Hospital P4P Project Lowers Costs and Mortality

BY ALICIA AULT
Associate Editor, Practice Trends

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 among 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 an average of $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 first to present some of the data looking at earlier data from the improvement project. He and his colleagues found that quality was higher among the 230 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). 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 demonstration covered the first quarter of performance 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. In the first year, the demonstration practices had 200 or more physicians, 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.

The practices that participated in the demonstration had affiliations that focused on better care, said Dr. Benjamin. The participating practices had affiliations with large, integrated delivery systems, and large investments in information systems, according to a report on the demonstration.

The demonstration 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
New York Bureau

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 in favor of electronic health record adoption and implementation, the GAO found.

The GAO report to Congress analyzed the Physician Group Practice Demonstration project, which began in April 2008 and identified 782 physicians to provide training in the program. Among the 72 MD/PhDs who matched into dermatology residency programs 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 MD/PhDs—meaning that MD/PhDs were 1.58 times more likely to stay in the private sector after completing residency and 1.58 times more likely to stay in that position.

Among the 72 MDs/PhDs who filled full-time faculty positions as of December 2004, 9.7% were dermatology chiefs or department chairs. This compared with 11.2% of full-time academic MDs who filled chief or chair positions, reported Dr. Wu and his colleagues.

It is imperative that academic dermatology residencies should focus on attract investigators that can discern those who are truly interested in academics. The title of MD/PhD could be used as an instrument for entry into an academic position after completing residency and 1.58 times more likely to stay in that position.

Among the 72 MDs/PhDs who filled full-time faculty positions as of December 2004, 9.7% were dermatology chiefs or department chairs. This compared with 11.2% of full-time academic MDs who filled chief or chair positions, reported Dr. Wu and his colleagues.

It is imperative that academic dermatology residencies should focus on attract investigators that can discern those who are truly interested in academics. The title of MD/PhD could be used as an instrument for entry into an academic position after completing residency and 1.58 times more likely to stay in that position.

Among the 72 MDs/PhDs who filled full-time faculty positions as of December 2004, 9.7% were dermatology chiefs or department chairs. This compared with 11.2% of full-time academic MDs who filled chief or chair positions, reported Dr. Wu and his colleagues.