Getting What We Pay For

Reducing Wasteful Medical Spending

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COMMUNITY CATALYST

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About Community Catalyst

Community Catalyst is a national non-profit advocacy organization dedicated to making quality, affordable health care accessible to everyone. Since 1997, Community Catalyst has worked to build consumer and community leadership to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone—especially vulnerable members of society.

For more information about Community Catalyst projects and publications, visit www.communitycatalyst.org.

Overview

$2.4 trillion buys a lot of medical care
- We have spent about $2.4 trillion during 2008, over $6.5 billion per day or about $7,900 per person.
- We spend at least 50 percent more per person than every other country, and twice as much as countries such as Canada and Germany.[1]
- One out of every six dollars in the U.S. economy is spent on health care, and this is expected to grow to nearly one in five dollars by 2017.[2]

But we're not getting good value for our money
- Our high level of spending might be tolerable if it purchased a high level of health. But we are no healthier, as a nation, than many other countries that spend much less per person.
- A great deal of research has found no connection at all between the level of spending and the quality of health care, and some has even found that higher spending is associated with *lower* quality.
- A large part of spending on health care does no appreciable good. As much as 30 percent of health care spending in the United States – *perhaps $720 billion this year* – was wasted[3] and could have been eliminated without health care quality or the nation's health suffering at all.

We can save money and improve quality at the same time
No one is deliberately throwing money away, but millions of dollars are wasted by deficiencies in how care is delivered and paid for. The deficiencies include:
- **Overuse:** Many services are provided simply because they are available, not because they have been shown to be effective.
- **Underuse:** Many treatments that are proven effective are not delivered, increasing the need for more expensive services later
- **Misuse:** Errors and rework make medical care both costly and substandard. Also, ignoring patients' preferences in making decisions about care often results in more expensive services *and* less satisfied patients.
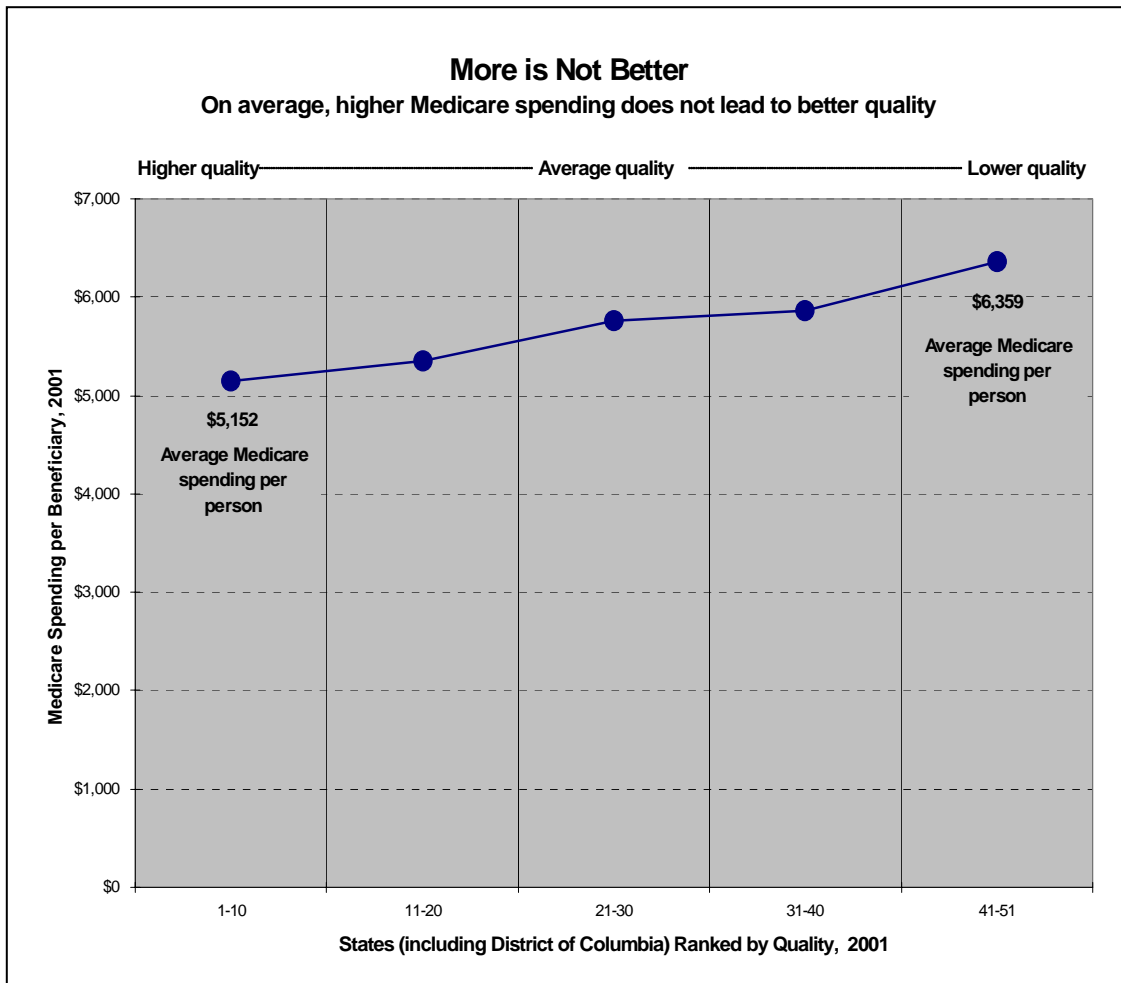
Consumer advocates and policymakers can promote changes to reduce these sources of waste and improve patient care, such as:
- Requiring disclosure of medical errors and misuse of care
- Informing patients and their doctors about the effectiveness and costs of treatment options
- Paying for care based on quality rather than quantity

