# Addressing Rising Health Care Costs
## *A working meeting for consumer advocates*

## Health Care Cost Strategies: How Strong Is the Evidence?

**James W. Fasules, MD FACC FAAP**

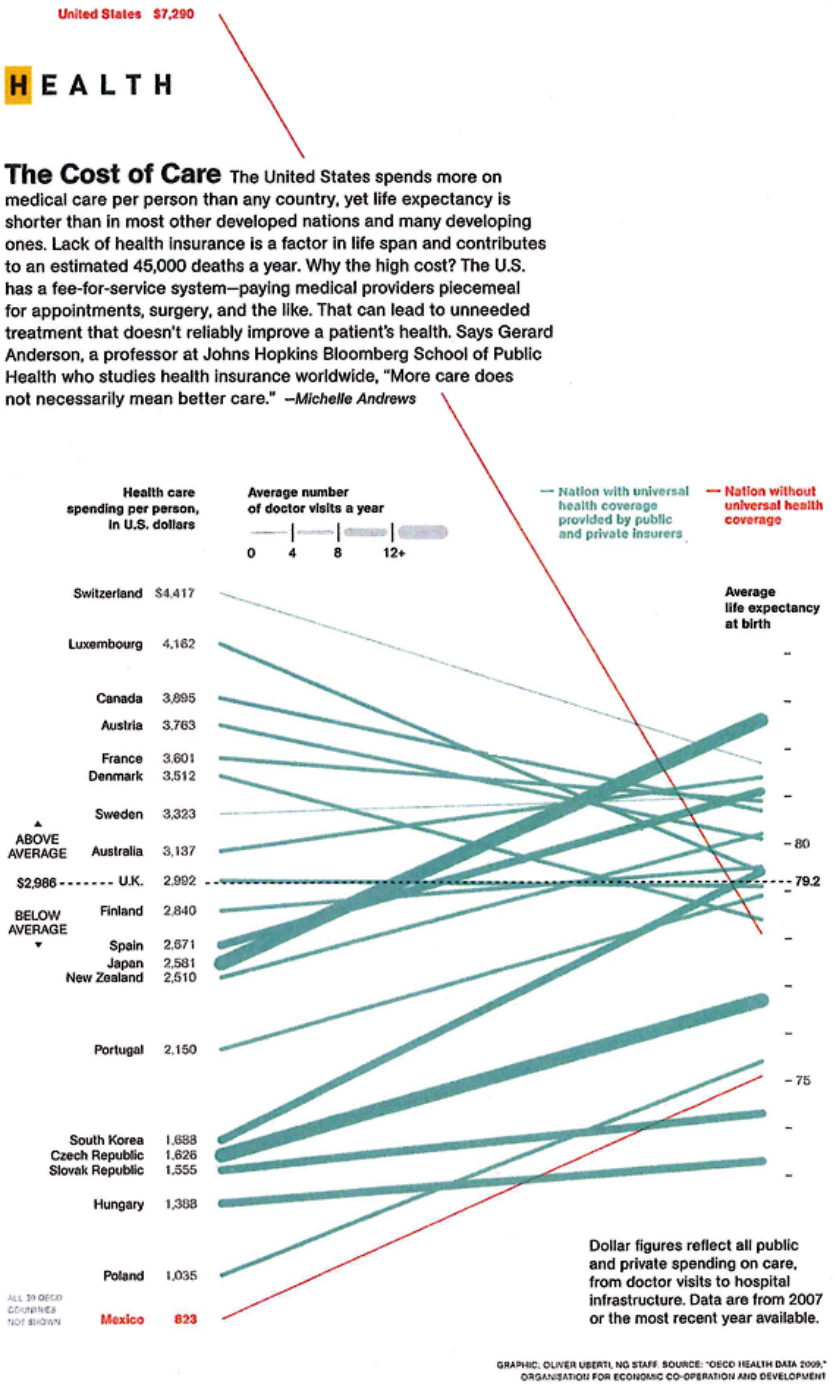
**New Orleans, Nov 2013**

ConsumersUnion
POLICY & ACTION FROM CONSUMER REPORTS

Robert Wood Johnson Foundation

# Healthcare Costs: Why the Nation Worries

## We spend more than we get in return



