

Area efforts to hold down health costs a template for success elsewhere

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As leaders in Washington look for ways to bring exploding health care costs under control — a critical element for health care reform — they may want to look right here.

Because businesses, doctors and insurers in Kansas City are doing a good job of bending the cost curve down.

Kansas City ranks in the bottom third for per-capita Medicare spending among major hospital regions. And while Medicare costs are growing, at 2.9 percent a year, that is significantly slower than the national rate.

It's not that Kansas City's cost of living is so much lower than in other parts of the country; it's about average. It's not that people are healthier and need less care; smoking and obesity are big problems here. And it's not that Kansas City is lacking high-tech gadgets like CT scanners or surgical robots; we've got plenty.

But Kansas City does seem to be playing it smart about how it uses its health care resources.

Local initiatives — from “report cards” on doctors to community discussions of end-of-life care — are improving health care quality and keeping costs low.

“There's just a collaborative spirit in this city,” said Bill Bruning of the Mid-America Coalition on Health Care. “We have employers, physicians and health plans working together. The collaboration keeps spending from getting too far from the norm.”

And the data show that the area's doctors are prudent about how they use the technology and facilities at their disposal.

As in other parts of the country where costs are relatively low, Kansas City doctors order significantly less of the stuff — lab tests, X-rays, minor procedures and referrals to specialists — that run up medical bills.

“I think the doctors in Kansas City are pretty good. They have a good ethic,” said Nathan Granger, a Kansas City family physician with a master of business administration. “They're not just in it for the money. They really care about their patients.”



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Big disparities

Washington has started looking to localities where health care costs are low for ways to put a damper on runaway spending nationwide. The potential savings are enormous.

Medicare spent \$16,351 on its average enrollee in Miami in 2006 — more than twice as much as the \$7,604 spent in Kansas City.

Extreme regional differences abound: \$8,331 per enrollee in San Francisco versus \$10,810 in Los Angeles, for example.

Since 1992, Medicare spending per enrollee has been growing by a national average of 3.5 percent a year.

Trim that back to the 2.4 percent rate maintained by low-growth San Francisco and an amazing thing would happen, researchers at Dartmouth University say: By 2023, Medicare will have saved a total of \$1.42 trillion.

The Dartmouth researchers have been crunching terabytes of Medicare data and pumping out research studies for decades.

They have focused on Medicare because it is the single largest source of data nationwide, but the implications of their findings extend throughout the health care system.

High spending, they have found, does not lead to better medical results or even to greater patient satisfaction.

Patients with colon cancer, heart attacks or hip fractures in high-spending communities were no more likely to be alive five years later than patients living where spending was low.

And patients in high-spending areas were less likely to get preventive services such as flu shots and Pap smears.

Few in Washington were interested in these findings until they ran up against the potential costs of health care reform: As much as \$1.6 trillion over 10 years, the Congressional Budget Office said.

Now the Dartmouth research is being cited by Peter Orszag, the White House budget director. He points to estimates by economists that the nation's health care costs could be reduced by 30

percent, about \$700 billion a year, if the practices of low-cost regions and hospitals were widely adopted.

And a startling article in The New Yorker that uses Dartmouth data has become required reading in Washington.

The article compares the Texas border towns of McAllen and El Paso. The towns have similar demographics, public health statistics and medical facilities. But Medicare spending averaged about \$15,000 per enrollee in McAllen, double the average amount spent in El Paso.

“For a long time nobody paid attention to these numbers,” said economist Jonathan Skinner, one of the Dartmouth researchers. “Now everybody agrees physicians and hospitals could cost less and provide better quality.”

Cost-lowering keys

The Kansas City area shares some of the character traits of other low-cost areas, such as Rochester, Minn., which is dominated by the renowned Mayo Clinic.

Physicians at Mayo are on salary. They are not financially motivated to do extra procedures or bring patients in for extra visits.

In Kansas City, many physician practices are owned by large hospitals and hospital systems that put doctors on salary, Granger said.

“That’s definitely a great way to keep costs down,” he said. “They’re driven by what’s best for the patient, not for their pocketbooks.”

And relatively few physicians here own surgical centers, facilities that do CT scans or companies that provide durable medical equipment, which would all give doctors more incentives to run up costs, Granger said.

That is in contrast to costly McAllen, where many physicians have become health care entrepreneurs.

The Geisinger Health System in rural Pennsylvania and Intermountain Healthcare in Salt Lake City keep costs low by using teams of health care professionals and computerized medical records shared by doctors and hospitals.

Although there is no one health care system that dominates Kansas City, “we have relatively well-coordinated care,” said John Sheldon, president of the Metropolitan Medical Society of Greater Kansas City.

“There’s a well-oiled, stable referral network that’s been established over the years. Physicians are working well together to avoid excessive utilization.”

Sheldon is a cancer specialist at Research Medical Center. He points to how cancer care is coordinated at area hospitals by multidisciplinary teams that meet regularly to discuss treatment options for their patients.

“We all basically agree to follow the consensus,” he said.

Kansas City also has been keeping health care costs down through home-grown initiatives that could be applied in other communities:

Doctors are getting feedback on how they’re doing.

Since 2002, the Kansas City Quality Improvement Consortium has been giving hundreds of primary care doctors “report cards” on how well they are following accepted guidelines for treatment of conditions such as diabetes and asthma.

By the third year of reports, the proportion of their diabetic patients with uncontrolled blood sugar levels dropped from about 38 percent to just 8 percent.

“By providing physicians information, you do change practice patterns,” said Cathy Davis, who leads the consortium of local medical societies, insurance companies and medical schools.

“A diabetic who controls his diabetes has fewer complications and that means lower costs.”

The business community is staying involved.

The Mid-America Coalition on Health Care brings together many of the area’s largest employers with hospitals, insurance plans and health organizations to look for practical ways to hold down health care costs.

“(Employers) recognized that whatever is wrong with the health care system at the end of the day, they’re paying for it,” said Bruning, the group’s president.

The organization has identified some of the most costly health care issues facing employers and developed model wellness programs and an initiative to improve treatment of depression.



It also has taken on technical projects such as making health insurance cards more legible. Clearer cards mean doctors waste less time and money dealing with rejected insurance claims.

Doctors are discussing end-of-life issues with patients and their families.

Futile medical treatment during the final months of life is one of the costliest aspects of health care.

But locally, these costs are significantly lower, said Tom Bowser, president of Blue Cross and Blue Shield of Kansas City.

Much of the credit should go to the Center for Practical Bioethics, which has pioneered the rights of patients to receive appropriate care at the end of life, he said.

From 1998 through 2001, the center focused its attention locally on encouraging doctors and clergy to discuss end-of-life issues with patients, to improving treatment of pain and other palliative care, and to increasing referrals to hospices.

Hospice care, which is designed to comfort rather than cure terminally ill patients, is “the gold standard of end-of-life care,” said Myra Christopher, bioethics center president.

“The concept that more is better is just wrong,” Christopher said. “Yes, modern technology can result in miracles, but not when it’s applied indiscriminately.”

This is part of a series of articles examining key questions in the health care reform debate. We’re watching the plans as they evolve, focusing on what they’ll mean for you, your family, your business and your tax bill. At kansascity.com/healthyquestions, we’ve set up a page that will link you to studies, charts, position papers and stories about health care and health insurance reform.