Ensuring Value for Patients in a Cost Conscious World

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Disclosure of Financial Relationships

Virginia Hood MBBS, MPH, MACP
Has no relationships with any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients

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Overriding Issues in Health Care

- Issue of the decade starting in 2000: increasing quality of care and patient safety
- Issue of the decade starting in 2010: decreasing the cost of care
Rising costs of health care are unsustainable

% US GDP

CMS, Office of the Actuary, National Health Statistics Group
Projected Spending on Health Care in the U.S. as a Percentage of Gross Domestic Product

Congressional Budget Office. The long term outlook for health care spending, accessed Jan 2012
Health Care Spending by Country

Percent of GDP (2008)

Source: 2008 Data from the Organization for Economic Cooperation and Development.
Figure 2: Growth in Total Health Expenditure Per Capita, U.S. and Selected Countries, 1970-2008

Cost drivers in US Health Care

- **Technology**
  - No coordinated policy on health technology assessment
    - US has 54% more CT, 40% more MRI units than other countries except Japan
    - Excess capacity and higher cost add 40 billion
- **Chronic disease and aging**
- **Excessive pricing**
  - per capita prescription drugs – more use, higher cost
  - physician services *Health Affairs (2011) 30:1647-1656*
- **Fewer primary care services**
  - free market fails to raise prices for undervalued services
  - insurers and Medicare set prices - RUC recommendations
- **Liability**
  - tort reform could save $62 billion
- **Overuse and misuse** $200-700 billion

Source: CBO Long-term Budget Outlook, 2010

Commonwealth Fund, Primary Care: Better Outcomes, Lower Costs, Greater Equity – Oct. 2006
Conserving health care resources: why doctors?

"Health-care costs ultimately arise from the accumulation of individual decisions doctors make about which services and treatments to write an order for” ..... Gawande: The Cost Conundrum

The public trusts the medical profession to recommend changes to reduce costs rather than government, insurers or payers

“Physicians have a responsibility to practice effective and efficient health care and to use health care resources responsibly. Parsimonious care that utilizes the most efficient means to effectively diagnose a condition and treat a patient, respects the need to use resources wisely and to help ensure that resources are equitably available.” ..... ACP Ethics Manual: Sixth Edition, 2012
The Physician Charter states:

“While meeting the needs of individual patients, physicians are required to provide health care that is based on the wise and cost-effective management of limited clinical resources.”

“The physician’s professional responsibility for appropriate allocation of resources requires scrupulous avoidance of superfluous tests and procedures. The provision of unnecessary services not only exposes one’s patients to avoidable harm and expense but also diminishes the resources available for others.”
Physician-Driven Sources of Excessive Health Care Costs

- Preventable/avoidable hospital admission and readmission
- Inappropriate or non-beneficial treatment
- Overuse/misuse of diagnostic testing

Inappropriate diagnostic testing (i.e. testing that is overused or misused) is estimated to cost approximately $210 B per year (10% of annual health care costs)

Source: PriceWaterhouse (www.pwc.com)
GROWTH IN VOLUME OF PHYSICIAN SERVICES PER MEDICARE BENEFICARY, 2000-2009

- Imaging
- Tests
- Other procedures
- E&M
- Major procedures
- All services

CUMULATIVE PERCENTAGE INCREASE

2000 2001 2002 2003 2004 2005 2006 2007 2008 2009

From Reinhardt blog, NY Times, 12/24/2010
Why are diagnostic tests overused and misused?

- Lack of guidance/knowledge
  - Guidelines not available or followed
  - Comparative effectiveness research needed
  - Uncertainty about diagnosis
- Patient expectations
- Fear of malpractice
- Habit
- Personal gain

The “battle for the soul of American medicine” is over “whether the doctor is set up to meet the needs of the patient, first and foremost, or to maximize revenue.”

Gawande: The Cost Conundrum
ACP “Conserving Resources” Position Statement
January, 2011

- At patient-physician level
  - Physicians, in consultation with patients, should use health care resources wisely, based on evidence of safety and effectiveness, the needs and circumstances of the patient, and with consideration of cost.

