More Care Doesn't Boost Patient Satisfaction

BY SHARON WORCESTER
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Chronically ill inpatients who receive care of greater intensity rate the care less favorably than do those who receive care of lesser intensity, a new study shows.

Additionally, patients' ratings of satisfaction with their hospital care correlate with objective measures of technical quality for the hospital, according to Dr. John E. Wennberg, founder and director emeritus of the Dartmouth Institute for Health Policy and Clinical Practice in Lebanon, N.H., and his colleagues.

The findings appear to underscore the importance of coordination of patient care and communication with patients, the investigators said (Health Affairs 2009;28:103-12).

Good coordination and communication can lead to greater efficiency in health care, and efficient care is "entirely compatible with the sort of care that patients would like to receive," Dr. David Goodman, one of the paper's coauthors, said in an interview.

"One has to separate out the 'more' from the 'better.' There are many instances when the newest technologic advance and the most highly specialized physician absolutely lead to the best quality of care and the best outcomes, and also to the best patient experiences. This study does not question that in any way," said Dr. Goodman, professor of pediatrics and community and family medicine at the Center for Health Policy Research at Dartmouth.

For the study, the investigators used data from a national survey of patients' hospital experiences known as HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems), which is a project of the Centers for Medicare and Medicaid Services (CMS). Data from the survey, which included patients from 2,517 U.S. hospitals, were used along with CMS measures of technical process quality and were linked with data from the Dartmouth Atlas of Health Care. All data were adjusted for age, sex, race, and type and number of chronic illnesses.

Across 306 hospital referral regions, there was wide variation in health care intensity—as measured by the hospital care intensity (HCI) index, a measure of time spent in the hospital and the intensity of physician intervention during hospitalization—and other factors such as per capita Medicare spending, physician labor, bed input, and terminal care intensity.

HCI index scores varied as much as fourfold between regions at the higher end and the lower end of the scale. For example, the HCI index score for the Newark, N.J., region was 90% above the national average, while the score for the Salt Lake City region was 49% below the national average.

Patients living in regions with more aggressive patterns of care rated hospitals lower than did patients in areas with less aggressive care. About 14% of patients from hospitals with HCI scores in the highest quintile gave their hospital care low ratings, compared with 9% of patients from hospitals with HCI scores in the lowest quintile.

Of note, the tendency toward an association between low ratings and high HCI scores was seen regardless of whether there was a low or high number of primary care physicians in the region, but negative ratings were less likely in regions where primary care (vs. specialist care) dominated.

Hospitals with lower technical quality scores (based on performance in the management of acute MI and heart failure) also had lower overall patient ratings. Poor coordination of care and lack of communication with patients may explain why patients with chronic illnesses who receive more hospital care report worse personal experiences while in the hospital, the investigators suggested.

Regions with conservative use of inpatient care and happier patients used less physician labor for managing chronic illnesses. The mix of primary care and medical specialists also may play a role. Regions where primary care dominates tend to be more conservative in the use of acute care hospitals, suggesting that care coordination "may be an important factor in promoting conservative care," the investigators noted.

The number of physicians involved in a patient's care also appears to influence ratings. "If having too many physicians leads to disorganized care and duplication of services, this may provide an explanation not only for the poorer performance on technical quality measures, but also for the association between the percentage of patients seeing ten or more physicians and a negative hospital rating," they wrote.

Another factor that appears to be associated with patient ratings is the way medical practice is organized; large group practices dominated in regions that ranked in the lowest quintile of HCI index scores.

Based on the findings, it appears that "efforts to encourage better coordination of care, rather than simply training more physicians or spending more money, hold the key to future health care reform," the investigators concluded.

High-quality, carefully coordinated care should not be confused with delivery of more services, coauthor Dr. Goodman said.

"Unfortunately, I think we have very strong financial incentives that operate in many health systems for delivering higher quantity," he said, noting that physicians are paid for independently delivering a particular service, not for coordination of care.

Some activities perpetuate the idea that more is better. Building more intensive care units and adding hospital capacity takes a huge amount of money that could be better spent on reforming organizations and creating stronger primary care–centered delivery systems, Dr. Goodman said.

He cited proposals by Dr. Elliott S. Fisher, a professor of medicine and community and family medicine at the Dartmouth Medical School, who advocates "the accountable care organization," in which natural groupings of physicians in a hospital take responsibility for a given population and for measuring quality of care.

Research on this type of organization is ongoing, and data on the approach are anticipated soon, Dr. Goodman noted. ■

Medicare Selects Demo Sites for Testing Bundled Payments

BY ALICIA AULT
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Five hospitals have been selected to be demonstration sites for Medicare's test run of bundling payments for physicians and hospitals for a selected set of inpatient episodes of care.

The Centers for Medicare and Medicaid Services (CMS) says the goal of the 3-year Acute Care Episode demonstration project is to "better align the incentives for both hospitals and physicians, leading to better quality and greater efficiency in the care that is delivered."

The goal is to better coordinate inpatient care and achieve savings that can 'be shared between hospitals, physician, beneficiaries, and Medicare.'

In its June 2008 report to Congress, the Medicare Payment Advisory Commission recommended a voluntary pilot program to test the feasibility of bundling. The commission's staff said that such a demonstration project could give the CMS valuable data on how hospitals and physicians share payments and on how Medicare might share in the savings generated by bundling.

In announcing the selected sites, Acting CMS Administrator Kerry Weems said that with the demonstration project, Medicare "expects to demonstrate how to better coordinate inpatient care and achieve savings in the delivery of that care that can ultimately be shared between hospitals, physician, beneficiaries, and Medicare."

The demonstration will cover 28 cardiac surgical services—pertaining to valve replacement, defibrillator and pacemaker implantation, percutaneous coronary angioplasty, and coronary artery bypass graft—and 9 orthopedic surgical services—all related to hip, knee, and other major joint replacement. The CMS chose these procedures because they are high volume, easy to specify, and have quality metrics.

Medicare will make a single payment to the hospital for both Part A and Part B. The payment will be reviewed each year in October when inpatient and outpatient payment rates are set. The bundled payment will cover the same time window as that covered by a traditional inpatient payment, which includes preadmission testing. All physician services in the hospital from admission through the date of discharge are also covered.

The CMS sought applicants from Colorado, New Mexico, Oklahoma, and Texas. The selected sites are Exempla Saint Joseph Hospital in Denver, Lovelace Health System in Albuquerque, Hillcrest Medical Center in Tulsa, Oklahoma Heart Hospital in Oklahoma City, and Baptist Health System in San Antonio. Each hospital will be designated as a "valued-based care center" and promoted that way to Medicare beneficiaries.

Oklahoma Heart Hospital and Exempla Saint Joseph Hospital will be designated as value-based centers for cardiac procedures, Lovelace Health System will be a center for orthopedic procedures, and Baptist and Hillcrest for both orthopedic and heart procedures. ■