# Physician Directed Strategies

**Goals**

- **Improve care**
- **Less cost**
- **Partnership with patients**

**Primacy of care in an economic discussion**

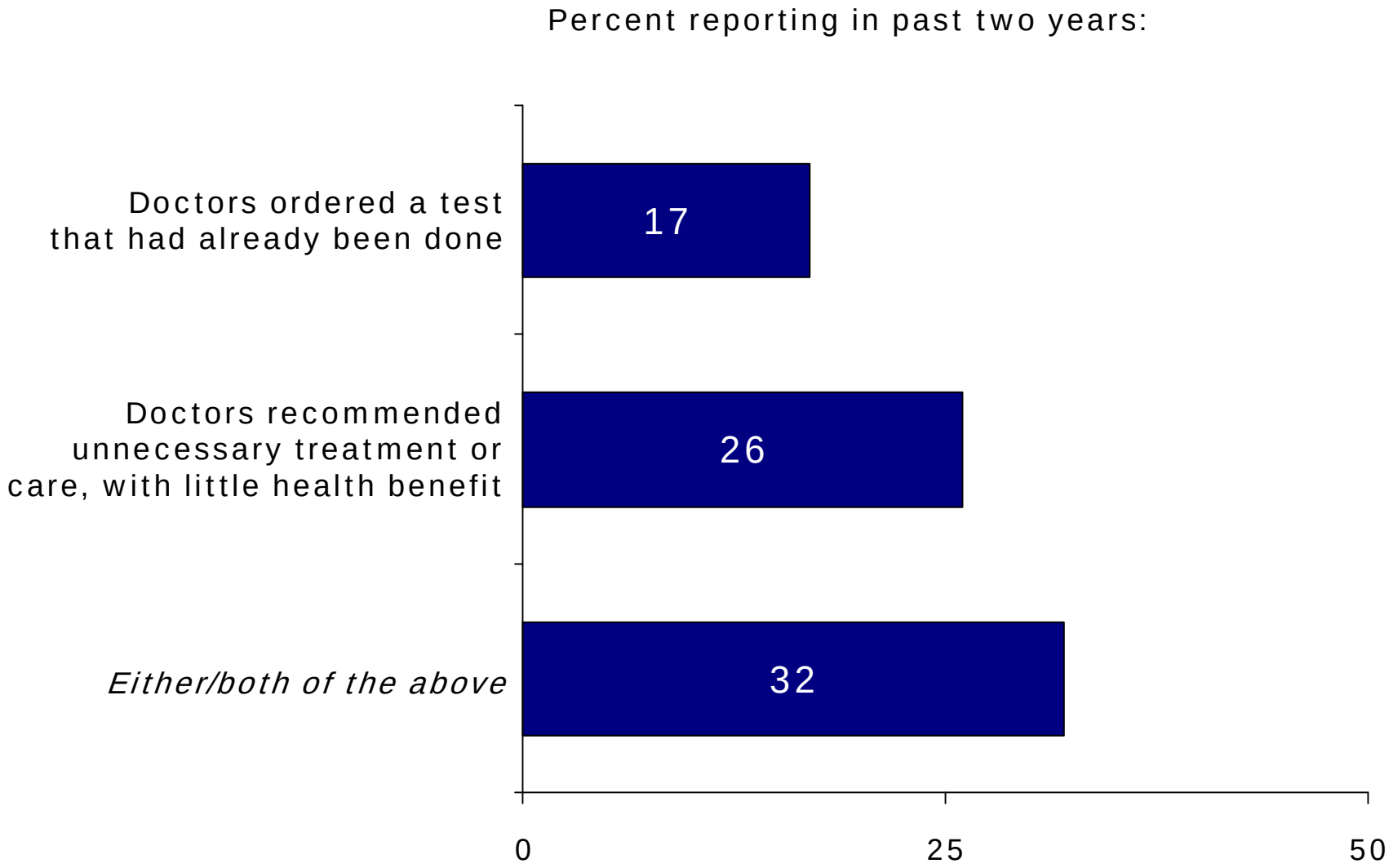
# MD-Patient Care Strategies

**Take home messages**

- **More ≠ Better; (new ≠ better: CER)**
- **Because you can doesn't mean you should**
- **Purely economic models often have unintended adverse consequences**

