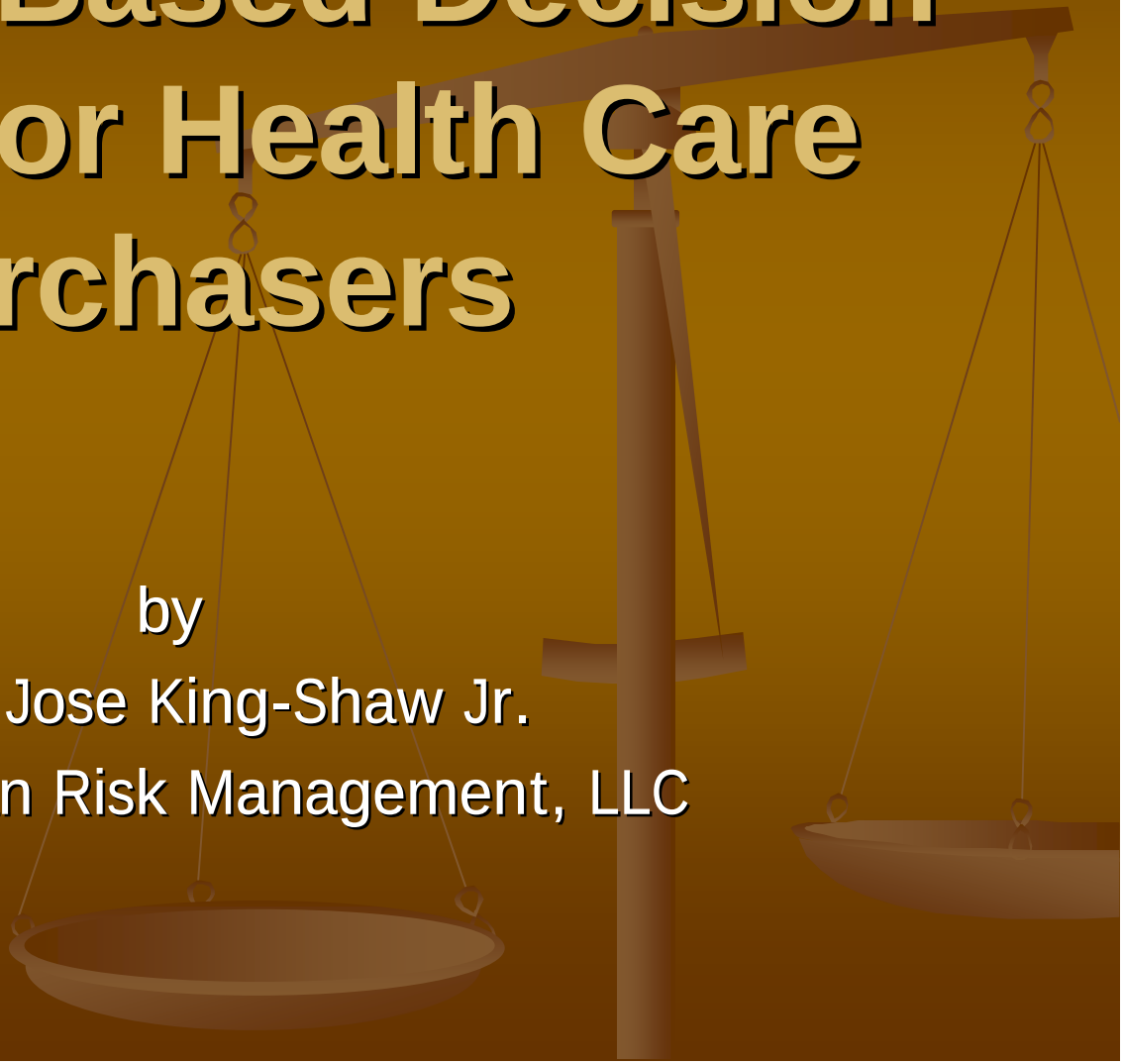
Evidence Based Decision Making for Health Care Purchasers



by

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Consensus

- The basis of all healing is a relationship between a physician and a patient.
- It is customized by the expertise of the caregiver...
- and the values, physical and mental conditions of the patient.
- Coverage and payment policy can empower that customized relationship...
- or disrupt that relationship.

Agreement

- Most patients and physicians have a wide range of options for addressing health and healing concerns.
- Some strategies and medicines are more effective for the individual or condition than are others.
- Patients and physicians deserve to have the most current, credible, relevant information on hand in making medical decisions.

Evidence Based Medicine: A Working Definition

When caregivers and patients draw on the most current, credible, relevant, scientific, external information along with their professional expertise to select the best medical options to meet each individual patient's specific needs.