Sources of wasteful medical spending

> **Overuse**

In some parts of the country, patients with complications from chronic diseases like diabetes are hospitalized frequently and get dozens of tests, while in other regions they are treated in their doctors' offices. As a whole the patients who get more intensive treatments do no better than those who get less care, but their care costs billions of dollars more. The expensive care is driven simply by its availability, the development over time of practice habits among doctors in an area, the belief that "more is better," and a payment system that rewards the overuse of care.[4] Perhaps one-fifth of all Medicare spending (as much as $90 billion today) could be saved if providers in high cost regions of the country practiced in the same fashion as those in the low cost regions, where quality is equal if not better.[5] Insurers and state Medicaid programs could also save money.

More is Not Better

On average, higher Medicare spending does not lead to better quality

Higher quality—————————————— Average quality ————————————— Lower quality

$5,152
Average Medicare spending per person

$6,359
Average Medicare spending per person

Medicare Spending per Beneficiary, 2001

States (including District of Columbia) Ranked by Quality, 2001

Sources: Kaiser State Health Facts; Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001." JAMA 289:3 (2003)

Ignoring Patients' Preferences

Wasteful spending also comes from patients not sharing in decisions about treatment options. Conditions such as osteoarthritis of the hip, a herniated disc causing back pain, and early stage breast or prostate cancer present a number of reasonable treatment choices, each with its own risks and benefits. Disregarding patients' assessments of these risks and benefits often results in more invasive and expensive treatment than patients would choose if supplied with complete information and empowered to participate with their physicians in treatment decisions.[6]

➢ **Preventable Medical Errors**

Errors such as incorrect diagnoses, delays in treatment, and inadequate follow-up cause tens of thousands of deaths every year. Errors in hospitals alone cause more deaths than motor vehicle accidents, breast cancer or AIDS. Medication errors, both inside the hospital and out, are also a significant source of injury and death. Not only are these errors harmful; they are costly. Total national costs for preventable medical errors are as much as two percent of national health expenditures, or about $48 billion this year.[7]

➢ **Underuse of Effective Care**

In addition to errors of *commission*, errors of *omission* are common in the delivery of health care. Fewer than half of all patients receive appropriate preventive screening or the professionally recommended treatment for their condition.[8] This underuse of effective care is a missed opportunity to limit the progression of illness and the need for more expensive services later on.[9] States with more general practitioners use effective care more frequently. In 2000, for example, Minnesota had about 2.5 times the number of GPs per person as Missouri *and* ranked higher in average quality of care, yet Medicare spent about $1,000 less per Minnesotan.[10]

