

The quality imperative: Why the kidney community must take charge



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“Quality is Job One” is a well-known advertising slogan for a top automobile manufacturer. In the health care arena, public and private payers are taking a hard, new look at quality. For example, the Medicare Modernization Act (MMA), passed by Congress last year, mandates hospitals report quality data to Medicare to receive a full inflation update. In July, Senate Finance Chairman Senator Chuck Grassley (R-Iowa) introduced legislation to strip the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) of its unique authority to accredit hospitals for Medicare, following findings from the Government Accountability Office that JCAHO surveys missed significant deficiencies. The result? Health care quality is now, more than ever, a political imperative.

The kidney community can take some pride in its quality commitment. For example, more than a decade ago, Medicare, concerned about patient mortality, worked with the kidney community to identify core indicators to measure dialysis quality, including adequacy and anemia management. Since then, according to a recent analysis, the percentage of dialysis patients meeting the adequacy standard has nearly doubled to 82% over that 10-year period, with similar impressive results for anemia management. In 2001, Medicare established the “Dialysis Facility Compare” website (www.medicare.gov) and posts online these two quality indicators and patient survival by facility to help kidney patients make informed choices selecting a clinic.

But the news is not all good. Other clinical issues linked to patient well-being, such as nutrition, use of arteriovenous fistulas, infection and inflammation, and treatment of comorbid conditions, such as cardiovascular disease, have significant opportu-

nities to improve.

Indeed, life expectancy statistics are sobering. According to the U.S. Renal Data System’s 2003 report, “The poor long-term survival of ESRD patients continues to be an area of concern. Expected remaining lifetimes for dialysis patients are only one-third to one-sixth those of the general U.S. population” (p. 106, Chapter 6, Outcomes: Hospitalization and Mortality, 2003 US-RDS ADR). Someone starting dialysis at age 20 can expect to live another 14 years (on average)—versus 58 for 20-year-olds, generally. For a 50-year-old person, life expectancy is 6 years versus 30 for others.

But there are long-term survivors on dialysis. In recent years, American Association of Kidney Patient’s (AAKP) mission has focused on *patient education*. We believe passionately that only a patient who *takes charge* of his or her health care can survive—and thrive. AAKP is an organization of survivors. Kidney patients do beat the odds, sometimes living 20 and 30 years or more on dialysis.

Having once been in the health care quality vanguard, where is the kidney community today? Perhaps the fair answer is it is struggling with new expectations from Congress and Medicare—with clear signs of impatience from both. As part of the MMA, Congress revamped the dialysis payment system to take the “profit” from ESRD drugs. That action reflects the belief that financial incentives drove ESRD drug usage. MMA also accelerated momentum on “bundling” ESRD drugs and lab services into the composite rate; and provided dialysis payments a modest, one-year inflation update of 1.6%, although the Medicare Payment Advisory Commission (MedPAC) recommended larger increases.

We at AAKP were not surprised. As early as May 2003, we shared our view that Congress would pass Medicare legislation, with ESRD drug payment reform and dialysis quality high priorities. The view was often found dismissed by others in the renal community. AAKP heard from congressional staff that a lack of alternative proposals forced Congress to act unilaterally, also

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an important factor limiting updates. Early in 2003, AAKP entered briefly into discussions with one dialysis provider to craft a proposal linking dialysis updates to quality. We believed Congress might have even been satisfied with a study.

In our view, there were other missed opportunities in MMA. With Congress poised to spend \$18 billion to improve Medicare payments for rural health, AAKP shopped a “cost-plus” reimbursement proposal for “critical access” rural and inner city dialysis clinics. Again, no takers.

Medicare has been equally short with our community. Last year, Medicare ripped up the longstanding monthly capitated payment (MCP) for nephrologists. Payment is now based on monthly patient encounters—another unilateral action. The kidney community is scrambling to respond.

Congress is now sending a clear message about new intentions for the Medicare ESRD program, including tying dialysis payments to quality. In June, Senator Max Baucus, the senior Democrat on the Senate Finance Committee, introduced S. 2562, the “Medicare Quality Improvement Act of 2004,” based on MedPAC proposals. Other members of Congress are also preparing ESRD “quality” bills.

AAKP welcomes Congress and Medicare’s “pay-for-performance” agenda. AAKP’s longstanding position is we support dialysis payment increases—and other reimbursement increases—when tied to quality improvement. As AAKP’s president, I am sometimes frustrated to hear or read that AAKP does not support payment increases. That’s simply not true! Just like every other American, our members expect accountability and quality in any purchase decision, including their health care services. Isn’t that just common sense? In fact, we wonder how often do dialysis providers market their clinics on quality?

To those who say health care services for kidney patients are just fine, I’ll paraphrase Robert Nardelli, the CEO of Home Depot: Here’s my simple belief. There is an infinite capacity to improve the health care of kidney patients. There is simply no way we are doing the best job possible.

Where do we go from here, and how can the kidney community retake the initiative on public policy? And let’s be clear: if we don’t, Congress and Medicare have more surprises ready to roll out. We have a great story to tell in Washington. Dialysis and transplantation are miracles, but three things would help: good ideas, budget savings, and momentum.

To supply ideas and momentum, the AAKP in October 2003 wrote to Tommy Thompson, secretary of the U.S. Department of Health and Human Services (HHS), and proposed a “National Commission on Kidney Patient Outcomes.” HHS needs more encouragement to make this happen. AAKP’s agenda includes the rush to bundling, CKD and chronic disease management, the new prescription drug benefit, how to advance new technology and biomedical solutions, transplantation, dialysis and other health care reimbursement, and patient education.

Let’s consider where the Congressional Budget Office might score ESRD program savings—savings for reinvestment in services to kidney patients. Here are two ideas worth \$19 billion over 10 years: First, can we reduce the \$6 billion spent annually on hospital care by just 15%? That collectively yields more than \$9 billion in 10 years. And if the 50,000 patients awaiting a transplant receive a kidney, our rough back-of-the-envelope calculations suggest another \$10 billion in savings (even subtracting the cost of surgery).

Thirty-four years ago, when AAKP was founded, our members were public policy “radicals,” lobbying Congress for any program to pay for dialysis to allow us to *live*. Private insurance coverage was limited, and hospitals often provided dialysis as charity, where “death” committees rationed care. Among AAKP’s most memorable moments was in November 1971. AAKP’s vice president, Shep Glazer, was dialyzed before the House Ways & Means Committee. Before Shep entered the hearing room, he told reporters, “Gentlemen, I am going to tell the committee that if dialysis can be performed on the floor of the Congress, it can be performed anywhere. Kidney patients do not have to be confined to hospitals. I want to show the committee what dialysis is really like. *I want them to remember us.*” And Congress did. A year later, in September 1972, Congress passed the special Medicare ESRD entitlement.

The next spring, AAKP announced “a new role in kidney health care delivery. We must be the consumer advocate and take a responsible position to ensure the following: 1) all patients who require treatment receive quality care; and 2) the patient and his or her physician make a joint determination on the type of treatment best suited to the patient.”

That message is as fresh today as it was 31 years ago. We believe the public policy risks and opportunities have never been greater—and we will step up. ■