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Let's Agree To Agree

Let's forget about Obama's selling of reform–it's high-class hucksterism. Let's forget about the conservative opponents who match or exceed his exaggerations with low-class fear-mongering. Both distort the facts.

This *Heartbeat* will discuss why it's important for physicians to become involved in the healthcare reform debate. With our pens or in rare instances computer keys, we're responsible in large part for the quality, quantity and cost of healthcare. We also have a vested interest in healthcare reform because it is our livelihood. Whether from the far right or radical left, I think there are issues on which we can agree to agree and participate. We can do this by "smart" responsible management of our patients and by voicing our opinions.

First we should be able to agree on the premise that we need healthcare reform. *The goals of healthcare reform are to expand coverage to the uninsured, improve coverage for the underinsured while simultaneously controlling the ever-expanding costs that are bankrupting our country.* And whether we believe there are 15 or 47 million uninsured, I think we can agree that there are too many. Most physicians, left or right politically, believe they have an obligation to care for less fortunate people with limited resources. One American now dies every 12 minutes from lack of health insurance.

In 1999 health care costs were 8% of the median family's income, today they are 18% and, if nothing is done, will be 35% in less than a decade.

If coverage is expanded and improved, how can costs be controlled? I believe physicians have more direct control over costs than many of the other sectors of the industry (hospitals, insurance, pharmacy), and I think we should be able to agree on a few examples.

Tort Reform

This is a no-brainer. All doctors need to be telling their legislators and the public that there has to be tort reform as part of any healthcare reform. The threat of lawsuits increases costs because it affects how we practice. It's not as large of a component of healthcare costs as most believe, but *tort reform would help to decrease healthcare costs and should be part of healthcare reform—and we should agree!*

Death Panels?

I believe we all should be up-in-arms about the "Death Panel" scare tactics and how lawmakers caved into them. Why shouldn't we be paid to discuss end-of life care with our patients? Patients, families and physicians *should* be discussing this, so that the patients' wishes are

known before they cannot express them. We frequently do not do it because of time constraints and lack of payment. Heroic and extra-ordinary care more often than not extends suffering rather than life. Yet, 25 to 30% of Medicare spending (which represents one-fifth of personal health spending) occurs in the patient's last year—most in the last week. No one wants to deprive ill seniors of desirable care, but they should be able to make an informed end-of life decision when they're able, and I believe most want less suffering. I know I do. *Appropriate end-of life counseling will improve quality of life and decrease cost. It should be done and it should be paid for.*

Generic Medications/Smart Dosing

We should all agree to use generic medications instead of brand-name when possible. If the brand-name drug is on formulary or tier 2, or there are coupons to decrease the co-pays, it may not affect the patient's immediate out-of-pocket cost, but it effects *total cost* and eventually elevates all of our insurance rates. A comparable situation: we often choose to pay outright for the cost of a fender bender rather than use our insurance and have our rates go up for 10 years. We now have generics available to treat blood pressure, cholesterol, diabetes, heart failure, etc. according to guidelines, and we should be using them.

♥ Tell your patients about Rite-Aid, Walmart and Target's $9.99 three month supply bargains. For those without prescription coverage, they are obviously beneficial. For those with insurance, it is often cheaper than their deductible. So the patient benefits, and overall costs are lowered. (I have a $40 deductible for my generic medications and I go to Rite-Aid.)

♥ Patients should not be on any angiotensin receptor blocker (ARB) unless they are documented to be allergic, have a cough or angioedema secondary to an ACE inhibitor (ACEI). No study has found ARBs superior to ACEI for blood pressure or heart failure. The only difference is significantly increased cost.

♥ There is almost no indication for using Coreg SR or Bystolic for the treatment of heart failure or high blood pressure when we have many other cost-effective generic choices.

♥ The best current evidence shows that most patients with hypertension require combination therapy. The best is a calcium channel blocker (CCB) and ACEI or ARB for the treatment of the majority of patients with hypertension, particularly those at high risk of a secondary event. Generic Lotrel (CCB/ACEI)—benazepril/amlodopine 5/20mg is the best buy for the money. Taking two 5/20s and chlorthalidone (Hygroton) 25mg is probably the best and one of the most cost effective triple therapy treatments.

♥ There is no benefit to using Lipitor 10mg to 20mg or Crestor 5mg to 10mg since generics can achieve the same degree of lipid-lowering at significantly decreased cost. (Remember two pravastatin 40mg costs only $20 for a three month supply).

♥ Doubling the prescription dose and using alternate day therapy for statins is very cost-effective when you need a brand-name statin to get your patients to appropriate lipid goals (i.e. Crestor 40mg or Lipitor 80mg every other day for those whom get to goal with Crestor 20mg or Lipitor 40mg). Again this decreases the cost to the patient and overall health care costs.

I still strongly advocate getting our patients to appropriate BP and lipid goals. *Smart prescription writing can significantly decrease costs without compromising quality of care. Use your power and control!*

Engage brain before putting *"pen in gear"*

We should always ask the question, "Will the result of a particular study or lab test alter my treatment plan?" If your eighty year old patient has already told you when you discussed end-of-life care that she/he would refuse any type of surgical intervention, your treatment will not change no matter what the results of an echocardiographic evaluation. The only thing it will do is increase healthcare costs.

If a study will tell you what you already know or will give an incomplete answer, it's wasteful to do it. Last week we had a ninety year old man come into the office for a consultation and request for a stress test. He has a known history of CAD and was taking all the appropriate treatments. He presented with a classic history of angina. We added beta-blockers and long-acting nitrates and sent him for coronary visualization. If I had done a stress test, it would have been positive (adding risk and cost) and then I would have proceeded to coronary visualization. If it was negative, I would have to assume that the stress test was a possible false negative because of the high-risk setting and strong clinical history and still would have to send him for coronary visualization. *We should use our clinical skills and diagnostics tests in a cost effective manner while providing quality care. We should be proactive "giving the right care at the right time every time," because it's the right thing to do.*

Cardiologists should Measure

If cardiologists measured fractional flow reserve (FFR) in conjunction with coronary visualization, better outcomes would be achieved at lower cost. FFR, in addition to angiographic guidance, as compared with PCI guided by angiography alone, results in a significant reduction in major adverse events at 1 year, a finding that supports the evolving strategy of revascularization of ischemic lesions and medical treatment of non-ischemic lesions. This study was in the January 15th NEJM of this year and was summarized in our January *Heartbeat.* These results were sustained out to eighteen months per a recent presentation earlier this month at the **European Society of Cardiology 2009 Congress** meetings—further validating the results.
Measuring FFR is a more accurate way of assessing the functional relevance of an angiographic stenosis that improves safety, reduces costs and enhances the beneficial effects of PCI. Cardiologists should use it more often, especially in those 50% to 80% lesions.

Conclusion

I hope we can agree that more people need access to health care and that we have the power to control many costs while still providing good care. We need to speak out and make our concerns known, and we need to do what we can to lower costs for our patients, and ultimately for the whole system.

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