

Comparing Outcomes of Care Before and After Implementation of the DRG-Based Prospective Payment System

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We compared patient outcomes before and after the introduction of the diagnosis related groups (DRG)-based prospective payment system (PPS) in a nationally representative sample of 14 012 Medicare patients hospitalized in 1981 through 1982 and 1985 through 1986 with one of five diseases. For the five diseases combined, length of stay dropped 24% and in-hospital mortality declined from 16.1% to 12.6% after the PPS was introduced ($P < .05$). Thirty-day mortality adjusted for sickness at admission was 1.1% lower than before (16.5% pre-PPS, 15.4% post-PPS; $P < .05$), and 180-day adjusted mortality was essentially unchanged at 29.6% pre- vs 29.0% post-PPS ($P < .05$). For patients admitted to the hospital from home, 4% more patients were not discharged home post-PPS than pre-PPS ($P < .05$), and an additional 1% of patients had prolonged nursing home stays ($P < .05$). The introduction of the PPS was not associated with a worsening of outcome for hospitalized Medicare patients. However, because our post-PPS data are from 1985 and 1986, we recommend that clinical monitoring be maintained to ensure that changes in prospective payment do not negatively affect patient outcome.

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TO EVALUATE whether patient outcomes have changed after the implementation of the diagnosis re-

lated groups (DRG)-based prospective payment system (PPS) and the professional review organization system, we conducted a study in which we compared outcomes before and after the PPS was introduced. In this article, we report on in-hospital mortality, mortality 30 and 180 days after admission, discharge to and prolonged stay in a nursing home, and readmission to hospitals.

METHODS

We present the study sample, design, and inclusion criteria elsewhere in this series.^{1,2}

We used the medical record as our source of in-hospital mortality information and Health Care Financing Administration files to determine mortality status subsequent to the patient's discharge. By using the patient's last name, first name, date of birth, and health insurance claim number from the medical record, we were able to accurately match 92% of the patients in our sample to the Health Care Financing Administration health insurance master file.

We assessed short-term mortality by studying both in-hospital mortality and death within 30 days of the acute care admission. We chose death within 180 days postadmission as our indicator of medium-term mortality. We used the medical record as the source of both the patient's preadmission residence and discharge destination and Medicare's Part B files of physician bills to study duration of nursing home stay. When a physician bills a nursing home for a visit, either the place of service is designated as a nursing home or a special visit code is used. This information was available for patients in three of the five sampled states. In states A and B, we report the number of patients for whom a bill was submitted during months 5, 6, or 7 after hospital admission for a physician visit to a skilled nursing home or other (residential) nursing home. In

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