  **(Jury still out on ACO, PCMH, Bundled payments)**

# Commonwealth Fund: One-Third of Adults Experience Duplicative or Unnecessary Care

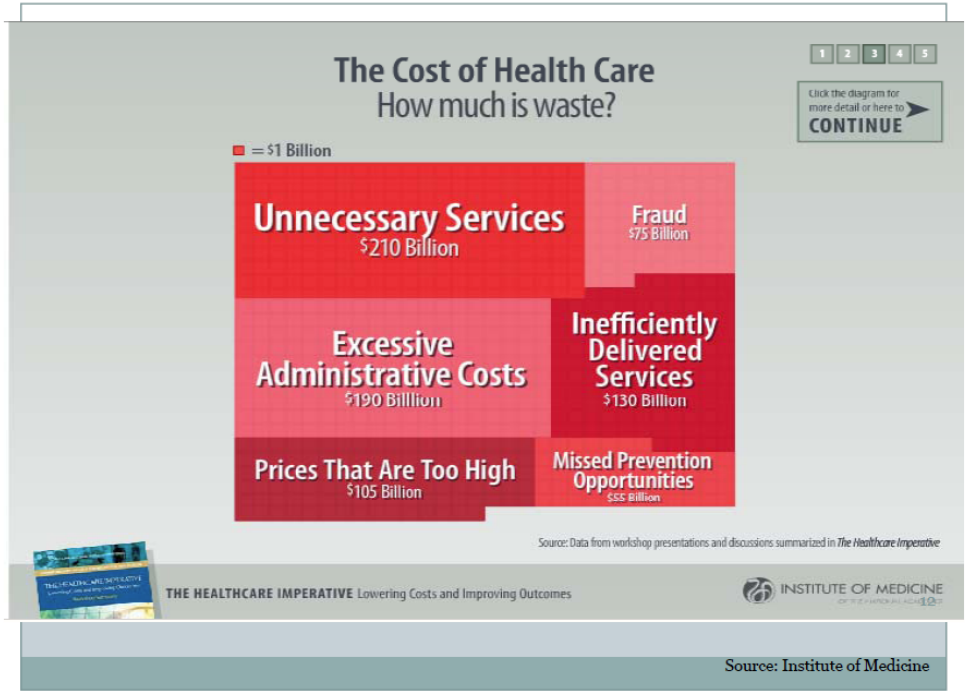



Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2008.

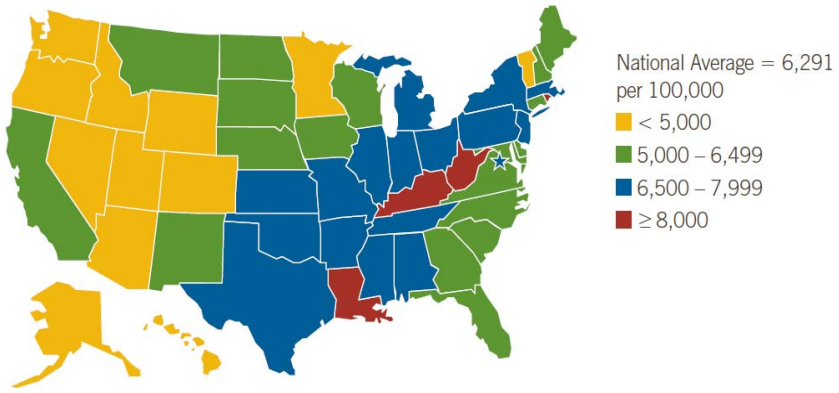
# Controlling the "MD's Pen": Provide the right care, at the right time, in the right setting, to the right patient

## Medicare RBRVS de facto limits MD payment

**[(Work RVU x Work GPCI) + (Practice Expense RVU x Practice Expense GPCI) + (Malpractice RVU x Malpractice GPCI)] x (Conversion Factor x BNA) = payment**




