Providing High-Value Cost-Conscious Care in the Inpatient Setting

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Disclosures

• None

Objectives

• Appreciate the problem with rising health care costs in US and its impact

• Understand what can be done to foster high value cost-conscious care

• Appreciate the role that hospitalists play in those costs

Road Map

• Scope of the problem

• Impact on society and individuals

• What we can do

• Activity
**Healthcare Costs**

- CMS National Health Expenditures
  - 2010: $2.6 trillion
    - $815.9 billion – Hospital care
  - 2014: $3.093 trillion
    - $973 billion – Hospital care
- Deloitte Center for Health Solutions
  - 2010: $3.2 trillion
    - $814 billion – Hospital care
    - $492 billion – "Supervisory care"

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**SOCIETY**

**Healthcare Costs**

- Gross domestic product
  - "Value of a country’s overall output of goods and services (typically during one fiscal year) at market prices, excluding net income from abroad."
  - 2010 (trillions of US dollars)**
    - United States: $14.582
    - China: $5.878
    - Japan: $5.497
    - Germany: $3.309
    - France: $2.56

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*http://www.businessdictionary.com/definition/gross-domestic-product-GDP.html#ixzz3FNJ4NB83
**World Development Indicators database, World Bank, July 2011.*
Healthcare Costs

- Workforce health
  - Other industrialized country employers/employees
  - Spend 63% less than US on health
  - US workforce health trails by 10%
- Emerging economies
  - Brazil, India, China
  - Spend 15% of US on healthcare
  - Trails US workforce health by only 5%


An Uninsured Patient’s Perspective

- Comedian Julian McCullough discusses his experience with health care in the US as an uninsured individual
- This American Life (NPR) (#439)
  - “Split a Gut”
Bankruptcy and Medical Bills

- Medical bills are the leading cause for personal bankruptcy in the US (62% in 2007)
- 78% bankruptcies caused by medical problems had medical insurance at the start of their illness
- Most medical debtors were well educated, owned homes, and had middle-class occupations

Impact to Patients

- Limited medical care in past 12 months
  - 53% of American families
- 19% reported financial problems due to medical bills
  - 13% depleted all or most of their savings
  - 7% unable to pay for basic necessities such as food, heat or housing

Case 1
- Summer 2012 in Connecticut
- Janice develops chest pain
- 64 yo former sales clerk, uninsured
- Taken via ambulance to Stamford Hospital
- 3 hours later...CP = Heartburn = good news
- Bad news = Bill $21,000

Case 2
- Emilia Gilbert (school bus driver)
- Bridgeport Connecticut June 2008
- Slipped and fell on face
- ER: 3 CT scans, blood work, exam
- Diagnosis: hairline fracture of nose
- Bill: $9,400
- Insurance coverage $2,500 per visit
- Her bill: $7,000

Billing Terms
- Charge
- Contractual adjustment
- Patient Responsibility
- Cost
- Medicare allowable cost
- 2004 Average charge/cost ratio 3.07*

Patient Responsibility
- Deductibles
  - Amount patient must pay for health care or prescriptions before prescription drug plan, or insurance provider begins to pay.
- Co-payments
  - An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or prescription.
- Co-insurance
  - An amount you may be required to pay as your share of the cost for services after you pay any deductibles.

Inpatient vs. Observation

- Change from IP to OP impacts patient co-payments and satisfaction
  - Patients often have higher out-of-pocket costs as outpatients
  - Outpatients must pay for self-administered drugs
- IP status requires meeting medical necessity
  - Documentation of all risk factors for the patient helps support medical necessity

Patient Responsibility

- BC Inpatient, LOS 4 Days
  - Charges $25,344, Ins Payment $16,653, Patient $800
- BC Outpatient, LOS 1 Day
  - Charges $16,352, Ins Payment $2,123, Patient $1,104
- Medicare Advantage, LOS 1 Day
  - Charges $8,114, Ins Payment $3,813, Patient $159
- Charity, LOS 5 Days
  - Charges $48,564, no payment
- Medicaid, LOS 13 Days
  - Charges $232,360, Ins Payment $25,345, No Patient Responsibility

Affordable Care Act

Health Plan Categories

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>% of health expenses covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Platinum</td>
<td>90%</td>
</tr>
<tr>
<td>Gold</td>
<td>80%</td>
</tr>
<tr>
<td>Silver</td>
<td>70%</td>
</tr>
<tr>
<td>Bronze</td>
<td>60%</td>
</tr>
<tr>
<td>Catastrophic</td>
<td>Restricted to &lt;30yo</td>
</tr>
</tbody>
</table>

WASTE

The Healthcare Imperative

• “Lowering Costs and Improving Outcomes”
• Institute of Medicine workshop series
• Motivating proposition for the series of meetings was to reduce healthcare costs by 10 percent within 10 years without compromising patient safety, health outcomes, or valued innovation.

