Costs, Mortality Drop 3 Years Into P4P Project

The management of pneumonia and heart failure improved most significantly.

BY ALICIA AULT
Associate Editor, Practice Trends

Hospitals participating in a Medicare-sponsored, pay-for-performance demonstration project continue to sustain initial gains in quality improvement and have seen a huge decline in costs and mortality 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 rate 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).

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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 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.

For instance, the hospital was struggling to meet a "door-to-balloon" time for acute myocardial infarction. Initially, the hospital was hitting a 2-hour mark for only 71% of cases. Now, 100% of eligible cases are given angioplasty within a recommended 90-minute target, Dr. Povroznik 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. ■

Financial Assistance Available for High-Cost Cancer Therapies

BY MIRIAM E. TUCKER
Senior Writer

WASHINGTON — Financial assistance is available to patients struggling with costs of the new—and extremely expensive—targeted therapies for renal cell carcinoma as well as other advanced cancers, Mr. James Goetz announced at the annual Community Oncology Conference.

As far as the patient is concerned, the approved agents sunitinib (Sutent), sorafenib (Nexavar), and temsirolimus (Torisel) are all in the same cost ballpark, with each resulting in a bill of about $135,000 for a 6-month regimen at St. Luke's Hospital and Health Network in Bethlehem, Pa., where Mr. Goetz is the network administrator of the Oncology Service Line.

"We're seeing more and more patients on Medicare without secondary insurance, those who are underinsured, and who have no insurance. . . . The onus of these expensive drugs is on the patient," he said.

But there are places to turn for help, according to Mr. Goetz.

First, all the manufacturers offer patient assistance programs, accessible on their Web sites (www.sutent.com, www.nexavar.com, www.torisel.com). Patients fill out a form and submit it to see if they qualify for financial assistance. "Sometimes it's successful, sometimes it isn't," he observed.

Nonprofit organizations can help fill in the gaps.

A highly recommended resource is the Patient Advocate Foundation (PAF; www.patientadvocate.org or 800-532-5274), whose mission is "to safeguard patients through effective mediation assuring access to care, maintenance of employment, and preservation of their financial stability relative to their diagnosis of life-threatening or debilitating diseases."

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The foundation employs professional case managers and attorneys to assist patients with a wide range of access-to-care issues, including pre-authorization, insurance appeals, and assistance with expedited applications for Social Security disability, Medicare, Medicaid, SCHIP, and other programs.

It also provides assistance with job retention, debt crisis, housing, transportation to medical treatment, and child care. In addition, it offers a "Co-Pay Relief" program for those who are already insured, and an assistance program geared specifically to patients with colorectal cancer.

"The PAF is a great resource that we give to many of our patients," Mr. Goetz said.

Other potentially helpful nonprofit patient assistance organizations listed by Mr. Goetz include the following:

▶ **Patient Access Network Foundation** (www.patientaccessnetwork.org or 866-316-7263) assists with medical expenses including medications, co-payments, insurance, and certain other out-of-pocket health-related expenses.

▶ **Healthwell Foundation** (www.healthwellfoundation.org or 800-875-8416) also assists with medical expenses, including medications, co-pays, insurance, and some other out-of-pocket expenses.

▶ **Cancer Care** (www.cancercare.org or 800-813-4673) assists with transportation, chemotherapy, pain medications, home care, and some child care issues.

Mr. Goetz declared no financial interest in any of the relevant manufacturers' drugs. The Community Oncology Conference and this newspaper are both produced by Elsevier. ■