## Hospital admissions for ambulatory care sensitive conditions, 2009



# Plenty of Pressures for Over Utilization

# Solution: Change Habits Through Data and Information "Just Say Whoa"

**"Five Things Physicians and Patients Should Question"**


**50+ specialty societies partnering with consumers organizations to help people better understand many common tests and treatments are unnecessary.**

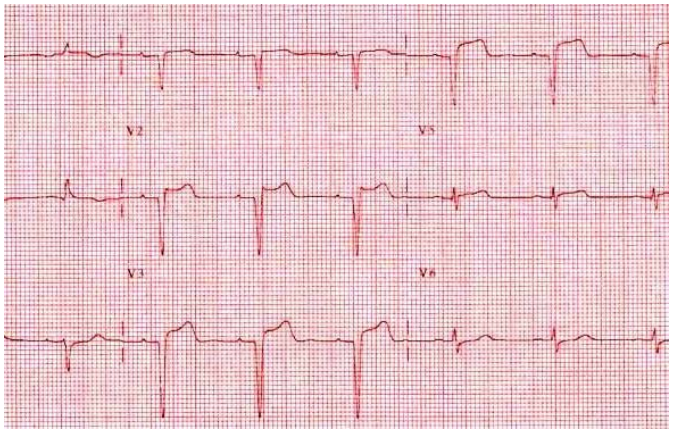
# Access to Science and Data are Essential to Improve Care Patterns

**Application to cardiac care (43% of Medicare expenses)**

- **Science:** what we can do
- **Guidelines:** what we should do
- **Appropriate Use Criteria:** direct guideline applications for specific conditions
- **Registries:** what we ***actually*** do

# Giving Providers Their Actual Data Leads to Improved Care for Acute MIs

**Door to Balloon (D2B) using NCDR PCI registry data led to systems improvement, faster transfer, ED activation of the cath lab and better outcomes**



**Pre-hospital ECG**

**Door to reperfusion times: decreased from 113 to 75 min**
**Mortality: decreased 27%**
**Smaller infarct size**
**LOS shortened: 5±7 to 3±2**
**Costs fell: $26K±$29K to $18K±$9K**

Circulation 2007
J Am Coll Cardiol 2009

# Controlling Imaging Growth & Variability

**Rapid growth and geographic variability in imaging especially nuclear stress tests**

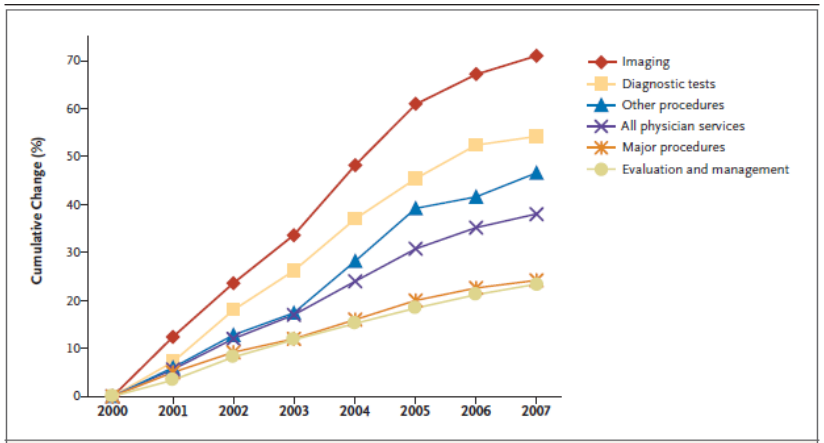
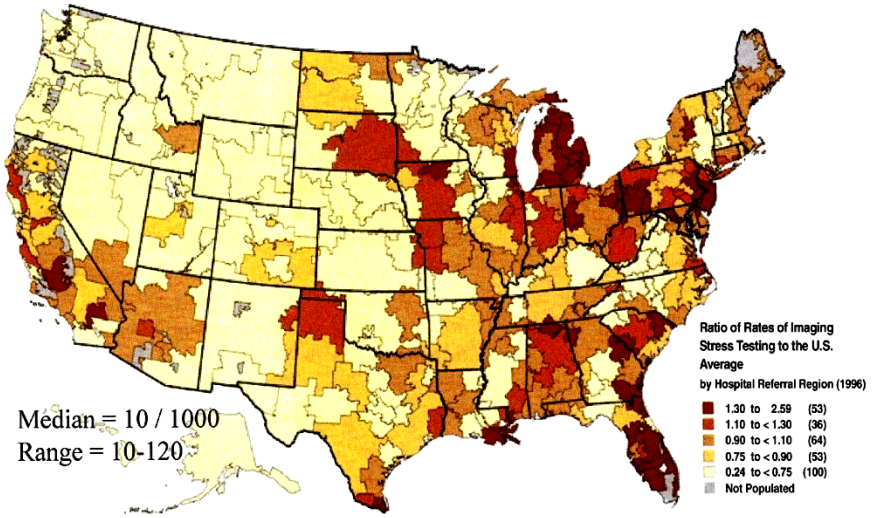



