Patient Wants Don't Sway Regional End-of-Life Care

BY JANE NEFF ROLLINS
Contributing Writer

LOS ANGELES — End-of-life spending for Medicare beneficiaries varies widely based on geographic location, but individual patient preferences do not drive these regional variations, Dr. Amber E. Barnato reported at the annual meeting of the Society of General Internal Medicine.

For example, average per capita costs in the last 6 months of life among beneficiaries in Portland, Ore., total $9,600, compared with $2,400 in Los Angeles, said Dr. Barnato, of the University of Pittsburgh.

A previous national survey with structured vignettes asking about patient preferences for treatment found that doctors in high-intensity regions are more likely to recommend tests and refer to specialists, and are less likely to recommend hospice care (Ann. Intern. Med. 2003;138:288-98).

The investigators surveyed a national probability sample of fee-for-service Medicare beneficiaries aged 65 years or older. Potential subjects were identified from the Medicare beneficiaries database for the entire United States; a sample of 3,845 people were asked to participate in the study, and 2,515 completed the survey.

The researchers asked respondents to imagine that they had less than 1 year to live. Participants then responded to questions about their preferences for active treatment, ventilator use, and palliative care.

The mean age of respondents was 75.6 years, 42% were male, and 82% were non-Hispanic white, 7% black, and 5% Hispanic.

Overall, 44% of participants said they worried about getting too little treatment in the last year of their lives, whereas 49% worried about getting too much treatment. A total of 16% would prefer potentially life-prolonging drugs that made them feel worse all the time, while 75% would prefer palliative drugs, even if they might shorten life.

Thirteen percent of respondents would prefer mechanical ventilation if it would extend their life by 1 week, and 22% would prefer MV if it would extend life by 1 month. A large proportion of respondents thought the likelihood of returning to normal activity after being on a ventilator was high, according to Dr. Barnato.

In general, participants' concerns about preferences for end-of-life treatment were not significantly different among quintiles of the End-of-Life Expenditure Index, although in higher-intensity regions respondents were less likely to want palliative drugs that might shorten life. This exception no longer held, however, once multivariable analyses were adjusted for sociodemographic variables and health status.

A major study limitation was the nonresponse rate. It is possible that the original hypothesis was not borne out because patterns of nonresponse differed by region.

The survey showed that almost all Medicare enrollees worry that the amount of treatment they want in their last year of life will not align with what they will actually receive. When asked to choose, most participants preferred treatment that would ease pain rather than extend life. ■

System Failures Cited as Major Contributor to Malpractice Claims

BY MARY ELLEN SCHNEIDER
New York Bureau

PHILADELPHIA — There are just as many systems failures at the root of malpractice cases as individual errors or negligence, Dr. Luke Sato said at the annual meeting of the American College of Physicians.

For example, the Risk Management Foundation of the Harvard Medical Institutes Inc., the insurance carrier for 18 hospitals and about 10,000 physicians in the Massachusetts area, has spent nearly the same amount of money over the years on malpractice cases involving clinical support processes as on cases resulting from a problem with the patient-clinician interaction.

"What we see is that this is a process reengineering problem," said Dr. Sato, assistant professor of medicine at Harvard University and chief medical officer and vice president of the Risk Management Foundation.

An analysis of 2,270 malpractice cases within the insurance carrier from September 1995 to August 2005 shows that there are four high-risk categories in their system—obstetrics, surgery, medication-related problems, and diagnosis-related problems.

The diagnosis-related cases are the most prevalent and expensive, Dr. Sato said. He advised physicians to take a look at their office processes and set up ways within the practice to gather and document information that is critical to both the continuity of care and to avoiding malpractice claims.

Physicians also leave themselves open to malpractice claims if they don't have proper systems for follow-up of abnormal test and lab results and other issues. Officials at Harvard's Risk Management Foundation have developed a best practice manual that includes examples from across the system.

One best practice was developed for following up on abnormal test results: The physician schedules a telephone appointment with a patient 1 week after a potentially concerning test. This forces the provider to find and review the results prior to the call, ensures that there will be some type of patient-physician discussion, and makes it easier to add the documentation directly into the medical record, Dr. Sato said. ■

Examples of best practices from the system are available online in the "office practices" portion of the Risk Management Foundation's Web site (www.rmf.harvard.edu).

Simple In-Office Measures Can Improve Elderly Quality of Life

BY JANE NEFF ROLLINS
Contributing Writer

LOS ANGELES — A practice-based, paper-and-pencil-based intervention can improve quality of care for community-based vulnerable elderly patients with dementia or incontinence, Dr. David B. Reuben reported at the annual meeting of the Society of General Internal Medicine.

The Assessing Care of the Vulnerable Elders (ACOVE-2) trial, funded by Pfizer and Rand Health, was implemented in two large group practices in California with patients aged 75 years and older who had dementia or incontinence. The intervention group included 357 patients, and the control group had 287 patients, said Dr. Reuben, director of the multicampus program in geriatric medicine and gerontology at UCLA.

Study sites included a primary care practice with 30 physicians serving 22,000 patients (67% of whom were in managed care programs) and a multispecialty practice with 100 physicians and 140,000 patients (50% in managed care programs).

The ACOVE-2 sites in the intervention group redesigned their practices to identify eligible individuals, collect data, develop structured visit notes to suggest appropriate care, provide patient education, and link patients to community resources.

The structured visit notes were filled out by the physician. For example, the visit note for preventing falls included check boxes for testing vision, gait, and balance. The dementia visit note included check boxes for long- and short-term memory, a simple math question about making change for a purchase, and a language-related question. The treatment plan section for incontinence included suggested drugs and dosages and had a place to check off recommended specialty referrals.

After the intervention, overall care patterns improved: 45% of patients at risk for falls received a specialty exam and 89% received recommendations to improve strength/gait problems, compared with 12% and 58%, respectively, before the intervention.

In addition, after the intervention, 33% of patients with incontinence received a recommendation for behavioral treatment before drug intervention, compared with 4% before the trial. However, there was no significant difference between the intervention and control groups in the management of dementia. In fact, in patients with positive screening results, the control group received cholinesterase inhibitors at higher rates than the intervention group.

The structured visit notes included check boxes to minimize the time needed to fill out each section. "If it was quick, we knew doctors would do it. If it took time, doctors wouldn't do it," Dr. Reuben said.

"I think the most interesting and controversial aspect of patient education material was the follow-up sheet," Dr. Reuben said. The follow-up sheet included patient instructions for treatment and a list of questions for the patient to answer as homework before the next visit. To show doctors that it did not take long to fill out the forms, small-group educational sessions—using real charts with all identifying material removed—outlined practical approaches to each of the conditions listed.

Physicians may encounter problems adapting ACOVE processes to their own practices, Dr. Reuben said. "One thing I can guarantee. If you try to do this exactly how it was done, it won't work or you won't do it. You must ask 'what can I do to tweak it?'" ■

More information about ACOVE, including forms and physician and patient education materials, are available at www.geronet.ucla.edu/centers/acove/index.htm.

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