➢ **Preventable Admissions and Readmissions to a Hospital**

Readmissions to a hospital within 30 days of a discharge cost Medicare $15 billion in 2005.[11] Many patients have to return to the hospital for conditions, such as asthma, diabetes and hypertension, which, if well treated in their doctors' offices, do not require hospitalization. Each of these preventable readmissions cost $7,400 in a 1999 study. Much of these costs could be saved, and patient satisfaction improved, through better care and coordination in and out of the hospital.[12]

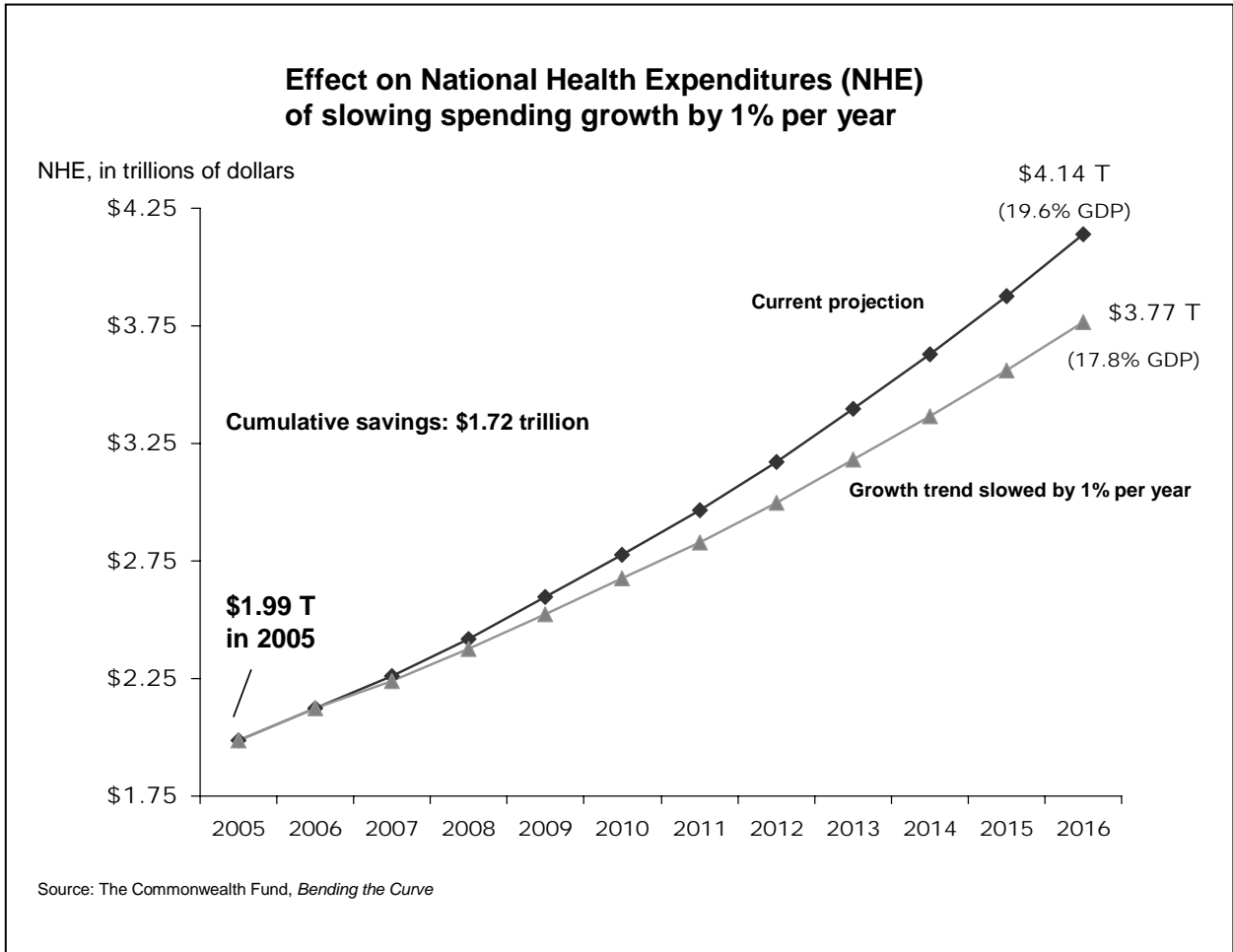## Strategies for Change

Promote the study of what works

One way to decrease the overuse of services and improve quality is with better information on what actually works, especially for new drugs and technologies. "Clinical effectiveness" studies evaluate the relative effectiveness, safety and cost of two or more medical services used to treat the same condition. The goal is to help patients and doctors make better decisions about treatments so that patients get better care.[13] The American College of Physicians, the largest medical specialty group in the United States, representing 126,000 internists, supports this approach.[14]