**Figure 1. Rates of Use of Imaging Services, as Compared with Rates of Other Physician-Ordered Services, per Medicare Beneficiary (2000–2007).**

Data are from the Medicare Payment Advisory Commission's analysis of physician claims for Medicare beneficiaries. Included are services paid under the physician fee schedule.




JACC-Imaging 2008; 1:241
NEJM 2009; 360:1030

# Reforming Cardiac Imaging: Also Isn't all About Economics

- Promote rational CV imaging practices

- Educate clinicians on their practice habits
  - AUCs – applying the guidelines in practice
  - FOCUS
  - Registries - PCI, Pinnacle
  - Transparency

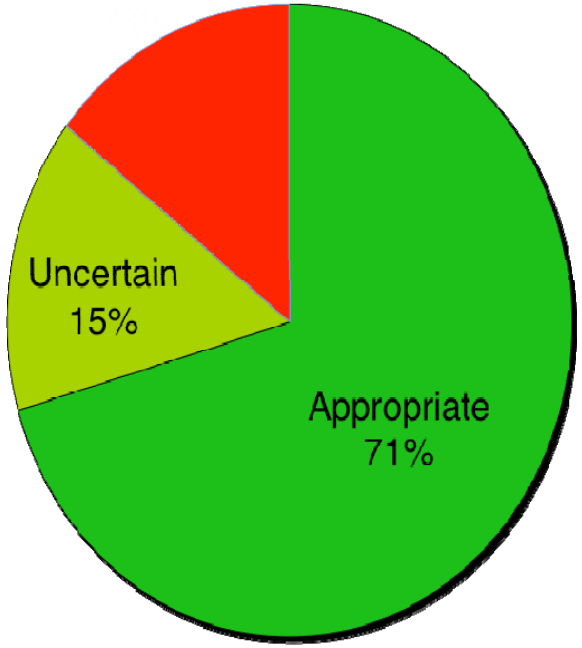
- Emphasize clinical indications to drive testing
  Because we should; not because we can

- Improve cost effectiveness of CV care without changing payment models

# ACC and United Healthcare AUC Pilot

SPECT-MPI Pilot

Single-Photon Emission Computed Tomography Myocardial Perfusion Imaging




(n=5,928)

