pp. 20-24). Hospitals have been organized to ensure efficiency for care givers and large, centralized ancillary services depart-

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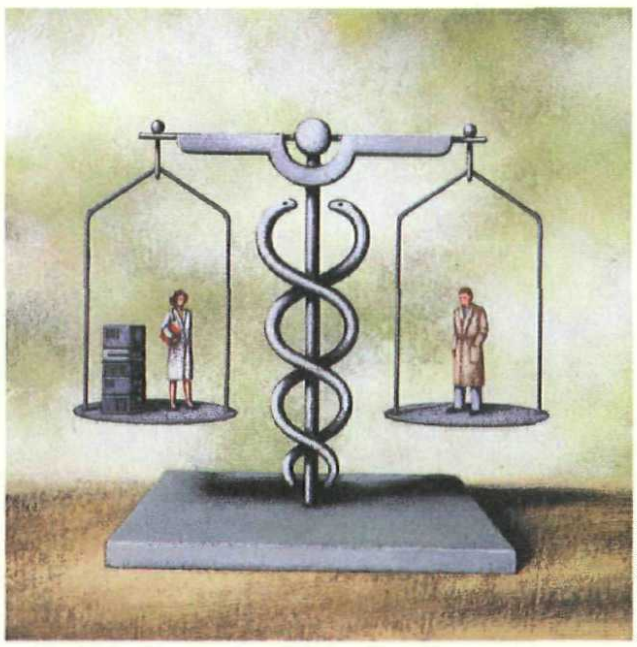

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ments, but are not organized to be responsive to patient needs.

The workshop motivated further initiatives by DCNHS-EC institutions. Several of the region's hospitals have been working to redesign their patient care and support systems to make them more patient centered and to improve coordination of care. This ongoing redesign work involves extensive retraining, cross-training, and redefinition of patient care and support roles.

In addition, a number of DCNHS-EC institutions expressed interest in sharing more clinical case-mix information with their physicians. To further these efforts, the Performance Enhancement Steering Committee and a small group of surgeons and nurses from a DCNHS-EC hospital helped develop a case management protocol for total hip replacements. Total hip replacements were chosen because the region's case management systems could provide good supporting data, the hospitals perform a relatively high number of the procedures, and one hospital interested in reducing the procedure's cost for patients volunteered to develop a sample protocol. This joint effort helped dispel some perceptions that physicians would not support efforts to reduce costs through use of protocols.

Workshop III An article from the *Annals of Internal Medicine* (Lawrence J. Schneiderman, Nancy S. Jecker, and Albert R. Jonsen, "Medical Futility: Its Meaning and Ethical Implications," June 15, 1990, pp. 949-954) provided a focus for

SURVEY ON APPROPRIATENESS OF

In 1991 the Daughters of Charity National Health System–East Central (DCNHS-EC) conducted a survey to better understand where each of its nine local health ministries stands in addressing resource utilization and appropriateness of care at the patient care–bedside level. Other survey goals were to identify and share concrete methods and tools for improving quality, appropriateness of care, and resource utilization and to establish a baseline from which progress on these initiatives can be measured.

Participants in the survey included the region's nine local health ministries, as well as two Catholic hospitals with which DCNHS-EC maintains an ongoing relationship.

The survey was sent to chief executive officers (CEOs), along with background information on the first and second workshops and plans for the third workshop. CEOs were asked to prepare an organized response with input from appropriate personnel in the local organization, including nursing, medical, quality assurance, and ethics staff.

The survey included questions in five areas:

- Systems and processes used to identify and address appropriateness of care and ethical issues
- Methods of providing support for ethical decision making by care givers
- The most difficult patient and procedure types
- Specific outcome targets currently in place
- Support needed in the future

Systems and Processes

Survey results indicated that most ethical and appropriateness of care issues identified at DCNHS-EC institutions are brought to the hospital ethics committee for consultation.

In addition to referring such issues to the ethics committee, many DCNHS-EC institutions:

- Conduct periodic medical staff and nursing ethics conferences
- Conduct periodic "ethical grand rounds" for physicians, residents, and nurses
- Provide on-call teams from ethics committees for consultation on difficult cases
- Review outlier cases for possible appropriateness or ethical concerns

All but one responding institution reported having a medical ethicist available for consultation and serving on the ethics committee. Four institutions have a full-time on-site medical ethicist.