Who is using clinical effectiveness information?

- Some hospitals and health plans decide what drugs to use and pay for based on information from projects such as the Oregon Health and Science University's Drug Effectiveness Review Project (DERP), a collaboration of public and private purchasers, including 13 states.[15] Consumer Reports makes information from DERP available on its "Best Buy Drugs" website (www.consumerreports.org/health/best-buy-drugs.htm).

- States are using "academic detailing" to improve quality of care, reduce prescription drug costs, and increase the value derived from drug coverage programs. Academic detailing resembles the marketing tactics of pharmaceutical companies but uses clinicians and pharmacists to bring objective, scientifically-based information on prescription drugs to physicians in their offices.[16]

- The Federal Agency for Healthcare Research and Quality, through its Effective Health Care Program, gathers evidence on the effectiveness of alternative treatments for conditions such as cancer, diabetes, digestive, circulatory and muscular conditions, and mental health.[17] It has published reviews for a small number of conditions, as well as summary guides to these reviews for consumers, clinicians and policy makers, on its website (www.effectivehealthcare.ahrq.gov).

- Great Britain's National Institute for Health and Clinical Excellence (NICE) has reviewed 100 technologies, provided guidance on 250 medical procedures and issued 60 sets of treatment guidelines.[18] Britain's National Health Service must cover procedures, devices or drugs that NICE approves.

- Many health plans in the United States now consider effectiveness information in making coverage decisions. Organizations such as the Blue Cross Blue Shield Association's Technology Evaluation Center (a collaboration with Kaiser Permanente) and ECRI's Health Technology Assessment Information Service make assessments about the effectiveness of treatments available to subscribers, including insurers. Though the assessment organizations themselves do not make recommendations about coverage, insurers use the information as part of their coverage decision-making.

The potential for savings, and for action

- The Commonwealth Fund estimates that a national Center for Clinical Effectiveness could reduce total health care spending by $367 billion over 10 years.[19] Though such a center would be more effective as a federal initiative, a regional effort, modeled on a multi-state consortium such as Oregon's drug effectiveness project could also be useful.
- Clinical effectiveness is also a part of the broader health reform debate. Presidential candidates Barack Obama and John McCain both advocated comparative effectiveness in their health care plans. There is also a bill (S. 3408) in the U.S. Senate to create an institute to evaluate the effectiveness of different medical treatments, drugs and devices.[20]

**Effect on National Health Expenditures (NHE)
of slowing spending growth by 1% per year**

NHE, in trillions of dollars

$4.14 T
(19.6% GDP)

Current projection

$3.77 T
(17.8% GDP)

Cumulative savings: $1.72 trillion

Growth trend slowed by 1% per year

$1.99 T
in 2005

Source: The Commonwealth Fund, *Bending the Curve*

Some things to consider

Using clinical effectiveness information can greatly improve the value of health care that patients receive. But there are risks as well. If health insurers, for example, use effectiveness research mainly as a means to save money by restricting care, or if members merely perceive insurers as acting this way, the result would be counterproductive. It is important, then, that clinical effectiveness information come from an unbiased source, that insurers and others publicly educate patients about its benefits, and that, when challenged, insurers and providers share the evidence on which a treatment decision is based.

Help patients make informed choices

Promoting shared decision making between patients and doctors about treatment alternatives is an effective way to improve care and reduce costs. Patient decision aids are tools that help people make better informed decisions about their care by providing details about treatment options and outcomes and by clarifying personal values.[21] Patient aids are printed materials, videos, workbooks with audio guides, or websites about specific health conditions and treatment options. In some cases patients fill out personal worksheets which then help guide follow up discussions with providers. Patient aids are meant to enhance the provider-patient relationship.

