Colorado Long Term Care Insider

Valentine's Week Edition Of The Health Wonk Review

February 17th, 2011

Welcome to the Health Wonk Review! This week's edition has tons of great articles from some of the best wonks in the healthcare blogosphere. Health care reform, the individual mandate, cost control measures, patient-physician shared decision making, EMR, and ACOs are just a few of the topics discussed in this edition. We'll start things off with a few of my favorite posts:

Health News Review's Gary Schwitzer gives us a thoughtful article about the need for balance in our cancer screening process. Women have long been encouraged to get annual mammograms, and doing so is generally equated with being responsible and taking care of one's health. But the evidence (and we should always be looking at evidence, rather than "common sense" or current trends) indicates that mammography as a lifesaving test is not as cut-and-dried as many might think. Gary includes a link to a Washington Post article by Veneta Masson, a former nurse practitioner, who explains why she no longer gets mammograms, despite having a sister who died of breast cancer. A poem by Veneta is also featured on Gary's blog, reminding us to question what "normal" means.

Health Beat's Maggie Mahar has written an excellent article about the rising rates of elective inductions and c-sections over the years. Our second baby is due to arrive this spring, and we're planning our second homebirth – so Maggie's article was particularly interesting to me. Although ACOG has deemed it unacceptable to induce delivery prior to 39 weeks without medical reason, babies are still being induced (and delivered via c-section) two and three weeks before their due dates (and it's important to keep in mind that due dates are just estimates – a healthy pregnancy can go all the way to 42 weeks and still be within the range of "normal"). Maggie explores the reasons behind the increase in scheduled births, and her article is a fascinating look at how both mothers and doctors view birth.

Austin Frakt, writing at The Incidental Economist brings us an excellent article about how health insurance reform (which was what a good deal of the PPACA involved) does little to actually bring down costs, mainly because the vast majority of health care spending is money that is paid to providers, not money used to maintain the health insurance system. Even if we revamped every part of our health insurance system to remove all inefficiencies, we'd still be spending nearly the same amount on health care as we are now.

The Healthcare Economist's Jason Shafrin gives us a fascinating description of a study that was done to see if research subjects could fake their way into being admitted to psychiatric hospitals merely by saying that they heard voices. The pseudopatients were admitted and almost all were diagnosed with schizophrenia (upon release, they were labeled as having schizophrenia "in remission"). Definitely an eye-opening look at how scientific (or not) our mental health diagnostic process is.

Joe Paduda of Managed Care Matters gives us a couple of strategies that could be used if we were serious about cutting federal health care spending: Require HHS to negotiate with pharmaceutical companies for Medicare Part D drug costs (currently such negotiation is specifically prohibited), and require HHS to base reimbursement rates on comparative effectiveness data rather than the cost of providing care. Two very good ideas, although I'm sure there's a lot of lobbying clout that would try to interfere with legislation aimed at either of these goals.

To add another twist the medical marijuana debate, **Jon Coppelman of Workers' Comp Insider** explains how legislators are trying to hash out (sorry) the details of legal medical marijuana and workplace regulations. The rights of employers to maintain a drug-free workplace and the rights of medical marijuana patients seem to be at odds with each other, and this issue promises to become more widespread as more states address the issue of legalizing medical marijuana.

Dr. David A. Kindig of Improving Population Health discusses whether chronic disease prevalence can be considered a population health outcome measure. Dr. Kindig explains that reducing disease prevalence is more of a means to an end (with the end goal of "living longer healthier lives") rather than an outcome in and of itself. He prefers to use "intermediate outcomes" and explains this with an example of how current smoking prevalence can predict the health of a population decades in the future.

Dr. Rich of The Covert Rationing Blog explains how the implantable defibrillator became an abomination. Dr Rich was one of the early pioneers who worked with implantable cardioverter defibrillators (ICDs) and has first hand knowledge of their use over the last three decades. Thanks to the ever-increasing complexity of ICDs, their price has not come down over the years. Their high cost serves to keep them as an elite technology rather that something available to everyone. But Dr. Rich believes that the number one reason ICDs are demonized is because they serve to prevent sudden death, which is the least expensive end-of-life scenario; people who get an ICD and go on to have expensive, non-sudden deaths are much more costly for our health care system. Definitely an interesting article from a doctor who has been involved with this technology for 30 years.

Health Blawg's David Harlow explains how Alternative Quality Contracts (ACQs) in Massachusetts are somewhat similar to Accountable Care Organizations (ACOs), although the latter have yet to be completely defined and rolled out. David describes a recent presentation by the CEOs of BCBSMA and Atrius Health (a group of 700 doctors who participate in the ACQ), who detailed how they've implemented the ACQ, and how it could work as a model for ACO implementation across the country.

Dr. Roy Poses of Health Care Renewal addresses the issue of corruption and conflict of interest in health care. He notes that recent news stories have focused on corruption in various large health-promoting organizations, and yet most health care organizations still have no initiatives in place to fight corruption and promote transparency and accountability.

Writing at his **Health Policy Blog, John Goodman** details the cost-shifting that will be necessary in order to implement the various reforms of the PPACA, and notes that there are no free lunches. Unless providers agree to earn less money across the board, patients with private health insurance will be paying more in order to compensate for lower reimbursement rates for Medicare and Medicaid patients. Healthy individuals will have to pay more for their health insurance in order for those with pre-existing conditions to be able to buy affordable guaranteed-issue coverage. And so on. John notes that under a reduced-reimbursement Medicare system, seniors might end up sharing 4 and 6-bed wards rather than having private rooms. One has to wonder if perhaps we've become a bit too extravagant in terms of what we expect from our healthcare. Do we want affordable medical treatment, or do we want a hospitalization to feel like a visit to a hotel? Maybe shared patient rooms isn't such a bad idea (for all of us, not just those on Medicare and Medicaid), if it would help to bring down the cost of care.