- At societal level, allocation decisions should
  - Be informed by evidence on the value of different interventions,
  - Be in accord with societal values,
  - Reflect moral, ethical, cultural, and professional standards,
  - Be developed with broad public input.

www.acponline.org/advocacy/where_we_stand/policy/health_care_resources.pdf
ACP high-value, cost-conscious care initiative

- Develop guidance for physicians about appropriate use of care, focusing initially on diagnostic testing
  - Assemble evidence-based and consensus-based recommendations

- Establish a national initiative
  - Multi-stakeholder effort to reduce marginal and ineffective care and promote high value care

- Educate target audiences about areas of overuse and misuse of care:
  - Practicing clinicians
  - Trainees (residents and medical students)
  - Patients

www.acponline.org/advocacy/where_we_stand/policy/health_care_resources.pdf
High-Value, Cost-Conscious Health Care: Concepts for Clinicians to Evaluate the Benefits, Harms, and Costs of Medical Interventions

Douglas K. Owens, MD, MS; Amir Qaseem, MD, PhD, MHA; Roger Chou, MD; and Paul Shekelle, MD, PhD, for the Clinical Guidelines Committee of the American College of Physicians*

Health care costs in the United States are increasing unsustainably, and further efforts to control costs are inevitable and essential. Efforts to control expenditures should focus on the value, in addition to the costs, of health care interventions. Whether an intervention provides high value depends on assessing whether its health benefits justify its costs. High-cost interventions may provide good value because they are highly beneficial; conversely, low-cost interventions may have little or no value if they provide little benefit.

Thus, the challenge becomes determining how to slow the rate of increase in costs while preserving high-value, high-quality care. A first step is to decrease or eliminate care that provides no benefit and may even be harmful. A second step is to provide medical interventions that provide good value: medical benefits that are commensurate with their costs.

This article discusses 3 key concepts for understanding how to assess the value of health care interventions. First, assessing the benefits, harms, and costs of an intervention is essential to understand whether it provides good value. Second, assessing the cost of an intervention should include not only the cost of the intervention itself but also any downstream costs that occur because the intervention was performed. Third, the incremental cost-effectiveness ratio estimates the additional cost required to obtain additional health benefits and provides a key measure of the value of a health care intervention.


For author affiliations, see end of text.
A Few Definitions

- **Value** = benefit / (cost + harm)
- **Efficacy** = impact of intervention under ideal circumstances
- **Effectiveness** = impact of intervention under typical (real-life) circumstances
- **Comparative effectiveness** = comparing benefits and harms of two strategies
- **Cost-effective analysis** = compares benefits and costs of two strategies

Adapted from *Ann Intern Med.* 2011; 154:174
## Benefit, Cost, and Value

<table>
<thead>
<tr>
<th></th>
<th>High Benefit</th>
<th>Low Benefit</th>
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<tbody>
<tr>
<td><strong>High Cost</strong></td>
<td>Anti-retroviral therapy for HIV</td>
<td>Routine MRI for low back pain</td>
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<td></td>
<td>Value: high or low</td>
<td>Value: low</td>
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<tr>
<td><strong>Low Cost</strong></td>
<td>HIV screening</td>
<td>Screening surgeons for HIV to prevent transmission to patients</td>
</tr>
<tr>
<td></td>
<td>Value: high</td>
<td>Value: low or high</td>
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- Systematic review of RCTs and meta analysis – no benefit for pain, function, QOL, mental health, overall
- Documented harms: low level irradiation, clinically irrelevant findings, increased costs
- Why ordered: financial incentives, defensive medicine, more expedient that explanation, “patient satisfaction”
Identifies 37 clinical situations in which a screening or diagnostic test does not reflect high value care.
Reducing inappropriate or non-effective and promoting high value treatments

- Encourage following treatment guidelines
  Avoid underuse of effective, overuse of ineffective treatments

- Promote comparative effectiveness research (CER): Patient-Centered Outcomes Research Institute (PCORI)

- Adopt payment & delivery systems as well as drugs and procedures that demonstrate value

- Counter misperception about rationing
Patient-Centered Medical Home

- Personal physician in a team-based practice
- Whole person orientation
- Coordinated care, integrated across settings
- Quality and safety emphasis
- Enhanced patient access to care
- Supported by payment structure that recognizes services and value rather than just volume
Results of PCMH Efforts

- Reduction in ED visits
- Fewer hospitalizations
- Lower health care costs
- Improved staff satisfaction
- Improved quality of both preventive and maintenance (chronic illness) care
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- Counter misperception about rationing
Rational care versus rationing of care

- Avoiding overuse/misuse = rational care not rationing of care
- Rationing: decisions are made about the allocation of scarce medical resources and who receives them, leading to underuse of potentially appropriate care
- Rational care: assuring that care is clinically effective, thus avoiding overuse or misuse of care that is inappropriate
Educating physicians about HVCCC

