Editorial

Critical Care Professionalism in the Age of Pay-for-Performance: From ICUs to Outpatient Critical Care Clinics

By Peter E. Morris, MD

In this, my first editorial as physician coeditor of the *American Journal of Critical Care (AJCC)*, I wish to express my very deep and sincere appreciation to several people who have gone to extraordinary lengths to help me along the coeditor's learning curve. To my colleague and coeditor Kathy Dracup, a special thank you and a promise to attempt to match in effort, as a coeditor, the wonderfully diligent work she and Chris Bryan-Brown have delivered since the journal's inception. My thanks also to the *AJCC* editorial staff and to the leadership and membership of the American Association of Critical-Care Nurses (AACN) for this opportunity to serve the journal.

With this new prospect I have been given shared responsibilities with Kathy Dracup to act on behalf of AACN to edit the scientific work submitted by authors in all critical and high acuity care fields. To Chris Bryan-Brown, now our founding coeditor, I am grateful for the guidance and advice he has given to continue with an attitude of multidisciplinary excellence for patient care. He has advised me to maintain the important emphasis that the patient is at the center of our thoughts, and I will certainly strive to do so.

In addition, a journal editor is given the unique opportunity to contribute to the field of critical patient care through peer review and editorial

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comments. To all present and future authors, reviewers, AACN members, readers, critical care experts, and other health professionals, I promise that my commitment will be passionate, focused, and flexible. This journal will continue to promote what is both novel and substantial for the care of critically and acutely ill patients and their families.

The Age of Pay-for-Performance

In thinking about messages to include in this first editorial, I feel compelled to write about how we, as critical care practitioners, continue to face new aspects of care and policy. No day goes by in the intensive care unit (ICU) or in hospital practice without one encountering terms and phrases such as "quality improvement" and "practice of evidence-based medicine," but one term in particular is rising in frequency, both in hospital administration and critical care circles, and that is *pay-for-performance*.

Pay-for-performance, sometimes called P4P, is a concept tied to the US healthcare system's reimbursement structure that is promoted by insurance carriers and the federal government to "motivate" healthcare practitioners to deliver the best care for patients. In the current hospital reimbursement structure, hospitals receive money from insurance carriers based on how the patient's hospital stay is characterized by disease-related groups (DRGs). Most hospitals employ staff to "abstract" a medical chart to calculate the DRG. The staff personnel list the patient's diseases and procedures encountered during the hospital stay using *International Classification of Diseases, Ninth Revision (ICD-9)* codes. The *ICD-9* codes are examined by computer software that "tabulates" the most appropriate DRG, thereby determining what payment the hospital may request from one or several insurance carriers.

With this concept, a hospital may be financially rewarded for performing a specific task at a benchmarked rate for a whole group of patients (eg, a high percentage of pneumonia patients receiving antibiotics within 4 hours after arrival would allow extra compensation to the institution). Likewise, if the benchmark is not met by a significant degree, the institution receives a financial penalty.

One of the most noteworthy experiments with pay-for-performance recently was published in the *New England Journal of Medicine*.[1] The Centers for Medicare and Medicaid Services (CMS) and Premier Inc partnered in this national Hospital Quality Incentive Demonstration pay-for-performance project. The investigation was structured to determine whether financial incentives were an effective intervention to improve the quality of inpatient hospital care.[2] The report reflected the experience of 207 hospitals, though the overall extra administrative costs of the data collection were not reported.[1] The hospitals reported their own experience in performance with core measures within acute myocardial infarction, heart failure, and community-acquired pneumonia.

Over a 2-year period, the estimate for incremental effect of pay-for-performance in improvement of the 207 hospitals was only 2.9%. In their discussion, the researchers themselves called into question the costs for pay-for-performance programs and asked whether the benefits of such programs are worth the added administrative costs and complexities they incur.

Controversy and Concern

Clearly, then, there is controversy and concern about the use of such systems. One important question is whether the pay-for-performance systems proposed by federal and private insurance carriers were developed sufficiently before their widespread application. Some worry that the theoretical merits of the pay-for-performance programs have not yet been borne out in pilot applications. The reality for ICUs is that pay-for-performance is well on its way, despite several serious misgivings like those outlined above.

