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From the Editor

Hips and Knees

David B. Nash, MD, MBA*

* Thomas Jefferson University

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From the Editor

Hips and Knees

Pennsylvania has done it again! With modest fanfare, the Pennsylvania Health Care Cost Containment Council (PHC4), an independent state agency charged with collecting, analyzing and reporting information (that can be used to make more informed decisions thereby improving the quality and restraining the cost of health care in Pennsylvania), has released the first ever publicly funded, statewide physician- and hospital-specific report on the outcomes of total hip and knee replacement surgery. If nothing else, this report is a tour de force of our data collection and dissemination capabilities. What does this report contain and what are its implications? What's missing and, as a result, what might be the final impact of said report?

The official report entitled, "Total Hip and Knee Replacements" for the Fiscal Year July 1, 2001 to June 30, 2002, was released earlier this past summer.¹ There are several key findings in this important report including the fact that total hip and knee replacements have steadily increased in Pennsylvania. Most notably, between 1993 and 2002 the number of knee replacements increased by more than 70 percent and the number of total hip replacements increased by nearly 50 percent. With this dramatic increase in surgery comes some untoward consequences including a readmission rate due to deep joint infection or device problems that resulted in nearly \$30 million in charges and more than 6,000 hospital days.

The report outlines, by individual hospital and surgeon, the total number of cases in Pennsylvania at a staggering 29,710 with 9,769 total hip cases and 19,941 total knee cases. In a press release accompanying the report, Marc P. Volavka, the executive director of PHC4 noted, "This report demonstrates that most hospitals and orthopaedic surgeons in Pennsylvania are providing good to excellent care overall. However, variation in readmissions due to complications and infections continued to present major opportunities for quality improvement and cost containment."¹

Putting the hip and knee report into national perspective is a complex issue. Astute readers of the Health Policy Newsletter know that we have covered aspects of this territory previously in "Heart Attacks in Pennsylvania" (September 1996), "Report on Report Cards" (May 1998), and most recently, "The Vision for a National Quality Report" (September 2001). Space precludes my ability to review the literature on the impact of public reporting. One thing is for sure, Pennsylvania has made a unique contribution to the national conversation about accountability and outcomes in health care. Pennsylvanians now have an opportunity to ask far more detailed questions of their prospective orthopaedic physician including issues such as: "What is your deep joint infection or device problem rate?; How many blood clots in the lung or leg did your patients have in the last year?; and, "What is the likelihood of my being readmitted to the hospital under your care?" We are now able to engage in a conversation with these provocative questions in a way that simply did not previously exist.

Yet, as in my previous columns on report cards and performance reports in medicine, I remain ambivalent about the overall impact of this report and its predecessor reports on coronary artery bypass graft surgery. Here's why. The literature on the public's ability to analyze this information certainly presents a rather dim view. Experts like Judith Hibbard from the University of Oregon in Eugene, and others, have been writing for nearly a decade about what the public really wants in a report card.² In a nutshell, the public has a difficult time discerning issues such as lower than expected or higher than expected rates of complications, readmission, or post-operative length of stay. It turns out, the public is interested, probably, in "Where will I be safer?" and "What is the likelihood of harm?" These are notoriously difficult issues to quantify. Also, we know that the public still, regrettably, chooses physicians largely based on the advice of family and friends without much regard to an internalization of the results of multiple public report cards available now online 24 hours a day.³

There is another dark side to public reporting that has recently come to light. Some national experts contend that there are "unintended consequences of public reporting including causing physicians to avoid sick patients in an attempt to improve their quality ranking, encouraging physicians to achieve target rates for health care interventions even when it may be inappropriate among some patients, and discounting patient preferences in clinical judgment."⁴ Public reporting of quality information promotes a spirit of openness that may be valuable for enhancing trust of the health professions, but its ability to improve health remains undemonstrated and public reporting may inadvertently reduce rather than improve quality."

The controversy surrounding the value of detailed public accountability for health care services remains unresolved. What else, then, is missing from this important new report? Of course, the report does not give us patient-specific information about their ability to return to productive work and to enjoy a renewed quality of life. Physician-specific reports on deep joint infection and blood clots are important as they may lead to work to improve the process of care. But, the report is only a jumping off point, a moment in time. It does not provide us, like all public reports, with a roadmap for improvement.

Some time ago, Marvin Bentley and I carefully studied the impact of public reporting for coronary artery bypass graft surgery in Pennsylvania.⁵ We found that, while individual referring physicians, patients, and managed care organizations may have given scant attention to CABG report cards, it was the hospitals who took the reports to heart and used them as quality filters to more carefully examine their own processes and systems of care. The fact remains, however, that as the data in the hip and knee report diffuses rapidly into the marketplace, we may regrettably see orthopaedic surgeons more carefully preselecting patients, turning away those who are obese with severe diabetes or with a history of multiple chronic medical problems.⁶

Is all lost, then, in the seeming morass of public accountability and our inability to effectively use the information? I think not! PHC4 has made, in my opinion, a major contribution to our understanding of the processes involved in providing such complex surgery as hip and knee replacement. The report has given hospitals a wake-up call to carefully self-evaluate and seek ways to improve the quality and safety of medical care. The report has given individual physicians ample reason to look in the mirror and ask difficult questions about their own performance. Careful readers of the report will note that some physicians do a handful of hip and knee

cases on an annual basis, while others do more than 340! I know which doctor I would prefer to go to, and it's no secret that most referring physicians would want a high-volume surgeon operating on them or a family member. As we move to a world of consumer directed health plans, the Pennsylvania report might come in very handy for individuals as they navigate the complex waters of hospital and physician selection.

I will go one step further. I challenge every other state to organize and disseminate a comparable report so that we can create a national benchmark regarding total hip and knee replacement surgery. In addition, I challenge the Center for Medicare and Medicaid Services to publicly endorse this report and begin a national dialogue regarding the possibility of linking outcomes to the payment process for total hip and knee replacement. Finally, I would urge every major employer in Pennsylvania to carefully study this report. As I noted in the Philadelphia Inquirer story that accompanied the debut of this report, "There is not a single doctor or hospital in the state whose performance is exemplary across all of the measures nor is there a single doctor or hospital whose performance is unacceptable.⁷ This report is only the beginning of the hard work necessary to improve the quality of hip and knee replacement surgery in the Commonwealth." I am proud of our department's involvement in this work through my service as the chairman of the Technical Advisory Group of the PHC4. The report has made us all take a long look in the mirror. The question remains, are we happy with the images that we see? As usual I am interested in your views, and you may contact me at my e-mail address, which is david.nash@jefferson.edu.

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