



BY JARROD SHAPIRO, DPM

# Should Medical Providers Be Held Responsible for Patient Outcomes?

Does the new system go too far?

*Practice Perfect is a continuing every-issue column in which Dr. Shapiro offers his unique personal perspective on the ins and outs of running a podiatric practice.*

In our ever-progressing world of evidence-based practice, the push for assessment, pay for performance, and MACRA/MIPS, it appears medical providers will be held increasingly responsible for the outcomes they produce in their patients.

In some ways, this is a good thing. Clearly we want the medical care we provide—and receive—to be as good as possible, and, of course, the best way to determine quality is to look at outcomes. Additionally, it's clear that the medical payment system in the United States, in which reimbursement occurs based on procedures, is flawed.

The thought that outside authorities can accurately assess the success or failure of medical providers' care is equally flawed. The greatest reason for this flawed thinking is that these outcomes relate to a highly complex system—namely the human being. It's one thing for diseases themselves to be complicated and require skill and training to resolve successfully. Medical providers are well trained, for the most part, and are required to maintain a high level of training to combat these diseases. But it's another thing to handle the psychosocial aspect of care, i.e., dealing with the actual person.

Considering this incredibly shift-



ing variable, the human being, to what extent should medical providers be held accountable for their patients' outcomes? As a podiatrist, you treat a wide variety of often-complicated patients. You should be concerned about how you will be held responsible for outcomes on which you may have a small effect on individual patient characteristics that disproportionately influence the long-term outcomes.

Let's take a hypothetical but too often real example. Doctor A is seeing Mr. B, a long-term poorly controlled diabetic patient who presents with a new onset foot ulcer and cellulitis. The ulcer has been present for three months and has been self-treated by the patient with

over-the-counter antibiotic cream. His hemoglobin A1c is 13.9, demonstrating his poor control. After obtaining foot radiographs, you see destructive changes of multiple metatarsal heads and recommend a transmetatarsal amputation.

Given the severity of this patient's disease, he is unlikely to heal this amputation without a few bumps in the road. His high blood sugars—which Dr. A has almost no real control over—heavily increases the risk of post-operative complications such as dehiscence or infection. Blood sugar control (and the improved healing ability that accompanies it) is only partly affected by medications. It also requires behavior

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control on the part of the patient, with improved dietary habits and exercise. How easy is that? Not very. Even if the patient has a strong desire to improve his blood sugar control, it will be made that much more difficult by the sedentary nature of the post-operative recovery with the inability to exercise and likely increased weight gain. The physician, then, has little control over the actual outcome of the surgery. He can do everything possible to maximize the chances of a successful surgery, but there are limits.

Now consider a medical world in which providers are “graded” by the outcomes of patients over whom they have little true control. What motivation would the provider have to work hard to treat this patient?

This situation actually exists currently in the transplant community. Transplant surgery is competitive, and funding and reputation are often determined in part by success rates (for example, the lower the rejection rate, the higher quality the center is deemed to be). A system of this type, then, motivates the transplant centers to be highly selective for whom they choose to allow organ transplant surgery.

Imagine what would happen to our healthcare system if everyone who treated diabetic foot complications screened out their high-risk patients and only treated those at low risk. Imagine how full our hospitals would be with untreated diabetic foot infections!

In this scenario, a foot and ankle specialist would be very hesitant to do surgery. For example, Jupiter and colleagues retrospectively reviewed the records of diabetic patients who underwent surgery during a five-year period and found that rates of post-operative infections rose steadily as the glycosylated hemoglobin approached 7.3%, and then steeply between 7.3 and 9.8% (leveling off after that).<sup>1</sup> It would be easy to use this data to discriminate against those patients with a hemoglobin A1c above a level of 7.3%. In the world of pay for performance, only the bravest doctors would consider high-risk surgery (almost all diabetic surgery would be considered higher risk) in the face of an elevated hemoglobin A1c.

How many healthy 20-year-olds do you treat for ulcers? Almost none. Charcot reconstruction? Forget about it. Fusion procedures in patients who smoke or have other co-morbidities? Not likely. Surgeons would not want to risk their statistics and lose money.

It's not enough that the United States is a litigious country; now add decreased pay for unfortunate outcomes, and you've created a poor system indeed with a negative feedback loop that disincentives doctors from treating high risk patients. Unless the risk is calculated in the outcomes assessment, the results are flawed.

Although the current procedure-based reimbursement system has significant flaws and needs adjustment, we must be cautious about how far the system goes in the direction of performance-based payment. The system must balance the complexity of the human body with the fact that providers can only control a portion of the factors that actually affect outcomes. Proceed with caution, medical community! **PM**

## References

<sup>1</sup> Jupiter DC, Humphers JM, Shibuya N. Trends in Postoperative Infection Rates and Their Relationship to Glycosylated Hemoglobin Levels in Diabetic Patients Undergoing Foot and Ankle Surgery. *J Foot Ankle Surg.* 2014 May-Jun;53(3):307-311.

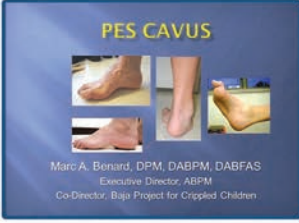
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