Such systems and processes have led to a number of developments. Respondents reported having established policies concerning patient self-determination issues; do-not-resuscitate (DNR) orders; and admission, transfer, and discharge for special care units. They have also increased early DNR orders for terminally ill patients, shortened ventilator time for patients in vegetative states, and reduced thrombolytic treatment time through protocols developed in the emergency room. A number of institutions have also added a section to medical staff meetings for review of difficult cases.

Support for Care Givers

To support ethical decision making by care givers, patients, and families, respondents reported that they take a number of simple steps. Pastoral care staff visit patients and care givers daily, identifying potential ethical problems and preparing patients and families for decision making. Videotapes and brochures dealing with end-of-life and patient self-determination issues are made available to patients and families. Some facilities hold periodic "Clergy Day Conferences" to discuss medical ethics issues with clergy from all faith traditions.

Difficult Cases

Responses to questions concerning the types of procedures that create the most significant ethical, resource utilization, or

the third workshop in October 1991. The authors stressed that physicians must distinguish between a treatment's *effect*, "which is limited to some part of the patient's body," and its real *benefit*, "which appreciably improves the person as a whole." And they argued that treatment decisions should be based on potential benefit rather than on mere effect.

In planning meetings for the workshop, a work group (which included three physicians) reviewed some of the difficulties DCNHS-EC hospitals faced in addressing the appropriateness of care issue. Among these were physicians' legal concerns and a mind-set dictating that everything possible should be done to save or prolong a patient's life. The group decided that the region needed to develop a methodology allowing its hospital's chief executive officers to objectively review how effectively their facilities were addressing appropriateness issues.

On the basis of the group's recommendations, the workshop included five major components:

- Data, presented by a physician, demonstrating that there is "inappropriate care" in medicine today
- A medical perspective on medical futility
- A legal perspective on the conflict between rationing and rights
- An ethical perspective on physicians' obligations to use available resources to keep patients alive

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CARE AND RESOURCE UTILIZATION

appropriateness issues underscored the need to improve education and dialogue concerning ethical use of medical resources.

There can be, for example, a difference between a patient's right to refuse treatment and a patient's right to demand treatment. Without a physician case manager, termination of treatment decisions may be left unaddressed in critical care cases involving a number of specialists.

High-risk cardiac patients, long-term ventilator patients, and extremely premature infants were identified as three types of patients whose treatment raised difficult issues regarding the ethics and appropriateness of care. Important resource utilization issues included misuse of the intensive care unit (ICU) and the coronary care unit for terminally ill patients and the transfer of terminally ill patients from extended care facilities to hospital emergency rooms. A number of respondents listed decisions to institute and later discontinue advanced life support as a frequently occurring ethical issue.

Outcome Targets

The surveyed institutions indicated they are still grappling with how to measure improvements in appropriateness of care and resource use. They are presently trying to achieve a variety of goals, including:

- Reducing variation in care patterns and costs through case management
- Reducing length of stay, particularly in the ICU
- Reducing costs in high-volume procedures
- Reducing outlier cases and referring them to the ethics committee for early consultation
- Utilizing critical care and telemetry beds more appropriately by ensuring adherence to admission and discharge criteria
- Studying the appropriateness of the use of observation beds

Support Needed

When asked to describe the resources, tools, and other support hospitals need to identify and address appropriateness of care and resource utilization issues, respondents pointed to three major areas: improved education, clearer expectations, and improved information. They cited a need for programs and workshops allowing physicians and other care givers to explore medical and ethical issues affecting healthcare decision making. Another priority was finding ways to interest and involve physicians in discussions on the appropriateness of care and resource utilization.

A number of those surveyed noted that physicians and other care givers are sometimes uncomfortable discussing end-of-life issues with patients and families. They indicated that early training (e.g., in medical school, residency programs) in this area would be beneficial.

Respondents said that poorly defined expectations ("Are we to provide appropriate care with the patient's consent or offer everything to everyone?") are another hindrance to the provision of appropriate medical care. In addition, they pointed out that few or no mechanisms exist for systematically involving constituencies in a dialogue about these issues.

They recommended that hospitals increase the involvement of patients, families, physicians, and other care givers in defining appropriate outcome expectations and care options—and that they do this in advance of interventions. Respondents also said that care givers need more tools to communicate, when the time comes, that no more can (or should) be done.

