POLICY & PRACTICE

Ads Influence Prescribing

Direct-to-consumer advertisements appear to have an impact on physician prescribing practices, a study by Richard L. Kravitz, M.D., of the University of California, Davis, found. A total of 152 general internists and family physicians were recruited from solo and group practices and health maintenance organizations to participate in the study, which focused on advertising for prescription antidepressants (JAMA 2005;293:1995-2002). Standardized patients were randomly assigned to make 298 unannounced visits, presenting either with major depression or adjustment disorder with depressed mood. When the patients with depression made a general request for an antidepressant, only 3% of the physicians prescribed paroxetine (Paxil). However, when they asked for the prescription by name, 27% were given a prescription for Paxil. In addition, patients with adjustment disorder symptoms were more likely to receive a prescription for an antidepressant if they made a brand specific request (55%) versus a general request (39%).

E-Prescribing Standards

Medicare should adopt a program-wide system of uniform national electronic prescribing standards for its new prescription drug benefit, according to the Pharmaceutical Care Management Association (PCMA). A uniform national standard is key to maximizing the participation of private plans in the Part D benefit and in helping to reduce regional variations in health care delivery and outcomes, PCMA said in comments sent to the Centers for Medicare and Medicaid Services on its proposed rule for Medicare e-prescribing standards. "PCMA believes that Medicare e-prescribing holds the potential to transform the health care delivery system," PCMA President Mark Merritt said in a statement. "Regrettably, a 50-state patchwork approach would increase costs, decrease efficiency, and severely undermine the promise of e-prescribing." The organization also urged CMS officials to pre-empt duplicative and conflicting state laws that could result in increased costs.

CMS: Pay for Performance Works

Preliminary data indicate that pay-for-performance is improving quality of care in hospitals. A 3-year demonstration project sponsored by the Centers for Medicare and Medicaid Services is tracking hospital performance on a set of 34 measures of processes and outcomes of care for five common clinical conditions. Reports from more than 270 participating hospitals on their experiences during the project's first year show that median quality scores improved in all of the clinical areas. For example, scores increased from 90% to 93% for patients with acute myocardial infarction; from 64% to 76% for patients with heart failure; and from 70% to 80% for patients with pneumonia. These early findings demonstrate that using financial incentives works to promote delivery of better patient care and to avoid costly complications for patients, said CMS Administrator Mark B. McClellan, M.D.

New Medicare Wheelchair Policy

Ability to function is the primary criteria in the new national coverage policy issued by CMS for power wheelchairs and scooters. The criteria look at how well the beneficiary can accomplish activities of daily living such as toileting, grooming, and eating with and without using a wheelchair or other mobility device. The criteria are "part of our efforts to ensure that seniors who need mobility help will get it promptly, and that we are paying appropriately for mobility assistive equipment," Dr. McClellan said in a statement. The coverage policy is one element in Medicare's year-old effort to improve the coverage, payment, and quality of suppliers for wheelchairs and scooters. That effort was launched after Medicare spending on mobility equipment rose to $1.2 billion annually.

Uninsured Rates Among the States

Minnesota has the lowest uninsured rate among employed adults (7%), followed by Hawaii, the District of Columbia, and Delaware, each with uninsured rates of 9%. The states with the highest rates of uninsured residents include Texas (27%), New Mexico (23%), and Florida (22%). The report was compiled by the Robert Wood Johnson Foundation, which analyzed 2003 data from the Centers for Disease Control and Prevention. Although some states fare better than others, the problem is pervasive among workers in every state. More than 20 million working adults do not have health insurance. In eight states, at least 1 in 5 working adults is uninsured, and in 39 other states at least 1 working adult in every 10 does not have health coverage.

Unhealthy Habits

Very few Americans are doing all they can to maintain a healthy life, according to a nationally representative survey of 153,805 adults (Arch. Intern. Med. 2005;165:854-7). Mathew Reeves, Ph.D., of Michigan State University, East Lansing, found that only 3% followed four steps that define a healthy lifestyle: not smoking, holding weight down, eating adequate amounts of fruits and vegetables, and exercising. Women tended to follow these steps more than men, as did whites compared with minority populations. But no one group came close to what is necessary to lead a healthy life, Dr. Reeves said. When assessed individually, these health statistics didn't look as grim: Of the respondents, 76% said they didn't smoke, 23% included at least five fruits and vegetables in their diets, and 40% maintained a healthy weight.

