POSTS MADE IN APRIL 2012

DOCTORS, HOSPITALS, PATIENTS, WHO'S MINDING THE STORE?

Leave a reply

A few weeks ago, I wrote a blog post about the cost of health care. My key point was that until there are significant changes in the health delivery system, there will not be reductions in the cost of care – not for patients, not for the overall system.

Just this week, an article, published in the **Archives of Internal Medicine**, and reported by the Associated Press, indicated that patients could pay as much for having their appendix removed as they might pay for a refrigerator or a small home! The study involved 19,368 California patients, ages 18-59, from hospitals throughout the state. To get the fairest comparison, the researchers included only uncomplicated cases with hospital stays of less than four days. The disparaties in patients' bills for this surgery ranged from $1,500 to $180,000 with an average of $33,000. The range could be partially explained by the fact that some patients had multiple issues, longer hospital stays, and more costly procedures. However, there is no realistic reason why there should be such a huge range.

There are many other disconnects in our health care system that account for the erratic pricing of tests and procedures, with no real justification. One of the most egregious practices that elevates the cost of care is continued inflation of tests and procedures by hospitals, that is passed along to insured consumers. The reason we are given, is that everyone must help cover the uninsured. It is a fact that hospitals that receive reimbursements from CMS for Medicare andMedicaid services must provide care to all, insured and uninsured. The question is whether the funds that are needed to care for the uninsured should be carried on the backs of everyone else? Compounding that situation is the fact that the bills issued to individuals who are uninsured are often considerably higher for the

same procedure as the bills issued to insured individuals who fall under the negotiated contracts between hospitals and insurers. This is a particularly outrageous and convoluted practice that needs to be addressed. There is also the issue regarding many of the urban teaching hospitals that are considered *not-for-profit;* pay no income property or sales tax, and are amassing, in their investment portfolios, billions of dollars, while continuing to pass along these high costs. This saddles many patients with excessive charges, and ultimately with bills that they cannot pay, at the same time that employers are footing a smaller portion of health care costs. It is easy to see why the patient who suddenly faces a catastrohic illness can also face bankruptcy.

A new model of paying providers, Global Payments, might help to control health care costs by eliminating the fee for service payment plans that encourage providers to order more rather than fewer tests and procedures. Under Global Payments, the provider is given a fixed amount of money for the care that a patient receives in a given time period, such as a month or a year. Although Global Payments will control some costs, whether this will benefit the patient and result in fewer co-payments or reduced costs for tests and procedures is questionable.

So how can e-patients fight this system? They must stop allowing themselves to be victims that are on the receiving end of whatever the doctor orders and the system charges. Instead, they must become full participants working with their physicians collaboratively to discuss treatment options and costs. They must engage in comparative shopping so they become educated about health care pricing and can use their purchasing power to force the system to become accountable. Finally, they must make wise choices about their care, and understand that they are dealing with a system that is full of loopholes and greed on the part of too many providers, insurers, pharma companies and medical suppliers who, for too long, have been more concerned with their bottom line than with patient care.

CHOOSING WISELY

Leave a reply

Last week nine prominent physician groups, led by the American Board of Internal Medicine, released a list of 45 common tests and treatments that research indicates often have no benefit, and could even harm patients. They have embarked on a campaign entitled: "Choosing Wisely," that urges doctors and patients to work together to question and challenge the use of these tests and to carefully consider whether they are truly needed, based on each individual situation.
Read this article for more information: **Choosing Wisely Campaign Aims To Cut Use of Unnecessary Medical Interventions**
The Choosing Wisely campaign is aimed primarily at providers. It suggests that the tests and procedures considered standard, that many providers view as evidence -based best practices, are really not. The message to providers is that they need to stop and think carefully before ordering tests by weighing a patient's age, risk factors and other variables. A study in the September 2011 issue of the Archives of Internal Medicine found 80 percent of surveyed doctors said they order some tests that may not be necessary out of fear they might get sued for malpractice. The campaign suggests that this is not appropriate.
Read this article for more information: **Physicians' Views on Defensive Medicine: A National Survey**
Choosing Wisely is also aimed at patients, urging that they become more active participants in their care; educate themselves about tests and procedures that their doctors are ordering; engage in discussions with their providers about whether or not these tests are really necessary.This discussion should be a standard part of patient/physician interaction during the office visit. A 2010 Consumer Reports survey of 1,200 healthy adults showed that almost 50 percent of them had received screening tests for heart disease that were considered "very unlikely or unlikely to have benefits that outweigh the

