CMS Hospital Database to Drive Accountability

The effect of the new hospital database on the physician-patient relationship remains uncertain.

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

WASHINGTON — The new database on hospital quality from the Centers for Medicare and Medicaid Services may herald a new era in patient assertiveness in terms of health care preferences, several experts said at a briefing sponsored by the Alliance for Health Reform.

"We're beginning a change in how doctor-patient relations are established and [considering] how paternalistic they have been, I think we'll see major changes in the future where they become less that way," said Elliot Sussman, M.D., president and CEO of Lehigh Valley Hospital and Health Network in Allentown, Pa. "When people come into a community, they'll look at measures like this and say, 'Which are the kinds of places I want to be cared for at, and who are doctors on staff at those places?' "

In fact, such changes have already begun to occur, he said. "We've seen experiences where people change their doctor relationship because 'I really like Dr. Jones, but he's not on the staff of what seems to be the best hospital. Either he does that or I'm going to find myself a new physician.' "

CMS launched its "Hospital Compare" database on April 1. Available at www. hospitalcompare.hhs.gov, the database looks at hospital performance on 17 different measures related to the treatment of three conditions: heart attacks, heart failure, and pneumonia. Users can search by hospital name or geographic location.

Gerald M. Shea, assistant to the president for government affairs at the AFL-CIO, said that the feeling of partnership that comes from empowering consumers should spill over onto the physician side of the equation. "I could make the argument that there are very serious limits to how much consumers can drive change in the health decision making process," he said. "An equally fruitful strategy would be trying to change the preparation and education of physicians, so they come to this suggesting that a partnership would be a good idea."

Databases like these are more about using accountability to improve care than about helping consumers.

DR. KAHN

In fact, physicians also have much to gain from being able to access hospital quality data, said Margaret E. O'Kane, president of the National Committee for Quality Assurance.

"Physicians have been working in an information vacuum as well—both doctors involved in performing particular procedures in the hospital, and the primary care physicians who are making referrals to specialists," she said.

"We can't underestimate the impact that transparency has on changing everything. I feel very optimistic this will lead to lot of positive changes." Ms. O'Kane commented.

One panelist warned that empowerment does have its limits. Charles N. "Chip" Kahn, president of the Federation of American Hospitals, said that as databases such as Hospital Compare begin adding more measures, "it will be more and more difficult for the average consumer … to figure things out other than, 'This is either an okay place or a dreadful place' and you obviously want to stay away from dreadful places."

In the end, he said, databases like this "are more about using accountability to improve care than they are about consumers making more decisions."

Ms. O'Kane said she was confident that "intermediaries" would rise up to help consumers interpret the database information. And she also had a prediction.

"What we've seen so far is not hospitals that are excellent at everything or terrible at everything, but hospitals that are excellent at one thing and maybe not so great at others. "As process engineering becomes more core to the hospitals, you'll see hospitals that will break out and be excellent across the board." ■

National Medicare Policy on Kyphoplasty: Not Anytime Soon

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

BALTIMORE — Although some local carriers already cover vertebral augmentation through vertebroplasty or kyphoplasty, the Centers for Medicare and Medicaid Services does not intend to consider a national coverage policy for the procedures, especially given the lack of solid data available, Stephen Phurrough, M.D., said at a meeting of the Medicare Coverage Advisory Committee.

"We have no open national coverage determination, and we have no plans to open a national coverage determination," said Dr. Phurrough, who is head of Medicare's coverage and analysis group.

The group does plan to "produce some type of guidance document that may distill what we think about this particular field of spinal disease," he said. That document will then be made available for comment.

Dr. Phurrough's remarks came after a day of mostly favorable testimony on vertebral augmentation. "We are showing that these patients are better, and we're making a difference in their pain," said Isador H. Lieberman, M.D., a surgeon at the Cleveland Clinic Foundation.

Dr. Lieberman and colleagues performed a prospective controlled trial on 329 vertebral augmentation patients, 70% of whom had osteoporosis. Duration of symptoms prior to the procedure was 1 week to 5 years; mean follow-up was 55 weeks; and the average hospital stay was 1.1 days.