Better access to integrated clinical, financial, and demographic data was also mentioned as an important need. Those surveyed noted that such information would be particularly helpful to hospital and medical staff committees working to improve appropriateness of care.

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Presenters emphasized the importance of distinguishing legal issues from medical and ethical issues.

• Results of a survey of the nine DCNHS-EC local health ministries (and two other related Catholic hospitals) to determine what they are doing to address appropriateness of care and resource utilization issues at the patient care level (see **Box**, pp. 28-29)

The workshop sessions highlighted the need for explicit discussion of such important issues as the true goals of medicine, public expectations regarding patient care, and assumptions about patients' rights to demand treatment and physicians' rights to refuse to provide unnecessary or futile care. Presenters stressed the need for objective feedback on practice patterns and meaningful research on technology assessment and outcomes. They also emphasized the importance of distinguishing legal issues from medical and ethical issues.

Continuing Dialogue and Commitment

To ensure appropriateness of care and ethical use of resources, we need to involve all interested parties in a dialogue on these issues. These constituencies include physicians, nurses (and other care givers), patients and their families, managers, board members, lawyers, ethicists, and the community.

The process also requires a sustained commitment to action. To date, DCNHS-EC and its nine local health ministries have only initiated the dialogue and laid a foundation for future work in improving appropriateness of care and the ethical use of resources. Some of our next steps include the following:

• Accomplish at least one objective in each DCNHS-EC health ministry in fiscal year 1993 that demonstrates improved appropriateness of care (e.g., implementing case management and patient treatment protocols, new data bases for assessing outcomes of selected procedures, or new procedures to improve appropriateness of laboratory testing)

• Use annual planning and budgeting review sessions to assess performance on such objectives and to routinely review accomplishments in annual sponsorship reports

• Develop more specific cost, utilization, and productivity targets

• Continue developing and sharing comparative data on treatment profiles for specific surgical procedures through DCNHS-EC's Performance Enhancement Steering Committee

• Facilitate working sessions for DCNHS-EC managers who maintain their institutions' case-mix information systems to improve our use of the systems and to make information more accessible to those who need it

• Work with DCNHS-EC physician and executive leaders to present additional workshops on appropriateness of care and resource utilization

• Update and readminister the survey of DCNHS-EC healthcare institutions

The support of local management, governance, and physician leaders is critical to the region's ongoing dialogue on appropriateness of care and resource utilization. With this sustained effort and commitment, we hope to be able to document, measure, and evaluate our progress over time. □

Interested persons may borrow videotapes of Workshop III or obtain copies of the survey form and summary of results by contacting Ronald L. Mead at 812-963-3301.

IMPROVING UTILIZATION

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days caused by a delay in service or procedural problem may or may not require physician review. Finally, the utilization management committee reviews causes of nonacute days and recommends steps to eliminate them.

• Completion of a transitional care study to identify the benefits of transferring medically stable Medicare patients to the Skilled Nursing Facility. Two physicians reviewed 30 cases chosen at random from a one-year period and identified the point at which patients would have been medically stable enough for transfer. Two nurses, familiar with operation of skilled nursing facilities, also reviewed these cases to determine which of these patients would have been eligible for skilled nursing. The study identified possible benefits for this hospital of changing patterns of utilization in this critical area.

A Successful Program

Saint Vincent's efforts have been highly effective. Medicare average length of stay dropped from 7.47 days in 1990 to 6.74 days in 1991. By the end of June 1992, the average had fallen to 6.31 days.

These reductions have not only helped Saint Vincent improve its bottom line, they have also heightened hospital managers' awareness of the importance of supporting physicians in their efforts to provide high-quality care to patients. By looking closely at variations in practice patterns and providing systematic support to the medical staff, Saint Vincent has been able to steward scarce medical resources and at the same time enhance the quality of its services.

As the medical review officer and staff physician Thomas E. Brewer recently commented: "Quality is inevitably enhanced when a hospital looks closely at variation in practice patterns and systematically provides supports to its physicians so that the causes of variation can be better understood." □

The authors dedicate this article to the memory of Thomas E. Brewer, MD, medical review officer, who recently died as a result of injuries sustained in an automobile accident.