risks," reinforcing the need for evaluating the wisdom of so much testing.
Read this article for more information: **Rating Heart Risk Tests**
The 45 tests and procedures in question include: routine and exercise electrocardiograms (stress tests), routine x-rays for low risk ambulatory patients, antibiotics for mild sinus infections, pap smears for low risk or young women, DEXA for osteoporosis, x-rays and other scans for headaches and low-risk back pain, and chemotherapy for patients with advanced solid-tumor cancers who are unlikely to benefit. They have been carefully vetted by specialists from the nine societies who are participating in the Choosing Wisely campaign and who all agree that more careful deliberation is critical. For a specific list of the Societies go to
Here's a link to the **Choosing Wisely** website.
Aside from the fact that the specific 45 tests and procedures may have no benefit to patients, and could even harm them, there is a huge financial impact. Unnecessary testing accounts for $2.6 trillion dollars that Americans spend annually on health care. This money could be used in so many beneficial ways for patients. Additionally, the high cost of wonderful new medical treatments now available, far exceed our nation's ability to pay for them now and in the future. So how do we achieve a balance?
Read this New York Times article for more information: **Do You Need That Test?**
Although some might argue that eliminating these tests is a form of rationing health care, unnecessary testing is all about making choices. Physicians need to be more deliberate in deciding the best way to treat their patients. Patients need to understand the pros and cons of a specific treatment approach and collaborate with their physicians to decide on how to proceed. Many Americans engage in a kind of voluntary self-rationing. Some choose living wills where they instruct loved ones not to expend family funds and taxpayer money to keep them alive by extraordinary means. There are cancer patients,who, faced with very slender odds of survival, choose palliative care rather

than embracing more aggressive costly therapies, even if covered by their insurance. Choosing Wisely merits close attention because it is a way to eliminate unnecessary costly testing while helping us reign in and reduce costs.

LOSE WEIGHT, GET HEALTHIER, NOT SO EASY!

Leave a reply

In my last blog ("*Should We Be Paying Individuals for Good Health Habits? You Bet!")*I advocated that healthcare insurance companies should reward their customers for practicing good health habits including: exercising, losing weight and quitting smoking by reducing insurance premiums thus putting money back into their customer's pockets. In the long term this alone will lower the number of people who suffer from chronic disease and save millions in healthcare costs. Many applaud this idea which is embedded in the healthcare reform legislation that is currently being discussed. Several health plans now pay a percentage of a person's health club or weight loss program fee. However, in spite of exercise and a million different diet programs, when it comes to losing weight and keeping it off, most people simply cannot win this battle. Who cannot say that they have lost 10 pounds only to gain back 15 pounds a year later? We live in a society where richer, fattier food in large portions is marketed to the American public as a way to experience the good life.
In a recent Boston Globe column: *"Putting Obesity Out of business"* Ellen Goodman points out that overweight people are not where they are just because they do not have the will power to resist food but because we live in a country that makes it cheaper to buy fast food than fresh food; where portions served are bigger and where the food industry works very hard and spends a lot of money to make it attractive to make us eat more.
Accolades should be given to the Starbucks coffee shops in New York City where they are posting the outrageous number of calories in the drinks and pastries they sell, which for many are standard breakfast fare every day, (caramel macchiato grande whole milk 319 calories;

white chocolate mocha venti, with skim milk 628 calories, classic blueberry muffin 422, mixed fruit scone, 335 etc.). Every Starbucks should adopt that policy.

If it became a law that every food company from MacDonald's with its Big Mac – 540 calories, large fries – 539 calories, to the local ice cream parlor posted the calories of the foods that they sell; perhaps we would see a reduction in the pounds that people are carrying with them.

Hopefully, with more education, less marketing hype from the big food companies and posted calories people would begin to understand the real story behind what they are ingesting.

There are over 130 million Americans who suffer from chronic conditions, many caused by abusing their bodies with drinking and eating bad calories and introducing smoke and inappropriate drugs into their bodies. Millions more are on the brink of Type II diabetes, asthma, heart disease caused by over-indulging in bad eating and drinking. In discussions on healthcare reform, shaking up the food companies could go a long way toward a healthier nation which is one of the underlying causes of the problems the industry faces today.

PERSONALIZED MEDICINE AND PARTICIPATORY MEDICINE INTERSECT

Leave a reply

Since the time that the Human Genome Project was completed in 2003, gene sequencing technology has moved rapidly, becoming less expensive and therefore more available. In the very near future the cost of doing a whole genome sequencing will be under $1,000 and affordable to many individuals in the mainstream. What this means is that physicians will be able to tailor medical treatment to the individual characteristics of each patient, based on their unique molecular and genetic profile that indicates whether or not they are susceptible to certain diseases.

This will help physicians determine which medical treatments will be safe and effective for each of us and which might be counter. It means that individuals will have to become even more engaged in their health

care, because they will be faced with the dilemma of having to make decisions about their life and life style based on knowledge about what they might be physically dealing with, as they age. It is in the nature of humans to want knowledge and information, especially about themselves. Ultimately many individuals, who can afford to, will make the decision to do whole gene sequencing.
There are already studies where findings based on genetic variations are initiating changes in options and treatment approaches. For example, researchers, using gene sequencing, have learned that not only does lung cancer vary in patients based on the specific genes that contribute to its onset and progression, but that different individuals with the same lung cancer respond to different drug treatments, also based on their genetic differences. Put into practice, this approach has resulted in more positive outcomes.

