# Demo P4P Project Cuts Hospital Costs, Mortality

BY ALICIA AULT
*Associate Editor, Practice Trends*

Hospitals participating in a Medicare-sponsored, pay-for-performance demonstration project have sustained initial gains in quality improvement and have seen a huge decline in mortality and costs for selected conditions over the first 3 years of the project, according to data released by Premier Inc., a hospital performance improvement alliance.

Overall, the median hospital cost per patient dropped by $1,000 in the first 3 years, and the median mortality dropped by 2%. The project has 250 participating hospitals, and more than 1 million patient records were analyzed.

Premier, which is managing the Centers for Medicare and Medicaid Services–funded Hospital Quality Incentive Demonstration project, estimated that if every hospital in the United States achieved the same benchmarks, there would be 70,000 fewer deaths each year and hospital costs would drop by as much as $4.5 billion.

At a briefing to release the results, Mark Wynn, Ph.D., director of payment policy demonstrations at CMS, said that the hospital project is considered one of the agency's primary arguments in favor of value-based purchasing, a policy CMS regards as the most effective way to reward efficiency and value.

Dr. Wynn acknowledged that the financial incentives have been very small, but even so, there has been significant improvement. "Relatively modest dollars can have huge impacts," he said.

Dr. Evan Benjamin, chief quality officer for Baystate Health System in Springfield, Mass., agreed that even small financial carrots have an effect.

Dr. Benjamin was the lead author of a study looking at earlier data from the improvement project.

He and his colleagues found that quality was higher among the 250 hospitals that were given incentives than it was in control hospitals that were required to report their data publicly but were not given pay-for-performance incentives (N. Engl. J. Med. 2007;356:486-96).

There's room for even more improvement, Dr. Benjamin said at the briefing, noting that most of the hospitals started at a relatively high level of quality and that larger financial incentives might push greater gains.

The Hospital Quality Incentive Demonstration project began in October 2003; the data released covered every quarter through June 2007.

Hospitals were given aggregate scores for each of five conditions—acute myocardial infarction, heart failure, coronary artery bypass graft, pneumonia, and hip and knee replacement—based on reporting for 27 process measures. Hospitals with fewer than eight cases per quarter were excluded, and all the data were adjusted using the All Patient Refined–Diagnostic Related Groups (APR-DRG) methodology created by 3M Information Systems.

Overall, hospitals improved by an average 17% on a composite quality score used by the project. Improvements were largest in pneumonia and heart failure.

For instance, only 70% of patients were receiving appropriate pneumonia care at the start, but by June 2007, 93% were.

For heart failure, the numbers rose from 64% to 93% of patients getting quality care. Savings were also greatest for heart failure, at about $1,339 per case.

There was a continuing downward trend in performance variation among the hospitals, with all moving toward the ideal, said Richard Norling, president and CEO of Premier Inc. For the hospitals that were on target 100% of the time with 100% of patients, costs and mortality were lowest, he said.

For instance, the mortality rate for coronary artery bypass graft patients was close to 6% at hospitals that met appropriate care benchmarks in only half the patients or fewer. Mortality was just under 2% for facilities that met those benchmarks in 75%-100% of the patients, Mr. Norling told reporters.

Attaining the goals of the demonstration project required huge cultural shifts and large investments in information systems, according to two hospital executives whose facilities participated in the project.

Before the project, the Aurora Health Care system was reactive and was achieving only incremental quality improvement, despite having a culture and leadership that focused on better care, said Dr. Nick Turkal, president and CEO of the Milwaukee-based nonprofit system.

Participation in the demonstration project has changed the mind-set of the health care system staff to "a pursuit of perfection," Dr. Turkal said at the briefing. The system's 13 hospitals have 100,000 admissions annually. Data on meeting the pay-for-performance goals are given to employees every 60 days, and are updated regularly on the system's Web site for the public to see. Mortality and costs are down significantly across the system, but "we're not done yet," he said.

The demonstration project has proved that incentives can work, said Dr. Wynn. CMS is tinkering slightly with the project, however. Starting this year, there will be incentives not just for improvement over baseline and for hitting the top 20%, but also for hospitals that show the greatest improvement. A total of $12 million will be available, he said. ■

# Emergency Care Lacking at Doctor-Owned Specialty Hospitals

BY ALICIA AULT
*Associate Editor, Practice Trends*

Physician-owned specialty hospitals are largely unprepared to handle emergencies and should be more closely tracked to ensure that they comply with Medicare rules, according to a report from the Inspector General of the Department of Health and Human Services.