The researchers found that the vertebral augmentation patients showed a "statistically significant improvement in bodily pain, mental health, physical function, social function, and vitality," compared with the controls, said Dr. Lieberman, who serves as a consultant to several companies that make surgical equipment for vertebral augmentation. "Overall, these patients do well with this intervention."

The patients showed a 'statistically significant improvement in bodily pain, mental health, physical function, social function, and vitality.'

Dr. Lieberman gave several reasons why no randomized controlled trials had been done on the benefits of one procedure vs. the other. "I've been involved in five attempts. To sum it up, it's lack of collaboration—we haven't been able to get various factions to decide on how to do the study or whether to participate," he said.

There are also study design and institutional review board (IRB) issues. "One study I was potentially involved in demanded a sham procedure; my IRB would not let me do a sham procedure," he said. Getting funding for the study also is a problem.

But probably the most important problem is recruitment. "We're dealing with an elderly population who don't have time or patience to come back for all these follow-ups or fill out all this paperwork," Dr. Lieberman said.

Kevin McGraw, M.D., a Columbus, Ohio, radiologist, testified that conservative treatment of vertebral fractures—usually bed rest—is not without its risks.

"During bed rest, virtually every organ system is adversely affected," said Dr. McGraw, who testified on behalf of the Society of Interventional Radiology. "Bone density declines about 2% per week, and muscle strength declines about 10%-15% per week. Nearly half of normal strength is lost during the first 3-4 weeks of bed rest."

Other serious consequences of bed rest include pressure sores, deep vein thrombosis, and pulmonary emboli, he continued. "If we subject patients to 6 weeks of bed rest, they've lost 12% of bone density and half of their muscle strength, they have developed a decubitus ulcer, and they have a 10% chance of a pulmonary embolism. The Society of Interventional Radiology believes that since vertebroplasty results in early mobilization, it is superior to conservative treatment."

Fergus McKiernan, M.D., of the Center for Bone Diseases at the Marshfield (Wisc.) Clinic, sounded a note of caution about the available data on vertebral augmentation.

First, he noted that one common method of reporting vertebral height restoration following vertebral augmentation invariably favored smaller restorations. For example, "if a 4-mm regression of the superior endplate is followed by a 3-mm restoration, one could say this 3 mm constituted a 75% vertebral height restoration," he said. "Using this same method, if a 25-mm regression of the superior endplate is followed by a 5-mm elevation, this reporting method would assign a 20% vertebral height restoration."

Journal editors should require disclosure of anterior, middle, and posterior heights when reporting height restoration "as the vertebrae may fail in the middle portion, and yet there may be no change in anterior height," said Dr. McKiernan. "Without knowledge of all vertebral heights, claims of vertebral height restoration based [solely] on middle height may not be clinically relevant."

He also said that one recent article touting the benefits of kyphoplasty cited two papers from his own research group. This citation was problematic because his group does not perform kyphoplasties, only vertebroplasties. In addition, the authors used his group's papers to make a point about vertebral compression fractures less than 4 weeks old, "and our average fracture age is four months," Dr. McKiernan said. "The notion of less-than-4-week-old fractures appears nowhere in the text of either article."

Panel members appeared to agree with some of Dr. McKiernan's points when it came to voting on the questions put before them. When asked to rate how well the evidence addresses vertebroplasty's effectiveness on a scale of 1-5—with 1 being "poor" and 5 being "very well"—the panel's average vote was 2.0. When asked about mortality data, the panel was particularly skeptical, giving it an average score of 1.5. Results of a vote on the evidence for kyphoplasty were similar.

"As the technology diffuses a lot more, and as patients expect this, a whole group of patients you wouldn't think of doing this on will receive it," said panel member Alexander Krist, M.D., a family physician in Fairfax, Va. "There is [an unsystematic] process for figuring out who gets it and who doesn't. That would be my fear." ■

Pages 46a—46h