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**Chronically Ill Patients Get More Care, Less Quality, Says Latest Dartmouth Atlas**

***The Fix? A Major Overhaul of Medicare***

Lebanon, N.H. – Medicare pays many hospitals and their doctors more than the most efficient and effective health care institutions to treat chronically ill people, yet gets worse results, according to a new report from the Dartmouth Institute for Health Policy and Clinical Practice.

If the U.S. health care system mirrored the practice patterns of gold-standard health care systems such as the Mayo Clinic in Minnesota, Medicare could save tens of billions of dollars annually. Those savings would come just when Medicare needs that money most, as baby boomers prepare to retire in droves, putting unprecedented pressure on the health-care system.

“This report demonstrates the need to overhaul the ways we care for Americans with chronic illness,” said Dr. Risa Lavizzo-Mourey, president and CEO of the Robert Wood Johnson Foundation. “The extent of variation in Medicare spending, and the evidence that more care does not result in better outcomes, should lead us to ask if some chronically ill Americans are getting more care than they or their families actually want or need.”

The new edition of the Dartmouth Atlas of Health Care: *Tracking the Care of Patients with Severe Chronic Illness* shows that institutions that give better care can do it at a lower cost because they don’t over-treat patients. However, the Atlas documents that Medicare and most other payers encourage the over-use of acute-care hospital services and the proliferation of medical specialists thanks to misplaced financial incentives, especially for treating chronically ill people.

This is a serious problem. Caring for people with chronic disease now accounts for more than 75 percent of *all* health-care spending. And over-use and overspending is not just a Medicare problem—the health-care system as a whole lacks efficient, effective ways of caring for people with severe chronic illnesses.

Lead author Dr. John Wennberg and colleagues Elliott Fisher, M.D., M.P.H.; David Goodman, M.D., M.S.; and Jonathan Skinner, M.A., Ph.D., studied chronically ill patients because a third of Medicare dollars each year are spent on them during the last two years of life. Two-thirds of the people in the study were diagnosed with cancer, congestive heart failure and/or chronic lung disease.

The newest Atlas is an important policy guide as the government struggles to rein in Medicare spending which, like health care spending overall, is expected to double over the next decade. Latest estimates predict health care spending will reach \$4 trillion annually by 2017.

Wennberg called for a crash program to learn how leading organizations such as Mayo use fewer resources and spend less per capita than their peers while receiving high marks on quality measures. "Medicare policy, including reimbursement, should support "organized" systems of effective care management, with a strong primary care component," Wennberg said. "The federal government should also support better research into clinical practices for managing chronically ill patients."

It isn't so much what each medical service costs, the report says; it is *how many* services doctors prescribe. So getting usage under control is the most critical factor in controlling costs

The researchers, for instance, discovered staggering variations in the number of services that patients with severe chronic disease receive at the end of life, depending on the hospital, region or state and not on how sick they are.

For example, an elderly person spent an average 10.6 days in the hospital during the last two years of life in Bend, Ore., but 34.9 days in Manhattan.

The variation is even more striking in the last six months of life, when chronically ill patients visited the doctor an average of 14.5 times in Ogden, Utah, compared to 59.2 times in Los Angeles, Calif.

That creates wild variations in how much Medicare spends on these patients. The U.S. average was \$46,412. The highest spending was in New Jersey at \$59,379 per patient, or a quarter more than the average. The lowest was in North Dakota at \$32,523 per patient, or a quarter less than the average.

"We need to benchmark the best systems and use policy to drive providers toward the benchmark by holding them accountable for the volume of services they deliver," said study co-author, Dr. Elliott S. Fisher, director of the Center for Health Policy Research at the Dartmouth Institute for Health Policy and Clinical Practice.

What's more, the Atlas research shows that hospitals, regions and states that use more services per patient do not necessarily have higher quality care. In fact, it is slightly worse.

The Dartmouth Atlas Project studied the records of millions of Medicare enrollees who died from 2001 to 2005 and had at least one of nine severe chronic illnesses. Using those records, researchers benchmarked care nationally to the care provided in the region where Mayo has its flagship clinics and is far and away the dominant health care

provider. Total spending for the population in this study was \$289 billion over the five years. If the spending per patient everywhere mirrored that in Mayo's home region of Rochester, Minn., Medicare could have saved \$50.1 billion, or 17.3 percent of all spending on these patients alone. A benchmark to a higher cost but efficient region such as Sacramento, Calif., where labor costs are the 26th highest of the 306 regions, shows Medicare would still have saved \$28.9 billion.

The study paints a picture of a system in disarray over the treatment of these illnesses. There are no good, clear guidelines for when to hospitalize these patients, admit them to intensive care, refer them to medical specialists or—for most conditions—when to order diagnostic or imaging tests.

Lacking these guidelines, two factors drive decisions about care:

- Both doctors and patients generally believe that more services—that is, using every available resource such as specialists, hospital and ICU beds, diagnostic tests, imaging and the like—mean healthier patients.
- Based on this assumption, it is the supply of beds and treatments and specialists—not how sick people are—that determines how much they get used. The supply of services creates its own demand, so regions with more resources have more usage and thus higher costs.

The wide variations among academic medical centers clearly show the lack of scientific consensus on how to manage chronically ill patients.

Consider this comparison between the Mayo Clinic's flagship St. Mary's Hospital and UCLA Medical Center.

- Spending: UCLA spent more than \$93,000 per patient over the last two years of life. The Mayo Clinic, by contrast, spent \$53,432—a little more than half the amount of UCLA on similar patients over the same period of time.
- Utilization: Chronically ill patients in their last six months of life had more than twice as many physician visits at UCLA compared with Mayo, and they spent almost 50 percent more days in the hospital.
- Resource Use: Compared to the Mayo Clinic, UCLA uses one-and-a-half times the number of beds, almost twice as many physician FTEs in managing similar patients.

The report says academic medical institutions and federal agencies devoted to health research must begin producing studies on when to hospitalize chronically ill people, how often they should visit a doctor and the like.

The report also found that, contrary to conventional wisdom, adding alternatives to hospitals is not slowing down costs. Spending on hospitalization actually was higher in regions with more alternatives to hospitals—such as rehabilitation hospitals and skilled nursing facilities. Spending for hospice care was the only exception, and it had only a marginal effect.

The Dartmouth Atlas Project is run by the Institute for Health Policy and Clinical Practice at Dartmouth Medical School. The principal funding for the project comes from the Robert Wood Johnson Foundation. The entire Medicare claims data are available at [www.dartmouthatlas.org](http://www.dartmouthatlas.org).

With the release of this report, the Dartmouth Atlas Project introduced a new Web feature, the Hospital Care Intensity Index. It enables anyone to compare the intensity with which hospitals treat patients at the end of life—how many days they spend in the hospital and how often they see medical specialists. This is increasingly important to people who are in their last days of life and do not want to die in a hospital bed.

### **About the Dartmouth Atlas Project**

The Dartmouth Atlas Project (DAP) began in 1993 as a study of health care markets in the United States, measuring variations in health care resources and their utilization by both geographic areas. More recently, the research agenda has expanded to reporting on the resources and utilization among patients at specific hospitals. DAP research uses very large claims databases from the Medicare program and other sources to define where Americans seek care, what kind of care they receive, and to determine whether increasing investments in health care resources and their use result in better health outcomes for Americans.

The study was funded by the Robert Wood Johnson Foundation, in partnership with a funding consortium including the WellPoint Foundation, the Aetna Foundation, the United Health Foundation and the California HealthCare Foundation.

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