

Acute Care Consumes Most Costs at End of Life

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Medicare costs for chronic disease care at the end of life differed nearly twofold among the nation's "top five" academic medical centers as rated by U.S. News & World Report.

The finding, derived from data in the Dartmouth Atlas of Health Care 2008 report "Tracking the Care of Patients with Severe Chronic Illness," convincingly argues that providing more services isn't necessary for providing good care to these patients, according to the report's authors.

Their broader analysis examined 2001-2005 data from Medicare's 306 hospital referral regions, and was limited to services provided in the last 2 years of life for all enrollees who had any of nine specific severe and chronic diseases.

At the University of California, Los Angeles, Medical Center, Medicare spent more than \$93,000 per chronically ill patient in the last 2 years of his or her life.

The leading chronic diseases included: chronic heart failure, cancer, and chronic obstructive pulmonary disease. Costs and services were evaluated for inpatient hospital care, outpatient services, skilled nursing and long-term hospital care, home health care, and hospice.

A high supply of available health care services encouraged more use of services, Dr. John E. Wennberg and the coauthors of the report found.

Paradoxically, the highest volume of services was perceived to be poorer care by both patients and physicians. The researchers attributed this inverse relationship to increased chances for errors, complications, miscommunications, and confusion about physician responsibilities for care as the volume of services increases.

Overall, 55% of total costs were for acute hospital care. The next largest fraction of spending (nearly 16%) was for outpatient care.

The availability of alternative care—skilled nursing, rehab facilities, home health care, and hospices—did not necessarily lead to declines in hospitalizations or inpatient spending. Instead, admission to hospitals increased demand for discharge to other care sectors.

In regions with the most supply-sensitive care, patients spent nearly 22 days as inpatients and averaged almost 60 physician visits during their last 6 months of life. In areas with the least supply-sensitive care, patients spent about 6 days in hospitals and averaged 15 physician visits in their last 6 months.

To address the relationship between quality of care and cost of care, the authors took the novel approach of comparing Medicare spending and the availability and utilization of resources at the nation's top five academic medical centers (see box, next page). At the University of California,

Los Angeles, Medical Center, Medicare spent more than \$93,000 per chronically ill patient in the last 2 years of life.

At the Mayo Clinic, Rochester, Minn., and the Cleveland Clinic, however, the costs were about \$53,000 and \$55,000 respectively. Johns Hopkins Hospital, Baltimore, and Massachusetts General Hospital, Boston, ranked second and third in total Medicare spending.

As in the larger analysis, the differences in spending at the top five centers were

mainly driven by the supply of services. Compared with the other four centers, UCLA Medical Center has proportionately the highest numbers of physicians, hospital beds, ICU beds, and imaging and other services. Again, most of the differences in cost were in acute care; for example, 50% more days spent in the hospital in the last 6 months of life by patients at UCLA (18.5 days), compared with those at the Mayo Clinic (12 days).

The authors credited the group practice

model and coordination of care at the Cleveland Clinic and Mayo Clinic with the cost savings, and proposed that other systems emulate the spending, resource input, and utilization profiles of the relatively efficient clinics.

Benchmarking based on practices at efficient centers can then be used to calculate potential savings by reducing overuse of supply-sensitive services at high-cost centers.

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Medicare Costs per Patient During Last 2 Years of Life

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| UCLA Medical Center | \$93,842 |
| Johns Hopkins Hospital | \$85,729 |
| Massachusetts General Hospital | \$78,666 |
| Cleveland Clinic Foundation | \$55,333 |
| Mayo Clinic | \$53,432 |

Note: 2001-2005 data for total Medicare spending per patient.
Source: The Dartmouth Atlas of Health Care 2008

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The Dartmouth findings come as no surprise to emergency physicians, said Dr. Brent Asplin, head of emergency medicine at Regions Hospital and HealthPartners Medical Group in St. Paul, Minn.

"The emergency department has a view of what's going on in the broader health care system. We see the revolving door of repeat hospitalizations and emergency department visits for patients with poorly managed chronic disease.

"When you reward providers based on the volume of services, you will see higher utilization in areas with more providers.

We need to work toward a system that rewards value rather than volume," he said.

"One of the keys for addressing the wide variation in services is to restructure the way primary care is organized so there is a coordinated team to manage patients with chronic disease," Dr. Asplin said.

"Ultimately, we cannot hospitalize our way to better health," Dr. Asplin said, adding "It is much easier to send a patient with chronic disease home from the ED when you know there is a primary care team that will pick up that patient the next day."

Dr. Frank Michota, founder of the Cleveland Clinic's hospital medicine program, said the hospital strives for appropriate utilization by identifying "the hospitalization goal for each chronically ill patient who is admitted and driving the care plan to meet specific objectives."

"We have no illusions that we will make a chronically ill patient normal again, but our default position is to treat aggressively until it is clear that no reversible pathology exists," Dr. Michota commented.

"Full discussion with the patient or family on the feasibility or likelihood of achieving the goal is also important," he said. Medically futile care plans are not undertaken just because that is what the patient or family wants.

The report authors recommended research on how treatments affect outcomes, patients' lives, and the efficiency of clinical practice.

Evidence is lacking for how often to see patients, when to refer to specialists, and when to admit.

As a result, primary care physicians will refer to a specialist or admit to a hospital if those resources are available and payments for office-based care are constrained, they said.

Patients need to be followed over time and across settings by established group practices and integrated provider systems that are capable of organizing care over the span of an individual's chronic illness. Organizations that participate in this research should be rewarded through a proposed shared-savings program with the Centers for Medicare and Medicaid Services that is designed to encourage coordination and to reduce overuse of care, they proposed.

Physician groups and hospitals should be encouraged to become real or virtual integrated systems that are willing to be accountable for the coordination, overall costs, and quality of care provided to chronic disease patients.

The authors proposed a shared-savings approach in which payments are based on per-beneficiary costs relative to appropriate spending targets.

Shared savings would allow physicians and hospitals to preserve their net incomes while reducing total revenues resulting from unnecessary care and overuse of acute care hospitals.

In addition to the Robert Wood Johnson Foundation, other supporters of the Dartmouth Atlas project include the WellPoint Foundation, Aetna Foundation, United Health Foundation, and California Healthcare Foundation. The full report is available at www.dartmouthatlas.org. ■

Editor Robin Turner contributed to this story.

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