- Papers from ACP’s Clinical Guidelines Committee in *Annals of Internal Medicine*
- Incorporation of HVCCC education in ACP’s educational programs & products - *MKSAP*, live courses
- Development of case-based curriculum for trainees (in collaboration with AAIM and ABIMF)
- Patient education through ACP Foundation
- Collaboration with consumer groups
  - Choosing Wisely (ABIMF and 9 other medical groups and CR)
  - ACP and Consumer Reports
Bringing cost consciousness into training environment

- Habits start early
  - Focus on students, residents, fellows
  - Focus on diagnostic tests first

- Instilling value based care requires
  - Knowledge – what helps vs. what harms
  - Attitude – focus on appropriate care not cost
  - Culture – recognition that more is not better
  - Faculty development – trainees mimic faculty
  - Regulation- cost consciousness as part of residency competency requirements
Partnering with patients: what patients want from health care

- Timeliness; kindness; hope and certainty
- Continuity, choice and coordination - personal physician/team
- Rx: medications/surgery not behavior change - diet/exercise
- “Best medicine” from “best physicians” via testimonials
- Less interested in evidence, equity, conflicts of interests if it does not affect them, or real costs that they don’t bear
  
  *Detsky, JAMA 306: 2500-01, 2011*

- Don’t like inconvenience, discomfort, pain, harm
- Don’t like out of pocket costs
- Do want shared decision making and being informed
Partnering with Patients

- Patient education through ACP and ACP Foundation
  - Annals of Internal Medicine - *Summaries for Patients*
  - ACP Foundation’s Health TiPS
- Collaboration with consumer groups
  - National Physicians Alliance: “Top 5” campaign, 2011
  - Choosing Wisely - ABIMF, 9 other medical groups, CR, 2012
  - ACP and Consumer Reports, 2012
National Physicians Alliance
“Top 5” in Internal Medicine

- **Lower Back Pain**: Don’t do imaging for lower back pain within the first 6 weeks unless red flags are present.

- **Screening**: Don’t obtain blood chemistry panels (e.g., basic metabolic panel) or urinalyses for screening in healthy adults who don’t have symptoms.

- **EKGs**: Don’t order annual EKGs or any other cardiac screening for low-risk patients without symptoms.

- **Cholesterol Lowering Drugs**: Use only generic statins when initiating lipid-lowering drug therapy.

- **Bone Density**: Don’t use DEXA (bone density) screening for osteoporosis in women under age 65 years or men under 70 years with no risk factors.

*Arch Intern Med. 2011; 171:1385-1390*
Choosing Wisely® Partners

- ABIM Foundation (convener)
- American Academy of Allergy, Asthma & Immunology
- American Academy of Family Physicians
- American College of Cardiology
- American College of Physicians
- American College of Radiology
- American Gastroenterological Association
- American Society of Clinical Oncology
- American Society of Nephrology
- American Society of Nuclear Cardiology

- Consumer Reports

- 8 more societies will release lists later in the year
Screening exercise ECG in asymptomatic individuals at low risk for coronary heart disease
- Imaging studies in patients with non-specific low back pain
- Brain imaging studies (CT or MRI) for simple syncope and a normal neurological examination
- CT pulmonary angiogram as the first study in patients with low pretest probability of venous thromboembolism, rather than D-dimer
- Preoperative chest radiography in the absence of a clinical suspicion for intra-thoracic pathology

Choosing a type 2 diabetes drug

Why the best choice is often the oldest drug

If you’ve been given a diagnosis of type 2 diabetes, you might assume you’d need medication to help control the disease. But lifestyle changes alone can sometimes lower your blood sugar levels enough that drugs aren’t needed. And when they are, the best first choice usually isn’t one of the newer, heavily advertised ones on the market. Instead, it’s metformin, a drug that has been around for nearly two decades and is available at a low cost generic. Here’s why.

Newer drugs don’t work as well

Metformin, which is also sold under the brand names Glumetza, is the only blood sugar drug more than twice as effective as metformin. In a study of 2,000 patients with type 2 diabetes, those who took metformin had a 25% lower risk of developing heart disease compared to those who took the newer drug. Metformin is also the only blood sugar drug that can lower levels of LDL cholesterol, which is the fat that contributes to heart disease.

In contrast, the newer drugs either have no effect on LDL cholesterol or, in some cases, actually raise it. Finally, metformin doesn’t cause weight gain, while some of the other drugs can increase it by as much as 5 to 10 pounds.