- Patient aids can help patients increase their knowledge about the benefits and risks of procedures, reduce uncertainty about how to choose a course of treatment, and improve communication with providers.
- Patient aids also help patients make decisions based on their own beliefs and values, and based on scientific evidence.[22]
- Patients tend to choose less invasive procedures following the use of Patient aids,[23] so their use can also reduce health care costs, even if aid itself is expensive.[24]

Where is shared decision making being used?
- A number of academic hospitals use shared decision making, supported by materials and counseling from Dartmouth's Center for Shared Decision Making: The Dartmouth Hitchcock Center in New Hampshire, Massachusetts General Hospital, University of Arizona Cancer Center, University of California (L.A., San Diego and San Francisco), University of Cincinnati and the University of North Carolina.
- The National Cancer Institute and the U.S. Centers for Disease Control and Prevention have decision aids available on their web sites.
- Washington State became the first state to endorse the use of shared decision making. The state's 2007 health reform legislation (ESSB 5930) creates a collaborative to help implement and study the effects of Patient Aids at some group practices.[25] (See case study "Washington Shared Decision Making and Patient Aid Project" page 11.)

Some issues to consider
Several barriers are slowing patients' and doctors' adoption of Patient Aids in clinical settings. These include time constraints, difficulty using aids in an emergency situation, lack of awareness among providers, and insurers declining to pay for a doctor's time working through materials with a patient.

More research may help convince doctors and insurers that these aids can improve patient outcomes.

Another issue is controlling where information for the aids comes from and how it is framed. Patients and providers must be assured that the information is not influenced by groups with an economic interest in a particular outcome.

One for-profit company, Health Dialog, is working with the nonprofit Foundation for Informed Decision Making to address that concern. Health Dialog provides aids to Blue Cross Blue Shield of Florida, the State Health Plan of North Carolina and Massachusetts General Hospital, among others. The foundation creates the aids, and is governed by an independent board, strict conflict of interest rules and procedures to ensure balance.[26]

Tying Payment to Quality

Most hospitals and physicians are paid per service, with little regard - beyond general credentialing and licensure requirements - to the *quality* of care their patients receive.[27] Linking payment to the value of the services purchased – sometimes called "pay for performance" – could reduce costs, decrease complications and improve quality of care for patients.[28] Massachusetts, California, Pennsylvania, Florida and other states have begun collecting information on preventable complications to see how they can alter payments to reward higher quality, efficient care.

Where is pay for performance being used?
- As of October 2008, Medicare no longer pays hospitals for errors, injuries or infections they cause. The policy is designed to decrease the number of preventable problems in hospitals and, ultimately, reduce costs to the program.
- As part of Massachusetts' recent health reform law, the state has tied a portion of its Medicaid hospital payments to the achievement of quality standards and the reduction of racial and ethnic disparities.

Some issues to consider
- Pay for performance has not yet been proven as a means of improving the quality of health care
- Some experts express concern that such methods induce providers to "cherry-pick" the healthiest patients, or to deny care for people with complex health issues.
- Low-income consumers could be harmed if their providers are penalized financially more than others due to their patients being less healthy in general and less able to participate in follow-up care.

States might consider alternatives to pay-for-performance in their Medicaid programs:
- Reducing or eliminating hospital payments for potentially preventable complications, as the Medicare program has just introduced
- Paying for quality improvement efforts that increase the value of care.

What can consumer advocates do?

Rising health care costs and the tight budgets of families and governments make it increasingly important that advocates work to ensure health care spending provides value and quality for consumers. This work can help protect and expand access to care.

To begin, consumer advocates need to assess initiatives already under way:
- What is the context? Will cost and quality initiatives be part of a Medicaid defense strategy? Will the initiative be stand alone policy? Does it need to be part of a broad reform proposal?
- Is there a way to introduce the consumer voice to an already existing discussion?
- Who are the individuals, organizations or state agencies that may have a stake in the strategy?
- Are there potential new allies, such as medical schools, insurers, AARP or doctors' groups?

- What language will make clear that the point is not to cut services, but rather to improve quality?