Healthcare Waste

• $2.6 trillion healthcare costs
  – 30% ($780 billion) = Waste
  – 15% ($395 billion) = Physician controlled waste
    • $210 billion = Unnecessary services
    • $130 billion = Inefficient care delivery
    • $55 billion = Missed prevention opportunity

Excess Health Cost Domains

• Unnecessary services
• Services inefficiently delivered
• Prices that are too high
• Excess administrative costs
• Missed prevention opportunities
• Medical fraud

Potential Areas of Focus

• Care-related costs
  – Prevent medical errors
  – Prevent avoidable hospital admissions
  – Prevent avoidable hospital readmissions
  – Improve hospital efficiency
  – Decrease costs of episodes of care
  – Improve targeting of costly services
  – Increase shared decision-making

• Administrative costs
  – Use common billing and claims forms

• Related reforms
  – Medical liability reform
  – Prevent fraud and abuse
Opportunity Costs

• Unnecessary Days of Care
  – Patients in greater need of care may not be admitted because of diversion

• Unnecessary Services
  – Resources are diverted that could have been directed to areas of greater need

NEXT STEPS

Money Matters

• Value-based purchasing
• Readmission penalties
• Hospital acquired conditions
• Affordable Care Act

Resources

Healthcare Bluebook
Choosing Wisely
ACP: High Value Care
Society of Hospital Medicine
1. Don’t do work up for clotting disorder (order hypercoagulable testing) for patients who develop first episode of deep vein thrombosis (DVT) in the setting of a known cause.

2. Don’t reimagine DVT in the absence of a clinical change.

3. Avoid cardiovascular testing for patients undergoing low-risk surgery.

4. Refrain from percutaneous or surgical revascularization of peripheral artery occlusion in patients without obstruction or critical limb ischemia.

5. Don’t screen for renal artery stenosis in patients without resistant hypertension and with normal renal function, even if known atherosclerotics are present.

CASE
Case

- 42 yo man comes to the ER with syncope
- He was standing in line waiting to renew his driver’s license
- Felt tired, nauseated, few seconds later he passed out, witnessed, out for 15-20 seconds
- No confusion after event, but felt tired
- No medical history, his father had CAD at age 57, he is a smoker
- Taken to ER for further evaluation

Exam 124/82, 76, 12, AF, no orthostatic changes
- Normal exam including CV and neurologic
- EKG no abnormalities

What would you do now?

a) Check d-dimer
b) Check hematocrit
c) Order head CT
d) Order or schedule echocardiogram
e) Order or schedule carotid ultrasound
f) Order or schedule EEG

What would you do now?

a) Admit
b) Don’t admit
c) Arrange for 24 hour Holter as outpatient
d) b + c
Syncope

- Most often benign and self-limited
  - Can represent serious illness
  - Recurrent episodes can be psychologically devastating
- Etiologies
  - Neurally mediated (carotid sinus hypersensitivity, situational, or vasovagal)
  - Cardiac
  - Orthostatic

What should be done for everyone?

- Good history and exam
- Orthostatic changes
- EKG
- Try to differentiate high vs. low risk
  - History of CV disease, family history of sudden death, abnormal exam or EKG, arrhythmias, exertional or in supine position
  - Neurally mediated usually don’t require admission or additional testing
  - If unexplained further testing may be necessary

Prediction rules

- San Francisco Syncope Rule, CHESS
  - Congestive heart failure
  - Hematocrit < 30%
  - EKG abnormalities
  - Systolic blood pressure less than 90 mm Hg
  - SOB
- 18% who had one or more had a serious outcome compared with 0.3% when none present
- Validation studies have suggested lower performance

Prediction rules

- BRACES rule
  - BNP > 300 pg per mL (300 ng per L) or Bradycardia (<50)
  - Rectal examination with positive fecal occult blood test
  - Anemia (Hb < 9 g/dL)
  - Chest pain
  - EKG with Q waves
  - oxygen Saturation <94% on room air
- 87% sensitivity and 98% negative predictive value
Studies that may be indicated

- Labs
  - BNP
- Echo
  - Role not well defined, especially if normal exam and EKG, and no cardiac history
  - Most useful in those with unexplained syncope and a positive cardiac history or abnormal EKG
- Stress test
  - May be useful if at risk for CV disease, unexplained syncope, and if exertional

Studies that are NOT indicated

- EEG
  - Prolonged LOC, postictal state, witnessed seizure, aura
- Head CT
- Carotid ultrasound

Studies that may be indicated

- Monitoring
  - Higher yield with high pretest probability of identifying an arrhythmia
  - Loop event recorder much higher yield than Holter
- Tilt-table testing
  - Sensitivity and specificity not great
- EP studies
  - For patients with CAD and syncope, or cardiomyopathy
Take Home Points

- Goal = Reduce Healthcare Waste
- Think before you order
- Defer, if possible

QUESTIONS