—Jennifer Silverman

Hospitalists' Impact on Outcomes Not So Clear

Large study finds no evidence that hospitalists affect average length of stay, costs, or patient outcomes.

BY BRUCE DIXON
Contributing Writer

CHICAGO — The largest-ever study of the influence of hospital-based physicians on outcomes and costs has failed to show significant benefits, David Meltzer, M.D., reported at the annual meeting of the Society of Hospital Medicine.

"There was a slight trend toward lowering hospital mortality. Otherwise, we found no difference in outcomes between hospitalists and nonhospitalists," said Dr. Meltzer of the University of Chicago.

"I was somewhat surprised. We began the study expecting we'd see a larger difference," he told this newspaper.

The study, which involved 31,013 admissions at six academic centers over a 2-year period, compared costs and outcomes of hospitalized general medical patients treated by hospitalists or by nonhospitalist physicians. The researchers used administrative data, patient surveys (inpatient interviews and a 1-month follow-up survey), a chart review looking at process of care variables, data from the National Death Index, and surveys of attending physicians, staff, and primary care physicians.

TALK BACK

In your experience, how have hospitalists influenced the care that your patients have received?

Share your thoughts!
Send e-mail to imnews@elsevier.com; write to Internal Medicine News, 12230 Wilkins Ave., Rockville, MD 20852; fax to 301-816-8738; or click on the Talk Back box at www.einternalmedicinenews.com.

The investigators concluded that hospitalists did not affect the average length of stay, costs, or outcomes of care across all sites. "Length of stay and cost fell with increasing disease-specific experience, but hospitalist experience may have been offset by higher initial resource use," Dr. Meltzer said during a plenary presentation of the study, which was also presented in a poster session.

Hospitalist care was associated with significant reductions in mean length of stay at two of the six sites, Dr. Meltzer said.

Earlier, single-center studies of the effects of hospitalists have produced some mixed results. A 2000 review led by Robert M. Wachter, M.D., at the University of California, San Francisco, concluded, "Empirical research supports the premise that hospitalists improve inpatient efficiency without harmful effects on quality or patient satisfaction" (JAMA 2002;287:487-94).

Dr. Meltzer's own earlier study of over 6,500 patients at the University of Chicago showed that "hospitalist care was associated with lower costs and short-term mortality in the second but not the first year of hospitalists' experience."

During a later session at the SHM meeting, Dr. Wachter said that the latest study by Dr. Meltzer is not totally relevant to nonacademic hospitals. "It's a different kind of environment. The evidence for improvement resulting from the use of hospitalists remains robust with more than 20 published studies showing average cost and length-of-stay reductions of about 15%."

Dr. Meltzer cited several caveats that may take some sting out of the findings. One study limitation is the "spillover effect," he explained, which may help to raise the quality of the nonhospitalist comparison group and lead to underestimation of the value of hospitalists.

"Interns and residents work with hospitalists and learn new ways of doing things that may be more efficient and lead to better outcomes, and they remember [these new ways] at the end of the month and then go work with and teach other attendings. So we're used to thinking that teaching is from the attending to the resident to the intern, when in fact there's teaching within those levels and even up the levels," Dr. Meltzer told this newspaper.

Another equalizer is "a sort of selective attrition effect where, because the hospitalists are taking up more ward months, the department or section can be more selective in whom they put on the wards, so you get only the best attendings on the wards and, not surprisingly, they do a little better than the group as a whole would have done if you had not been able to sort of weed out those who might not do such a good job," he said.

Dr. Meltzer's third caveat is that, as earlier studies show, hospitalists improve over time. "I think our data are consistent with the hypothesis that hospitalists have real effects, but that those effects don't appear so immediately in the data that we see for all these reasons."

Finally, Dr. Meltzer was impressed by the finding that the average hospitalist in the study cared for 134 patients, compared with a 46-patient case volume for the average nonhospitalist.

"What's even more striking," he said, "is that when we go to disease-specific experience, the average hospitalist cared for two-and-a-half patients with that same diagnosis, and the average nonhospitalist cared for less than one (0.93). We found that every doubling of disease-specific experience decreases length of stay and cost by about 3%."

The next step, Dr. Meltzer added, is for someone to conduct a similar study in community hospitals. And "further work is needed to assess physician factors, site factors, and spillover effects that could influence comparisons between hospitalists and nonhospitalists." ■