

Enlisting Patients in the Fight to Cut Costs

By **RONI CARYN RABIN**

Dagmar Frias never really got the hang of her asthma medications. She would use an inhaler whenever she started wheezing, but the drugs she was supposed to take every day remained in her dresser drawer, untouched.

Then late last year, her 1-year-old daughter, Amelia Marquez, had a severe asthma attack that put her in the hospital for five days. Since then, Ms. Frias has become something of an expert on managing the disease.

She is scrupulous about giving Amelia her medications three times a day, and has learned to watch for signs of an imminent attack, like the heavy breathing and the telltale cough, and the way Amelia scrunches up her shoulders when she's short of breath. Ms. Frias said she has been taking her own medicines and has had no new asthma attacks.

"Honestly, in the America we live in right now, it's such a hectic America, it's easy for a mother to forget," said Ms. Frias, 27, a mother of four from the Bronx. "But if you have a regular doctor who sits with you and makes sure you understand what's going on, it really helps. My message is: knowledge is power."

Ms. Frias credits her daughter's pediatrician, Dr. Delaney Gracy, the clinical co-director of the Childhood Asthma Initiative at the New York program of the Children's Health Fund, a partnership with Montefiore Medical Center. The initiative trains physicians to follow rigorous national care guidelines that call for complicated, time-consuming yet necessary patient assessments before prescribing asthma drugs — evaluations that other doctors may skip.

The program has developed a 12-point asthma questionnaire that has been incorporated into the patient intake form, and a brightly colored picture workbook about asthma that parents can read with their children and use as a guide.

Initiatives like this one are in keeping with a central goal of the new health care law: providing more patients with dependable ways to manage chronic illnesses, preventing flare-ups that can make them worse and lead to expensive emergency care.

But whether these principles can rein in runaway health spending is a matter of debate. Though chronic ailments like asthma, diabetes and heart disease consume a disproportionate share of health care costs, many critics are skeptical about the potential of improved care alone to reduce expensive hospitalizations and cut costs.

"I think it would be optimistic to assume these programs alone are going to be the savior of the cost issue that we're challenged with," said Robert Parke of the actuarial firm Milliman Inc., who is a member of the American Academy of Actuaries' working group on disease management.

"That's not to say we shouldn't be doing them," he went on. "Even if they don't save you money, even if they break even, they still might be the right thing to do because they're improving the quality of care. But there's a cost involved in managing them, and the savings may be more than offset by those costs."

He and other experts noted that Medicare's efforts to stem costs through chronic disease management and care coordination among the elderly were largely unsuccessful, leading instead to higher fees.

One exception is a program carried out by Health Quality Partners, a nonprofit care group based in Doylestown, Pa., which reduced hospitalizations among the most high-risk Medicare patients by 24 percent and lowered monthly hospital costs by \$255 per beneficiary, according to one analysis.

Unlike other programs that keep in touch with chronically ill elderly people by phone, Health Quality Partners makes home visits to monitor patients' progress and holds group classes close to patients' homes, said Ken Coburn, the group's chief executive and medical director, adding, "We're really on the ground, where people are living their lives."

Nevertheless, a February 2009 study in *The Journal of the American Medical Association* found that 13 of 15 such Medicare programs failed to reduce hospitalizations, the most expensive aspect of care. A growing number of experts are convinced that the only way to reduce health care spending is to change the way doctors and hospitals are paid — linking reimbursement to better patient outcomes.

But a recent analysis of the Childhood Asthma Initiative suggests that aggressive management of chronic diseases by a primary care provider can produce better outcomes while reducing costs. The study followed some 200 inner-city children with asthma, from toddlers to teenagers, and compared their condition at an initial assessment and then after six months. When the children first came in, one-third were on all-important controller medications; that figure increased to more than two-thirds after patients were properly assessed.

Six months later, 19 percent reported having gone to the emergency room because of an asthma attack, down from 61 percent at the initial assessment, and only 2 percent had been hospitalized, down from 28 percent.

The study, published in *The Journal of Health Care for the Poor and Underserved*, estimated that the program saved \$4,525 in annual health care costs per patient — 11 times the cost of the intervention, estimated at \$420 per patient, said Dr. Irwin Redlener, the paper's senior author, who is a professor at the Mailman School of Public Health at Columbia and also president and co-founder of the Children's Health Fund.

"We need to say to doctors, 'If you follow these guidelines — developed by your peers — you'll see better outcomes in terms of the management of the illnesses and the well-being of your patients,'" he said.

But Dr. Redlener agrees that if physicians are going to be asked to spend more time with their patients, they need to be paid for their time, and pay practices must incorporate incentives that tie reimbursement to best practices and better outcomes.

"Meaningful health reform without fundamental changes in reimbursement policies may be a nonstarter," he said. "If we don't change the incentives, we'll get more of what we already have, and drive physicians toward volume, rather than quality."

The new health care law encourages government programs to evaluate new payment systems, allocating \$10 billion to develop innovations within the Centers for Medicare and Medicaid Services. Payment reform models that improve quality and reduce spending could be expanded throughout Medicare, Medicaid and the Children's Health Insurance Program as early as next year.

The law also calls for experimental incentive programs in the Medicaid systems — for example, combining payments for an entire medical episode and allowing the providers to share in any cost savings they achieve. That could help reduce not just hospitalizations but also repeat admissions, which occur when a patient doesn't get the right follow-up care after being discharged from the hospital.

"A lot of things need to be tried, and some will work better than others," said Stuart Guterman, assistant vice president for the Commonwealth Fund's program on Payment System Reform, who noted that without action, health spending would nearly double by 2019, to \$4.5 trillion from \$2.5 trillion.

"We know one thing: if we don't do anything different than what we're doing now," he said, "we're headed for catastrophe."

This is the ninth in a series of articles on how the health overhaul will affect everyday lives.