Once this information is at hand, consumer advocates need to decide which approach and strategies will work best in their state.

Advocates can take the lead on cost and quality initiatives by urging policymakers to develop more and better information to determine clinical effectiveness, integrate the use of patient decision aids into clinical practice, and to pay providers for value not volume.

Following are a few steps consumer advocates can take to advance consumer-friendly cost containment and quality:

Build public support for change:
- Research and publicize overuse and underuse of medical care (see Dartmouth Atlas of Health Care at www.dartmouthatlas.org for research and data. These data will give many communities comparisons with other locations where spending is lower and quality better.)
- Focus public attention on preventable medical errors by organizing harmed consumers to speak out about their experiences. SeeHealth Care for All of Massachusetts's Consumer Health Quality Council at www.hcfama.org/quality/stories.
- Set up an online consumer story bank to gather stories.
- Advocate for public reporting of medical errors. Promote institutional policies that support medical error data collection.

Provide policymakers with models*:*
- Gather and distribute copies of patient decision aids to lawmakers, providers and insurers, along with research about the impact on patient choices and on costs. Visit the Foundation of Informed Decision Making (www.informedmedicaldecisions.org) and Center for Informed Choice at the Dartmouth Institute for Health Policy and Clinical Practice (www.dartmouth.edu/~cecs/cic/index.html) to learn more about decision aids and shared decision making.
- Educate policymakers, providers and medical institutions on results of academic detailing in states such as Pennsylvania, Vermont and South Carolina. See Prescription Policy Choice's report "Academic Detailing Planning Initiative" at www.policychoices.org/reports.shtml for more information on these programs. See The Prescription Project's report "The Cost Effectiveness of Prescriber Education (Academic Detailing) Programs." Available online at www.prescriptionproject.org/tools/solutions_reports/files/0010.pdf.
- Develop and circulate policies and guidelines about evidence based prescribing and academic detailing. Visit The Prescription Project website for more information (www.prescriptionproject.org).

Case Study:
Washington Shared Decision Making and Patient Aid Project

Washington is conducting the first state-sponsored test of patient decision aids. Authorized by the legislature in 2007, the Shared Decision Making Project and Patient Decision Aid demonstration project is designed to help patients make better choices about needed treatment.

The state's Health Care Authority, which oversees many state health programs, is selecting multi-specialty group practices to use patient decision aids and to measure their effect. The first demonstration site, Group Health Cooperative, will roll out aids in its group practices this winter, and make the aids available online for its members. Group Health Cooperative is a nonprofit, member-governed health care system that integrates care and coverage for 580,000 patients.

Group Health Cooperative chose to participate in shared decision making because "…we think it can help us reduce costs while improving health outcomes and patient satisfaction," said Karen Merrikin, executive director of public policy. "We also hope to generate evidence to inform policymakers about the impact of patient decision aids on decision quality, health care use and costs of care."[29]

Group Health Cooperative is implementing shared decision making for elective surgical procedures, including: hip and knee osteoarthritis; coronary artery disease; benign prostate disease; prostate cancer; uterine fibroids; herniated lumbar discs; and early stage breast cancer. Group Health's model of integrating care delivery and medical coverage within one organization, their commitment to health information technology and their own research arm, Group Health Center for Health Studies, allows them to both implement and evaluate the impact of the shared decision making approach.

The Health Care Authority plans to identify two additional sites by the end of the year and to collect data about shared decision making and patient aids. The goals are to assess the costs and savings of using shared decision making; to determine whether it improves treatment decisions and reduces variation in care; and to discover in which conditions decision aids have the greatest impact on outcomes. In addition, the authority will examine barriers to implementation and sustained use of decision aids by providers and patients.[30]

Shared decision making and patient decision aids were included in a bill, ESSB 5930, at the suggestion of Washington's Blue Ribbon Commission on Healthcare Costs and Access. Senator Cheryl Pflug (R) helped build bipartisan support for passage.

The Health Care Authority is supporting the Shared Decision Making Project and Patient Decision Aid initiative with internal resources, including staff. The authority plans to seek separate state funding for the initiative in 2009. A stakeholder committee made up of provider groups, academic institutions, insurers and a consumer organization develop project criteria and evaluation tools, provide strategic planning guidance, identify potential demonstration sites, and pursue funding opportunities. [31]

The Puget Sound Health Alliance sits on the stakeholder committee as a consumer representative and also helps publicize the initiative.

