Hospital P4P Project Lowers Costs and Mortality

BY ALICIA AULT
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Hospitals participating in a Medicare-sponsored pay-for-performance demonstration continue to sustain initial gains in quality improvement and have seen a huge decline in costs and mortality for selected conditions over the project's first 3 years, 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 median mortality dropped by 1.87%. 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 a year.

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. CMS has been pushing that policy as the most effective way to restructure Medicare reimbursement 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.

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 said.

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 has changed the mind-set 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.

Improvements are possible regardless of facility size or location, said Dr. Mark Povroznik, director of quality initiatives at United Hospital Center, Clarksburg, W.Va. The 375-bed facility has about 15,000 admissions a year and is facing a large and growing uncompensated care burden, he said at the briefing.

The facility has gone from being among the top 20% in two conditions during the first year to being on track to hitting that mark for four conditions in the upcoming year, said Dr. Povroznik. The payout has been tiny, with an estimated $143,000 in bonuses due for 2007, but the rewards are large in quality improvement, 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. ■

Pay-for-Performance Demo Price Tag May Be Too High for Small Practices

BY MARY ELLEN SCHNEIDER
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A Medicare demonstration project testing pay for performance among large multispecialty physician groups is yielding good data on care coordination programs, but expanding the program to small, single-specialty practices could present challenges, according to an analysis by the Government Accountability Office.

Small practices would have difficulty absorbing the high start-up costs associated with care coordination programs and the hefty price tag for electronic health record adoption and implementation, the GAO found.

The GAO report to Congress analyzed the Physician Group Practice Demonstration project. The demonstration tests an alternative payment approach that combines Medicare fee-for-service payments with incentive payments for achieving cost savings and hitting quality targets.

The demonstration, which began in April 2005, includes 10 multispecialty practices, each with 200 or more physicians. Officials at the Centers for Medicare and Medicaid Services recently added a fourth year to the project, which now is scheduled to end on March 31, 2009.

CMS reported the first-year results in July 2007. In the first year, two group practices earned bonus payments of about $7.4 million in total.

But it may be difficult to broaden this approach to other physician practices because of the large size and high revenues of the participating practices, GAO said. All of the demonstration practices had 200 or more physicians, while 83% of all physician practices are solo or two-person groups, according to GAO.

The practices weren't just bigger in terms of the number of physicians but also had more support staff and larger annual medical revenues. On average, the demonstration practices had annual medical revenues of $413 million in 2005. By comparison, only about 1% of single-specialty practices in the country have revenues exceeding $50 million a year.

Since most of the participating practices had affiliations with large, integrated delivery systems, they had access to the funds to start or expand quality programs. GAO estimated that on average, each participating practice invested about $489,000 to start or expand its demonstration-related programs and spent about $1.2 million on operating expenses for these programs in the first year.

The practices that participated in the demonstration also had a leg up in terms of electronic health record systems. Eight of the 10 participants had an electronic health record before the project began. By comparison, in 2005, only 24% of physician practices in the United States had a full or partial electronic health record, GAO said.

The majority of the participants in the demonstration also had past experience with pay-for-performance programs either through a private or public sector organization. ■

Dermatologists With PhDs More Likely to Go Academic

BY KATE JOHNSON
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To revitalize the field of academic dermatology, residency programs should focus on attracting medical doctors who also have PhDs because they are more likely to choose careers in academia, according to Dr. Jashin J. Wu of the University of California, Irvine, and his associates.

"Unfortunately, there are less and less dermatology residents going into academics—they prefer to go into private practice—so there will be less and less dermatologists to provide training in the future. It is important for us to find out why," Dr. Wu said in an interview.

In the study, he and his colleagues analyzed 107 U.S. dermatology residency programs as of December 2004 and identified 782 full-time faculty MDs. Of these, 72 (9.2%) were MD/PhDs (Dermatol. Online J. 2008;14:27).

Using the University of Alabama, Birmingham, National MD/PhD Residency Data, the investigators calculated that another 72 MD/PhDs matched into dermatology residencies between 2004 and 2007, filling 5.8% of 1,236 residency positions during this time period.

Using unpublished data to estimate the total number of dermatology residency graduates over the past 35 years, Dr. Wu and his associates extrapolated that 14% of MD/PhDs were full-time academic dermatologists as of December 2004, compared with 8.6% of MDs—revealing that MD/PhDs were 1.63 times more likely than MDs to enter an academic position after completing residency and 1.58 times more likely to stay in that position.

Among the 72 MD/PhDs who filled full-time faculty positions as of December 2004, 9.7% were dermatology chiefs or department chairs. This compared with 13.2% of full-time academic MDs who filled chief or chair positions, reported Dr. Wu and his colleagues.

"It is imperative that academic dermatologists identify markers that can discern those who are truly interested in academics. The title of MD/PhD could be used as an instrument by dermatology residency directors to choose dermatology applicants who are more dedicated to academics," they wrote. ■