Newer drugs are no safer

Metformin is less likely than some other diabetes drugs to cause low blood sugar levels. That can lead to sweating, shaking, slurred speech, and in some cases, coma. Metformin is also less likely to cause side effects such as bloating, diarrhea, gas, and nausea.

It’s less likely than some of the newer drugs to cause severe side effects. These side effects include heart failure with Avandia and Actos, and possibly bladder cancer with Avandia.

Newer drugs cost more

Metformin can cost as little as $4 for a month’s supply or as much as $50 for a three-month supply. In one of the three price groups, the lack of supply of generic metformin typically costs only about $15 compared to $100 to $200 for Actos and about $65 for Januvia.

When should you take other diabetes drugs?
The reason you should not take metformin if you have heart failure or moderate to severe kidney disease. In those situations, metformin can sometimes cause a potentially fatal buildup of lactate in the blood. In addition, lifestyle changes combined with metformin don’t always lower blood sugar levels enough. In those cases, it is often necessary to add a second drug.

Managing diabetes without drugs

A Consumer Reports survey of 1,000 people with type 2 diabetes identified the steps that most help them to manage the disease and avoid complications. Here are some of the most important ones:

• Eat less. Contrary to popular belief, the most important dietary strategy in our survey wasn’t limiting sugar or counting carbs but simply eating less. One effective way to do this is to reproduce your daily plates at home with smaller portions. And when we did it, take home half of your portion for the following day. Or try the leave no hunger strategy. Choose a main course and just two of the following, sides, appetizer, dessert, or alcoholic drink.

• Exercise more. Light to moderate physical activity can often help by increasing the amount of sugar burned by the muscles. Walking was the most popular form of exercise in our survey. Get moving that you drive home from office, park farther away, or take stairs instead of elevators.

• Be more responsible with your health care provider. Anticipate a vigorous exercise program.

• Put together the right team, our survey suggests that no single health care provider covers the needs of a patient with diabetes. Most often, it’s a team of doctors, nurses, dietitians, and some other specialists. The goal is to create a comprehensive plan that includes the most important treatments and medications.

Also in Spanish

Imaging tests for lower-back pain

Why you probably don’t need them

Back pain can be frustrating. It seems that getting an X-ray, CT scan, or MRI to find the cause would be a good idea. But that’s usually the case, at least at first. Here’s why.

They don’t help you get better faster.

Most people with lower-back pain feel better in about a month—whether they get an imaging test or not. In fact, those tests have added to patients’ worries about having cancer. Some of the tests are even worse, as they may lead to unnecessary surgery or other interventions.

They can cause pain.

X-rays and CT scans expose you to radiation, which can increase cancer risk. About 20% of the 1 million CT scans of the lower back performed in the U.S. in 2004. While back X-rays deliver less radiation, they are still 10 times stronger than a chest X-ray. That’s especially concerning to men and women of childbearing age, because X rays and CT scans of the lower back can cause teratogen and delayed fertility, and may cause cancer. The tests also often reveal spinal abnormalities that could be completely unrelated to the pain. For example, one study found that 40 percent of older people who report back pain still had spinal abnormalities that showed up on MRI.

High Value Care

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Do physicians agree that health care is overused

- Survey of primary care physicians
- 42% believe patients in their own practice are receiving too much care vs. 6% who say “too little”
- Perceived factors leading to overuse
  - Malpractice concerns: 76%
  - Clinical performance measures: 52%
  - Inadequate time to spend with patients: 40%
Tough challenges for achieving HVCCC

- End of life care
- Physician financial conflict of interest
- Defensive medicine
- Over-pricing and price transparency
- Patient knowledge attitudes beliefs; responsibility
- Fragmentation of responsibility/accountability for patient care
- Payer control over testing or treatment
  - pay for performance
  - guidelines and evidence change
  - interference with patient-physician decision making
Stewardship of resources is all our responsibility

- **Why**...unsustainable costs and unnecessary care that is neither safe nor effective

- **Who**.....we, individually and as a profession are responsible for leading this effort but we need partnerships with informed patients

- **What**.....make judicious choices among clinically effective alternatives; avoid overuse and misuse

- **How**...acquire evidence; educate all (6Ps); engage society in a discussion about how to conserve and allocate resources based on value
I will use those dietary regimens which will benefit my patients according to my greatest ability and judgment, and I will do no harm or injustice to them.

_The Hippocratic Oath_

_You must be the change you wish to see in the world_

Mahatma Gandhi

Thank you

 ….fostering excellence and professionalism in practice of medicine