The IG's office reviewed written policies for managing medical emergencies, staffing schedules, and staffing policies for 8 days at 109 physician-owned facilities identified from a list provided by the Centers for Medicare and Medicaid Services. There are an unknown number of physician-owned specialty hospitals, according to the IG, which is urging the CMS to begin compiling a list.

Of the 109 hospitals surveyed, 66 were surgical, 23 were orthopedic, and 20 were cardiac hospitals. Eighteen of the cardiac hospitals had an emergency department; only 11 of the 23 orthopedic hospitals and 31 of the surgical hospitals had an ED. Thirty-three of the 109 hospitals were in Texas, 15 were in Louisiana, 9 in Oklahoma, 9 in Kansas, and 8 in South Dakota. The rest were spread across the U.S.

While half of the physician-owned hospitals surveyed had an emergency department, more than half of those EDs only had a single bed. Only 45% of the EDs had a physician on site at all times.

Ninety-three percent of the hospitals met Medicare staffing requirements: having a registered nurse on duty at all times, and a physician on call at all times. But seven hospitals did not have an RN on duty, and one hospital did not have a physician on call or on duty on at least 1 of the 8 days reviewed. Two-thirds of the hospitals told staff to call 911 in case of emergency.

While transferring a patient with an emergent problem to another hospital's ED is acceptable, it might be a violation of Medicare conditions of participation if a hospital uses 911 to obtain medical assistance to stabilize a patient, according to the IG. Thirty-seven of the 109 hospitals (34%) engaged in that practice, the IG reported.

A hospital also is not in compliance if it uses 911 as a substitute for providing services required by the conditions of Medicare participation, noted the IG.

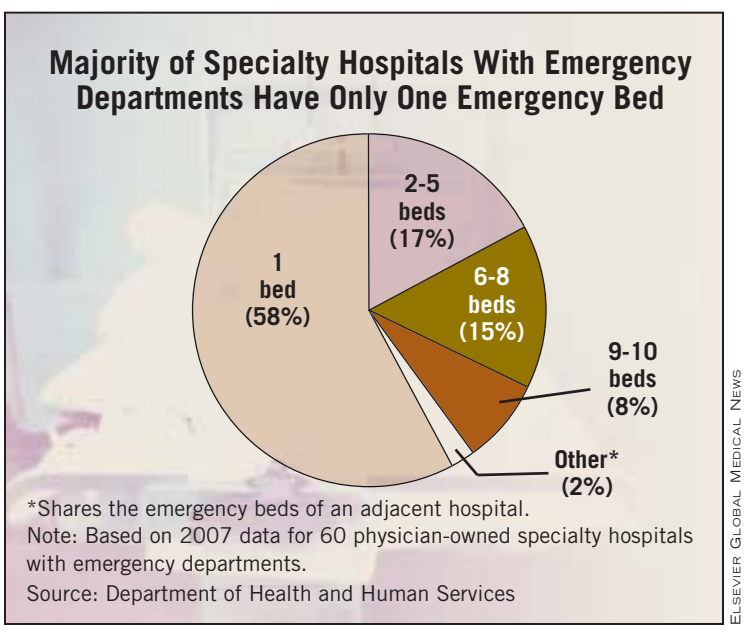
Almost 25% of the hospitals did not address in written policies the "appraisal of emergencies, initial treatment of emergencies, or referral and transfer of patients," stated the report.

The IG urged the CMS to enforce Medicare staffing requirements. Hospitals should also have written policies on how to use emergency response equipment or follow lifesaving protocols, said the IG.

The CMS issued a written response to the IG. The agency said it agreed with the IG's recommendations and it would examine current compliance through its routine hospital surveys. As many as 42% of the 109 hospitals would not have been subject to CMS oversight, however, because those facilities were accredited by the Joint Commission or the American Osteopathic Association.

Finally, the CMS said it would require hospitals to have written policies and procedures on managing emergencies, but that it would also consider whether regulatory changes are needed to establish specific requirements for equipment and staff qualifications.

Both the American Hospital Association and the Federation of American Hospitals pounced on the report, saying that it shows that physician-owned facilities are a threat to patient safety. Chip Kahn, president of the FAH, also called for a ban. The report, and "ongoing cherry-picking of healthier patients with good health coverage and increased utilization and associated health care costs, underscore yet another reason for Congress to pick up where it left off last year," he said in a statement. ■



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**Only half of the hospitals surveyed had an ED, and more than half of those had just a single bed.**