"[This project is] an important way to enable consumers to be more informed about options and make choices that fit well with their priorities and preferences," said Jill Hodges, consumer engagement specialist, of the Puget Sound Health Alliance. [32]

Hodges said consumer advocates can play an important role in ensuring that patient aids are provided in multiple languages and with the cultural context to meet the needs of diverse communities.

Case Study:
Geisinger "ProvenCare" Paying for Quality

Through a pay for performance initiative, Pennsylvania's Geisinger Health System has reduced complications suffered by patients undergoing non-emergency coronary artery bypass surgery and reduced hospital charges.[33]

The program, called ProvenCare, sets out 40 steps from surgery preparation to follow-up care that the cardiac team is expected to follow to help improve patient outcomes. Steps include screening patients for stroke risk, giving antibiotics within a certain amount of time before surgery, and making sure that a patient knows to take a daily aspirin following surgery.[34] Geisinger's hospitals and doctors have a significant incentive to adhere to the steps, because they have promised their insurance company that they will assume half the costs resulting from post-operative complications – costs that can run as high as $15,000 per patient.

Geisinger Health Plan (the insurer in the ProvenCare program) pays a flat fee that includes preoperative care, all services associated with the surgery and inpatient stay, plus 90 days of follow-up care. The fee set by the health system is based on the cost of routine services plus an amount equal to half the average cost of complications.[35] If the costs are higher than the flat rate, they are the responsibility of the hospital.

Patients are also encouraged to play an active role in their care. Patients must sign an agreement promising to communicate with their providers, to involve family and loved ones to develop and sustain their personal health plan, and to complete the assigned after-surgery care. For example, patients agree to forego tobacco products and to discuss nutrition and exercise with their heart surgery team.[36]

Geisinger reported the first ProvenCare results from a one year period (February 2006-2007) in the *Annals of Surgery.* That study compared the results of 117 patients with data on patients who received traditional bypass surgery care in 2005. For patients using the ProvenCare program:

- The average total length of stay fell from 6.3 to 5.3 days, which led to a 5% drop in hospital charges
- About half as many were readmitted to the hospital within 30 days. [37]

The most recent data reviews 181 patients over an 18 month period (ending July 2007). This updated data shows that after ProvenCare:
- Average total length of stay dropped from 6.2 to 5.7
- The 30-day readmission rate dropped from 6.9% to 3.8%
- Patients with any complications dropped from 38% to 30%.[38]

"By developing ProvenCare we've raised the bar ... and made it more likely that patients are going to have the right things done, at the right time, for the right reasons 100 percent of time," said Dr. Alfred Casale, surgical director of Geisinger Wyoming Valley Medical Center in Wilkes-Barre, Pennsylvania.[39]

ProvenCare may have worked particularly well at Geisinger because it is an integrated system made up of the Geisinger Clinic, three medical centers and the Geisinger Health Plan insurance company,

which has 210,000 members.[40] The system is well-coordinated, with a single corporate culture and a single health information system. At this point, only Geisinger's own health plan operates under ProvenCare, so the Geisinger system reaps any financial savings. It is not yet known if other health insurers will buy into ProvenCare.

Following the initial success, Geisinger expanded ProvenCare to urgent coronary artery bypass surgery and developed similar programs for hip replacement, cataract surgery and managing diabetes.[41]

- Geisinger's cardiothoracic surgeons developed the 40 steps based on previously conducted research and guidelines from the American Heart Association and American College of Cardiology. Doctors and other clinicians must document the 40 elements, though they do not have to follow each one if it is not in the best interest of a particular patient.[42] Using a computerized system, Geisinger tracks the program's successes and failures, including adherence to the 40 elements and patients' need for follow-up care. [43]

- Geisinger chose to start with bypass surgery because it is a fairly common procedure with wide variations in cost and quality across the country, and because Geisinger already had comparison data on outcomes and complication rates. [44]

- Geisinger is currently reevaluating the 40 steps to see if they should be updated due to more recent evidence based studies. [45]

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