The US Congress has declared through passage of the Deficit Reduction Act of 2005 that the CMS must develop a plan for hospital "value-based purchasing" by 2009. The Joint Commission already has published the *Specifications Manual for National Hospital Quality Measures – ICU*, which includes 6 separate ICU-related measures.[3] Four measures are recommended for national implementation:

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Ventilator-Associated Pneumonia Prevention, Stress Ulcer Disease Prophylaxis, Deep Vein Thrombosis Prophylaxis, and Central Line Associated Bloodstream Infection. Two are test measures not to be publicly reported "until additional information on training needs, reliability, and the impact of reliability on the predicted outcomes can be ascertained"; they are ICU Length of Stay (Risk Adjusted) and Hospital Mortality for ICU Patients.[3]

One example of potential flaws in the system as it relates to ICU performance is the controversy over how palliative care would be extracted. Garland[4] notes that ICU or hospital mortality rates are commonly used measures that are at first glance relatively simple to collect. However, although hospitals with high short-term mortality rates may be cited for areas in need of improvement, an alternative explanation could be that short-term mortality rates reflect better palliative care that is more consistent with patients' end-of-life wishes.[4] The pay-for-performance system proposed by the CMS using Joint Commission measures would be unable to make adjustments for palliative care time spent with dying patients and their families in the event of an associated in-hospital death.

The Human Element

A very important lesson that cannot be overemphasized in our daily work appears in AACN's *Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence*.[5] One key idea in this work that serves as a reminder not only to nurses but to all critical care practitioners is that we must maintain a high degree of engagement in directing and evaluating clinical care for our critically ill patients. The premise that only "systemic" solutions are needed to link patient safety and professional critical care performance detracts from that essential human element of critical care professionalism.

The human element means that we have the ability to pause and slow down, allowing our critical thinking skills to be enhanced for the patient directly in front of us. To address the pay-for-performance age, each of us can ask the question, *Where can I make a difference*? For example, every time patient care responsibilities change hands, the "information" transferred (both verbal and written information) should be considered as precious a cargo as our patients themselves.

Specific Pay-for-Performance Solutions for the Bedside Practitioner

With pay-for-performance systems, the metric by which ICUs will be graded will come from what we write in patients' charts and flow sheets. In this pay-for-performance world, a heightened attention will be brought to our documentation of all pertinent patient information, particularly within the first 24 to 48 hours of the patient's stay in the ICU. These assessments will certainly be important in mortality risk assessments that will be applied to ICU outcomes.

The Chronically Critically Ill and the Rise of Critical Care Outpatient Clinics

In a report from the US Congressional Budget Office, 48% of the top quartile of Medicare beneficiaries are characterized as having more than one chronic organ system dysfunction.[6] Without specifically mentioning the term, the report emphasizes precisely what critical care practitioners have known for some time: that there is a population of *chronically critically ill* who maintain a high hospitalization rate. How well we transition the ICU survivor and the chronically critically ill to the outpatient setting has been handicapped by outpatient systems that tend to have a single-disease management focus.

Although they are well meaning and their merit is supported by data, single-disease management approaches for asthma, diabetes, and congestive heart failure may be insufficiently flexible to handle the multiple-organ-dysfunction patient population. Such programs may not be the best way to improve care for post-ICU patients with multiple chronic conditions.[7] On the other hand, critical care outpatient clinics may better facilitate the transition of care from critical care practitioners to primary care practitioners.[7]

Critical care outpatient clinics could serve as a discrete mechanism for gathering recovery information on many aspects of critical illness. To learn how quickly immediate milestones can be reached in an ICU patient's recovery, the critical care community may be compelled to more closely associate with the immediate post-hospital phase. The critical care community could use immediate post-hospitalization information to better impact how the patient fares "downstream" by altering what we do in the ICU. Short-term outpatient care coordinated by critical care–minded practitioners for the chronically critically ill is a novel and potentially very useful approach

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not only for hospital and clinic administrators, but for bedside ICU practitioners as well.

Toward Critical Care Professionalism

Bringing pay-for-performance and critical care professionalism into perspective can translate into the here and now. First we must bear in mind that what we do right now affects not only whether the ICU patient becomes an ICU survivor, but also how quickly that ICU survivor can achieve recovery of speech, clear thinking, and motor skills. What we do *to* and *for* critically and acutely ill patients affects each phase of the patients' healing process. Critical care outpatient clinics are one means to facilitate performance measurements and exercise critical care professionalism. They also might help us improve our ability to determine which small changes in care now can both reduce mortality rates and decrease the amount of time required to reach recovery of patients' important functional milestones.

In the end, the most appropriate response we can make to pay-for-performance—and the one I think will most benefit our patients—is professionalism, which ultimately means that we must strive even harder to make better and closer observations of our patients across the spectrum of critical and high acuity care, from ICUs to outpatient critical care clinics.

The statements and opinions contained in this editorial are solely those of the coeditor.

FINANCIAL DISCLOSURES
None reported.

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