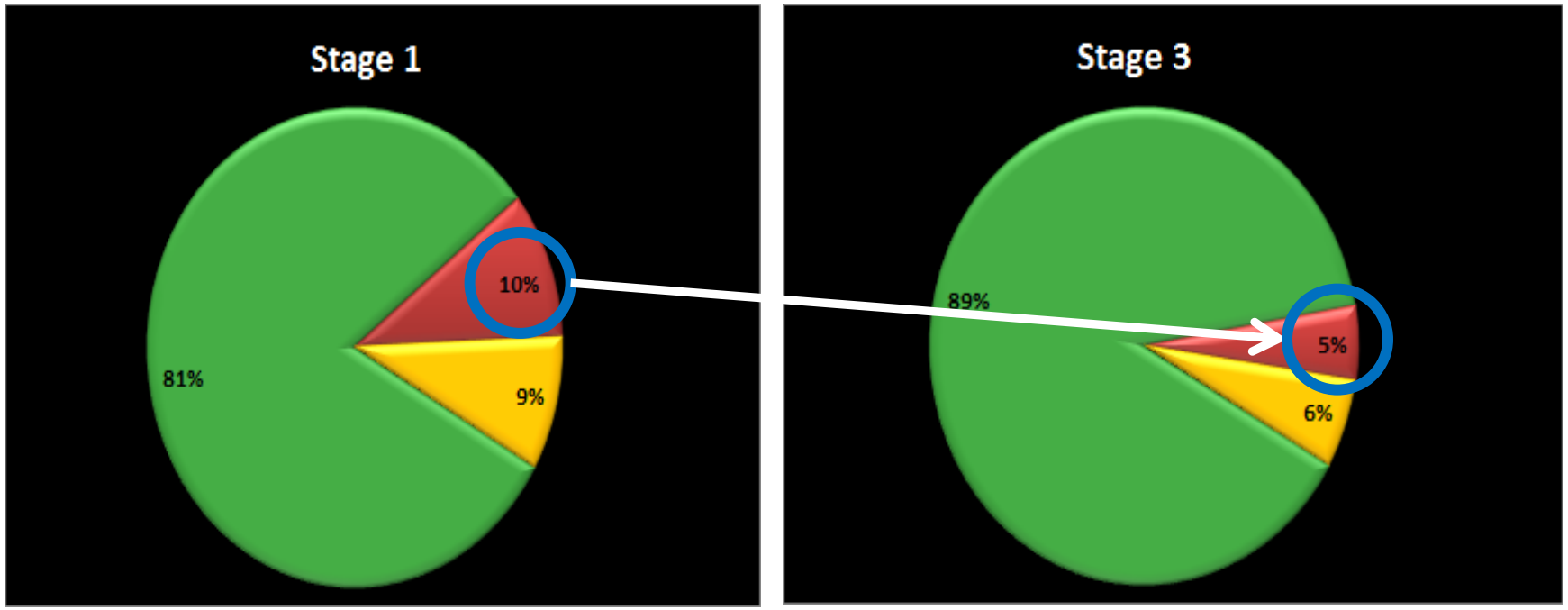
| INDICATION | % INAPPRO INDICATIONS | % TOTAL STUDIES |
|---|---|---|
| Detection of CAD. Asymptomatic, low CHD risk | 44.5% | 6.0% |
| Asymptomatic, post-revascularization < 2 years after PCI, symptoms before PCI | 23.8% | 3.2% |
| Evaluation of chest pain, low probability pt. Interpretable ECG and able to exercise | 16.1% | 2.2% |
| Asymptomatic/stable symptoms, known CAD,< 1 year after cath/abnormal SPECT | 3.9% | 0.5% |
| Pre-operative assessment. Low risk surgery | 3.8% | 0.5 % |
| **TOTAL** | **92.1%** | **12.4 %** |

**Rates same between patients with RBM and without RBM review**

# FOCUS: Providing Information on Practice Patterns and CQI Tools Reduced Unnecessary Testing

**Overall average of appropriate, inappropriate & uncertain usage rates at start for ONLY participants who completed the PIM.**