In cardiac disease as well, genetic tests which detect variations in the way people may be at risk of excessive bleeding, and other genetic tests that determine how people metabolize the drug Coumadin (warfarin) which is used to prevent blood clots, determine how the drug is administered to different individuals, and in what dosage.

Eventually gene sequencing will spread throughout the population. A study is underway at Inova Health Systems of 500 families whose newborns' medical history includes a preterm whole genome sequencing to identify molecular markers and genetic differences. The goal of the study is to learn more about disease prevention and detection as the newborns mature.

While this is a tiny segment of the newborn population, there will be a time (perhaps in 25 years, or less) when all babies will have their genome sequenced and the results preserved as part of their digital health record. This genetic information will become a standard element of a person's medical history, and will follow that individual

through life. It will determine many aspects of the individual's medical treatment.
There are many hurdles and challenges before whole genome sequencing will become ubiquitous. There are issues of bringing down the cost of whole genome sequencing so that it is affordable and perhaps even covered by medical insurance. There is a greater challenge of how to deal with the massive amounts of data that result from whole genome sequencing including who will pay for the analysis of the data, how will the data be stored and regulated and how privacy of health information will be attained.
Personalized medicine forces all of us to be more participatory in our health care because decisions about whether or not to opt for genome sequencing is one that we have to make for ourselves. We are also forced to make life altering decisions, based on the data, regarding:

- Whether we are going to address a potential disease that may be in our genetic markers, in advance of the onset of the disease
- What we will do with this information
- How the genetic information we receive might influence our decision to have children
- How to protect our children regarding what is revealed in their genetic history.

Personalized medicine is a revolutionary trend that deserves the attention of every individual who is engaged and educated about health care because the benefits are huge and the responsibilities, both on the part of the individual and society, to use this information for positive medical advancement and better personal outcomes is daunting.

ACCOUNTABLE CARE ORGANIZATIONS COULD BRING NECESSARY CHANGES TO HEALTH CARE

Leave a reply

According to a report issued by the Centers for Medicare and Medicaid Services (CMS), in 2011, beneficiaries with multiple chronic conditions accounted for 93% of Medicare fee-for-service expenditures. That means that two out of three Americans over the age of 65 have multiple chronic conditions. Most of these patients see multiple doctors. Too often,their experience is fragmented, resulting in disconnected care where their health records are not available at the point of care; where they undergo unnecessary duplicate medical procedures; and are constantly asked to fill out the same forms at a new doctor's office when their information is already located in their digital health record that should be available. http://www.healthcare.gov/news/factsheets/2011/03/accountablecare03312011a.html

Continuity of care is essential to all patients, especially those with chronic conditions. It is rooted in long-term patient-physician partnerships in which the physician knows the patient's history from experience and can integrate new information and decisions from a whole-patient perspective. The question is whether or not Accountable Care Organizations (ACOs) can provide that continuity?

Accountable Care Organizations,(ACOs) are part of the proposed new rules included in the Affordable Care Act,signed into law by President Obama on March 21,2010. The ACO is a network of doctors and hospitals that share responsibility for providing coordinated care to Medicare patients. ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor's offices, hospitals, and long-term care facilities. Under the proposed ACO rules, the Medicare Shared Savings Program rewards ACOs that lower escalating health care costs, while meeting performance standards on quality of care, and putting patients first. By focusing on the needs of patients and linking payments to outcomes, these delivery system reforms should improve the health of individuals and communities and slow cost growth.

For example, Jane is a diabetic with erratic blood sugar that causes dizzy spells despite her medications. As a result she was often going to the ER. When she joined an ACO, however, she was able to eliminate these trips to the ER, because the ACO coordinated her care among her doctor, a nurse and a diabetes educator with whom she talks daily about diet and exercise. The educator schedules her appointments and works with her on her meal plan. When Jane has a bad day, she contacts the nurse who meticulously goes through her food intake and helps her make better choices.

Patient and provider participation in an ACO is purely voluntary. With baby boomers entering retirement age, health costs for elderly and disabled Americans are expected to soar. ACOs focus on prevention and make providers jointly accountable for the health of their patients, giving them strong incentives to cooperate, avoid unnecessary tests and procedures, and meet quality targets. ACOs do not do away with fee for service, but they create savings incentives by offering bonuses when providers keep costs down and meet specific benchmarks.

ACOs are not a panacea, however, they offer the promise of patient-centered care that incorporates case management, management of electronic medical records, care coordinators and use of data analytic systems to track populations. This could mean a healthier future for

patients and potential cost savings to Medicare of up to $960 million in the first three years. Although that amount is far less than one percent of Medicare spending it is still a significant number that promises to grow.