Chronic Disease Costs Vary Widely Across the U.S.

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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 with any of nine severe chronic diseases. Chronic heart failure, cancer, and chronic obstructive pulmonary disease were the leading chronic diseases. 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 his coauthors 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. 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, the costs were about $53,000 and $55,000. 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).

Of the five hospitals, the most Medicare dollars were spent at UCLA Medical Center, at more than $93,000 per chronically ill patient in the last 2 years of life.

The authors credited the group practice model and coordination of care at the Cleveland Clinic and Mayo Clinic with the cost savings.

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.

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 "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," he said, adding, "Full discussion with the patient or family on the feasibility or likelihood of achieving the goal is also important." 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 at www.dartmouthatlas.org. ■

Editor Robin Turner contributed to this story.

Many Will Limit Medicare Patients

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105 providers. His is a retirement community: "So we do a lot of Medicare," he said, "probably 80%-85% of our practice." Seeing fewer Medicare patients is even less of an option than it is for some of his colleagues. Dr. Hempelman said he suspects that he'll be asked to see more patients per hour if the cuts go into effect as scheduled. "People will be hurried through, explanations will not be given. Service to the patient is going to suffer; I don't see how it cannot."

Dr. Linda Sigmund, who is one of eight physicians at a small neurology practice outside of Washington, D.C., said in an interview she won't be able to see any more patients per day. Her practice has already cut the follow-up visit time down to 15 minutes, and the new patients get a 45-minute consult. As it stands, she takes home a few hours of work each night, too. And she is not the only one who takes work home. "We have a lot of medical people in the building, and every doctor is carrying home a stack of charts," she said.

"I can't possibly continue to see Medicare patients to the extent that I see them [if there is] a 10% cut," she said. "This is the situation. We … had a meeting [last] summer and said, you know, if this cut goes through—and that was only 5%—we were already talking that we would have to limit the number of Medicare patients that we could see," she said. And now, with a 10% cut looming? "It would be impossible. It doesn't pay our expenses, let alone pay my salary. So that's a major problem." Dr. Sigmund has been at her practice for 20 years.

Dr. Hempelman said he thinks that one solution to the problem of inadequate reimbursement could be to end the "cottage industry" of small, isolated, private practices. He and his fellow neurologists at Banner had such a practice for 13 years, before Banner bought them last September. "One of the reasons that we joined Banner is because they have run their business very well, and they have cash on hand that will allow us to expand into other geographic areas and specialty areas. We were getting short on dough. It's quite likely that the fairly large multispecialty clinic is the model of the future."

Dr. Jones concedes that, without the cushion of a large backer like Banner, her tiny practice has had to make some changes. "Whereas I would like to have an assistant to the nurse practitioner and one to me, we won't be able to afford that, so we'll have to have one we share. Or a medical assistant who is also a receptionist," she said. She's cancelled journal subscriptions and opted not to join the Rhode Island Medical Women's Association. "It sounds silly. But I have cut back on things."

Several physicians interviewed on this topic said that the looming cuts have prompted them to get more involved in professional societies to lobby Congress on behalf of their colleagues. Dr. Sigmund, for example, is a member of the American Academy of Neurology, the Movement Disorder Society, the Medical Society of Virginia, the Virginia Neurological Society, and another local Northern Virginia society. She is also a part of the American Medical Association's team of grassroots advocates. "They send me stuff all the time about what's going on in Congress. So our group has written to our representatives several times … and now the cut is coming up again. And it's pretty hard to spend this much time, every time this comes up, to call or write a letter."

Most neurologists are just watching and waiting to see whether the July cuts will take place. Said Dr. Jones: "We [physicians] undervalue ourselves more than anybody. We are well educated, we're doing something special, and we're worth getting paid. I hire lawyers and I'm shocked at what they charge. I think physicians have got to stop saying OK. Enough is enough. Why shouldn't they cut us 10% if we're going to let them? It's smart on their part.

"There has to be a middle of the road between just taking the 10% cut and just cutting out patients. We have to find a way that we can meet in the middle ground. I guess financially if [other physicians] can do it, that's wonderful. I can't do it," said Dr. Jones. "I won't be in business." ■