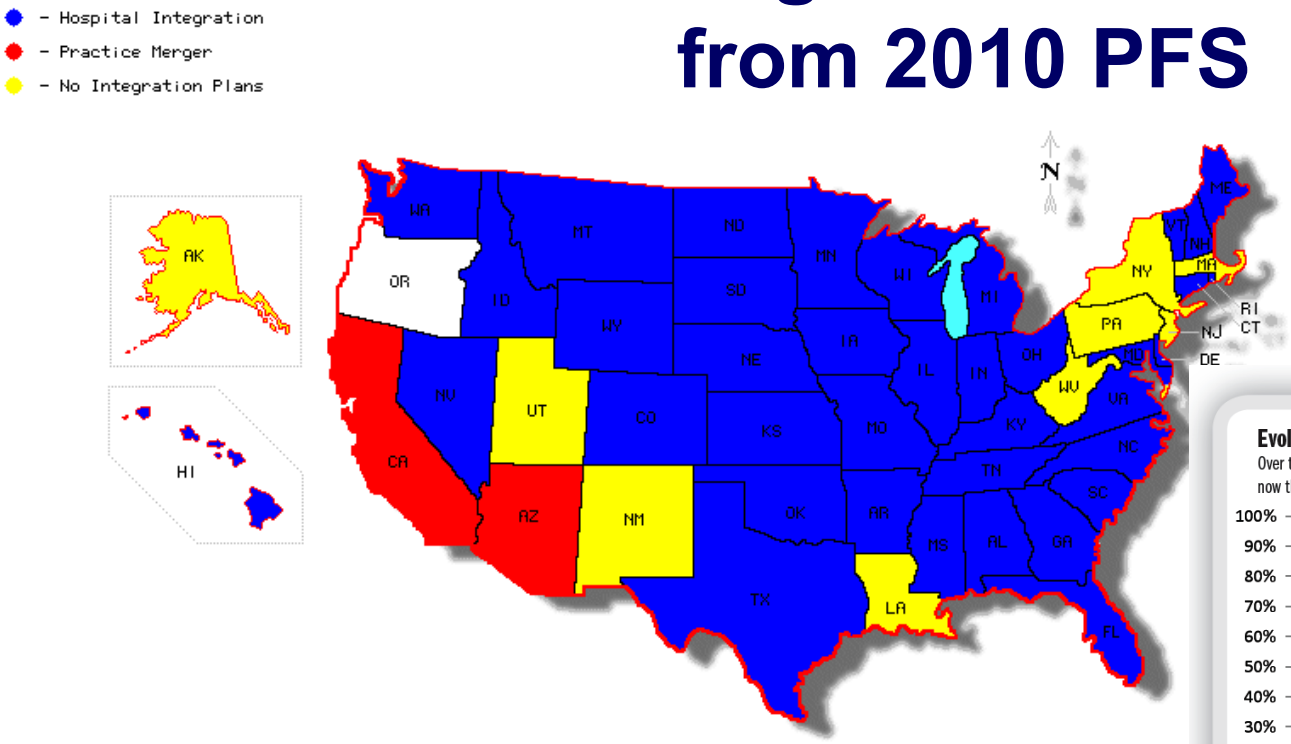
**Overall average of appropriate, inappropriate & uncertain usage rates end for ONLY participants who completed the PIM.**

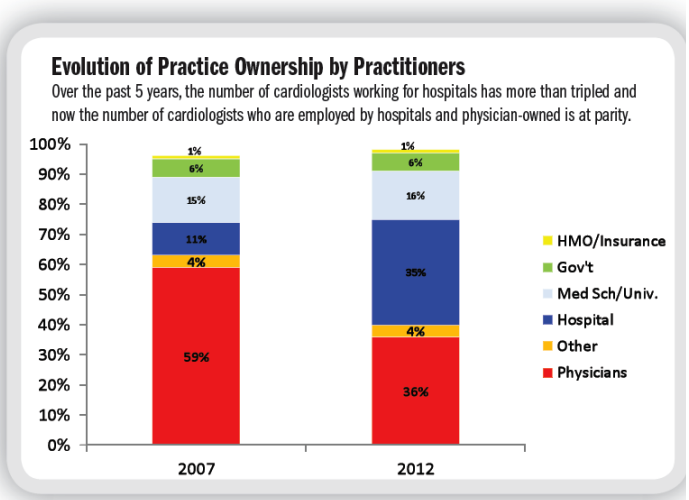



**50 %** reduction in the inappropriate rate from **10%** to **5%.** ($p<.0001$) n = 53

# Unintended Consequences of Blunt Economic Tools Can Increase Costs

## Practice Re-alignment Across The U.S. from 2010 PFS




The ACC's 2010 Practice Census was conducted from May
unique practices from 49 states and Puerto Rico participated in the study. The response rate was 31 percent.

# Conclusion: Changing Physician and Patient Behavior gets us Closer to the Six Triple Aim Priorities

1) Making care safer by reducing harm caused in the delivery of care
2) Ensuring that each person and family are engaged as partners in their care
3) Promoting effective communication and coordination of care
4) Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
5) Working with communities to promote wide use of best practices to enable healthy living
6) Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models