Avik Roy (whose blog has officially moved to a new location) has written a thought provoking article about how the individual mandate isn't a great solution to the problem of uncompensated and undercompensated care. Because one of the main tenants of the PPACA is to expand Medicaid, undercompensated care in the form of lower Medicaid reimbursement is likely to become a larger problem. And as Roy pointed out, the PPACA will not reduce the number of uninsured people to zero – there will still be millions of people without health insurance even under the PPACA, and they may still seek uncompensated care via emergency departments. All good points, but from a health insurance perspective there's another issue to consider: If health insurance is guaranteed issue (which it will be as of 2014) and there is no mandate, there's nothing to prevent people from waiting until they need care (not necessarily emergency care, but any care at all) to apply for private health insurance. At that point, the insurance company would have to cover them. The cost of their care would be paid for at a private insurance rate (so the providers would get their fair share) but the insurance company would have to spread that cost among all of the policyholders, including those who had been paying premiums while they were healthy. There are lots of angles to look at when it comes to the mandate problem, and Roy's article does a nice job of addressing several of them.

InsureBlog's Mike Feehan adds to the debate surrounding the constitutionality of the individual mandate in the PPACA. He points out that in the recent Florida ruling that found the mandate to be unconstitutional, the judge noted that the government's position during the preceding court battle in Virginia was that "*although people are required to buy health insurance under the act, they are not yet required to use it*." Mike brings up an excellent point when he asks why they would use the word "yet". The possibility that the government could one day compel people to seek preventive care (like those screening tests that Gary Schwitzer talked about) against their will is a disconcerting idea indeed.

Ken Terry of BNET Healthcare notes that insurers are striking back at high cost hospitals by encouraging members to utilize lower cost options instead. Although much of the focus of

"healthcare reform" has been on insurance reform instead, this is one strategy that could actually lead to lower healthcare costs. If large insurers offer financial incentives in the form of lower premiums and/or deductibles and copays for policies that utilize lower-cost facilities, high-cost hospitals might be more inclined to bring their fees more in line with the averages, even if it means being a little less profitable.

Medical malpractice reform wouldn't do much to stop excessive testing. **David Williams of Health Business Blog** explains why, and notes that "*Only payment reform, provider education and changes in patient demand are likely to make a big difference*." I agree. While malpractice reform is part of the big picture of healthcare reform, excessive testing will likely continue as long as providers get paid for doing the tests, and patients continue to want the tests.

Jessie Gruman, writing at Health Affairs Blog, gives us an excellent (and very personal) look at the nitty gritty details behind shared decision making between patients and providers. As a current cancer patient, Jessie details her own experience with sharing evidence and decisions with her oncologist, but also notes how difficult it is to be actively involved in the decision making process while also coping with the pain and fear that often accompany a serious illness. But despite the obstacles, she notes that shared decision making is the ideal scenario, and something that both patients and providers should strive for. All the best to you Jessie, as you participate in your recovery.

Continuing with the same theme, **Jaan Sidorov of The Disease Management Care Blog** explains what a hockey game can tell us about shared decision making. When we think of patient-centered care and shared decision making, we tend to think about treatment plans and specific medical interventions. But Jaan points out that patients also have the capability to make decisions that negatively impact their health (and fans at a hockey game display this quite well!) and that everyday decisions like what to eat and whether to exercise are part of a person's health just as much as their medical treatments for specific ailments.

At **Healthcare Talent Transformation, Jonena Relth and Esther Groves** explain how training (including a realistic assessment of how employees view the situation) can help make the adoption and implementation of electronic medical records a smoother process. Over the next several years, virtually all medical practices are going to implement EMR, and staff involvement and buy-in for the transition will be essential for success.

Brad Flansbaum of The Hospitalist Leader explains that language matters, and gives us a list of words that are tossed around to sound impressive but don't really mean much (and according to Brad, make it easy for doctors to pick out the consultant in the room). He also notes that patient and consumer are not interchangeable words. If you're guilty of using a lot of these terms, it may be time to acknowledge that "mistakes were made" and find some more meaningful phrases.

At **Neil Versel's Healthcare IT Blog**, we have a podcast with Evan Steele, the CEO of EMR vendor SRSsoft. A couple of years ago, SRSsoft wasn't interested in the certification process that would allow their clients to get "meaningful use" incentives from the government, but the company has recently shifted its position and is seeking "meaningful use" certification. The

Podcast provides an interesting look at the specifics of Evan's company as well as the implementation of EMR in general and the "meaningful use" incentives for providers.

Writing at **The Lucidicus Project, Jared Rhoads** shares the details of how Massachusetts has implemented their health insurance mandate. Health insurance carriers there have to send a 1099-HC to policyholders, and that information has to be provided when residents file their tax returns. In order to avoid fines ($93 for each month with coverage), residents have to be able to show that they were insured for the entire year. One has to wonder if perhaps a few years from now, all of us will be getting 1099-HCs, assuming that the individual mandate portion of the PPACA withstands its current legal battles.

Amer Kaissi of Healthcare Hacks describes a study done last fall that indicates that Americans are often confused by healthcare provider titles, and many are unsure of which professionals are medical doctors and which are not. Pending legislation might help to alleviate some of the confusion by requiring providers to clearly indicate their qualifications in any advertising.

Thanks for reading! Hopefully you learned something new and enjoyed this edition of the Health Wonk Review. Check back in on March 3rd for the next edition, which will be hosted at The Lucidicus Project by Jared Rhoads.