The Problem

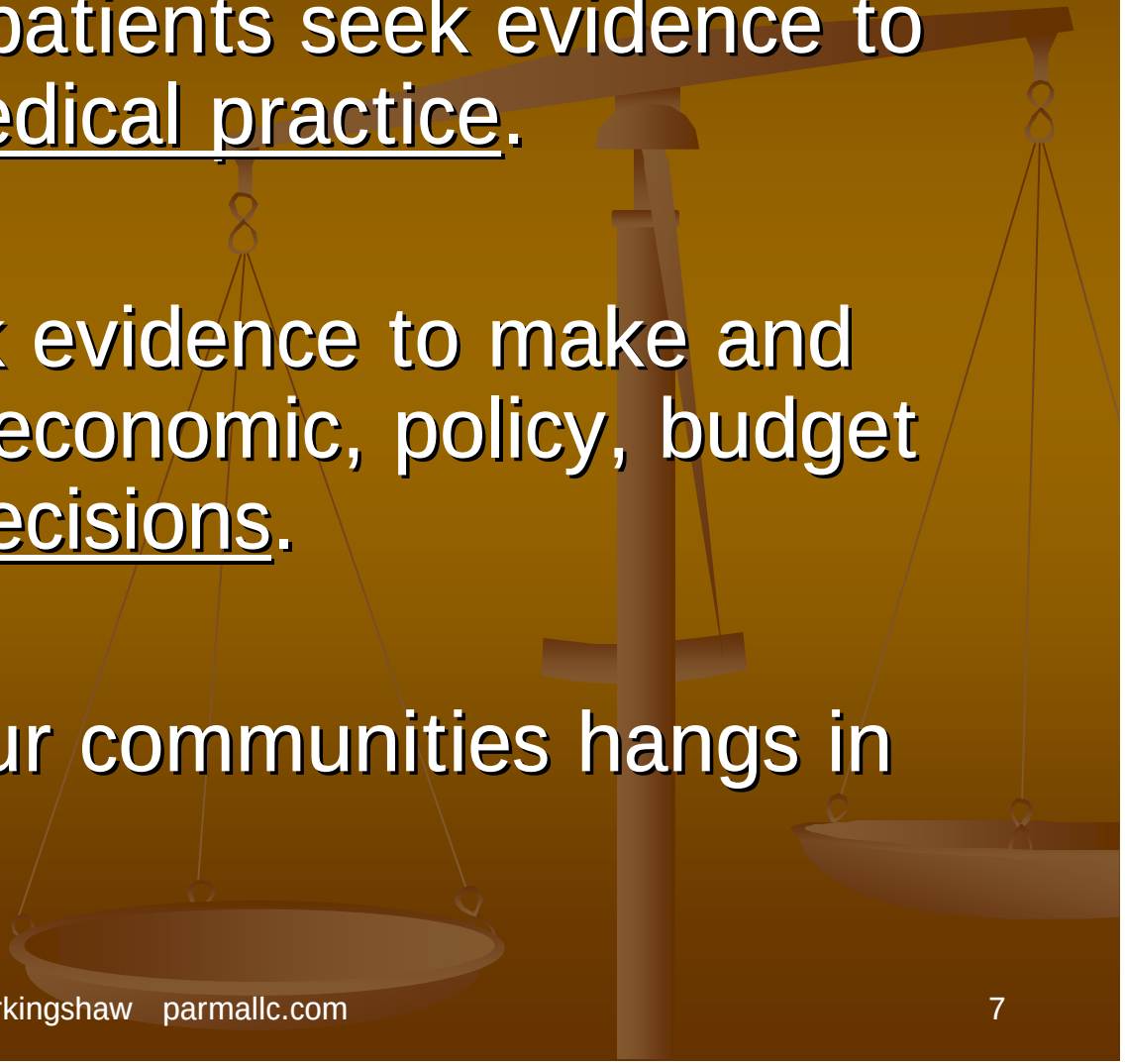
- Health care policy makers and purchasers often have conflicting pressures and priorities such as:
  - **allocating** resources: medicines v. hospitals v. physicians v. nursing homes v. home and community based programs v. managed care
  - **managing** cost: price v. coverage v. benefits
  - **financing** health care services v. education v. local projects
- Legislators, governors and policy directors must make these <u>difficult balance</u> decisions.
- Something called “Evidence Based Medicine” is seductively attractive yet potentially dangerous.

The Result

- Common EBM practices encourage defining “relevant evidence” in ways that can skew the coverage decision making process in a direction that:
- **limits** studies to those that can be used to defend the difficult and short term policy and budget decisions – such as RCT – and not the whole body of relevant work such as observational studies.
- **enables** the finding that “there is no therapeutic difference”, therefore leading to an erroneous conclusion that acquisition or unit price is the only relevant difference.
- **fails** to highlight differences in outcome or preference in specific ethnic and racial populations -- thus perpetuating some disparities.
- **comports** with state and federal “scoring” methodologies.

The Critical Difference

- Physicians and patients seek evidence to support best medical practice.
- Purchasers seek evidence to make and defend difficult economic, policy, budget and coverage decisions.
- The health of our communities hangs in the balance.



Politics, Policy and Purchasing

- Even with tight budgets programs for seniors and those with chronic conditions – medical and behavioral -- have rising priority for expansion.
- These conditions often require effective prescription drug therapies and disease management programs to improve clinical outcomes, quality of care and quality of life.
- Arbitrary benefit reductions for these populations and programs are difficult to defend commercially and politically.
- Hence an external process -- such as the Oregon model -- that appears “evidence-based” and offers political cover and has great appeal.

EBM and Medicare

- Government policy as a change agent.
  - AHRQ to conduct and support studies of outcomes, comparative trials, appropriateness to improve efficiency and effectiveness of Medicaid and Medicare programs.
  - Studies to focus on drugs and services that (1) impose high costs on the Medicare program, (2) are under or over utilized and (3) can impact high-cost conditions.
  - HHS to disseminate the results for use at "every decision point" – Medicare, Medicaid, commercial and for private investment.
- Cost-effectiveness becomes an accepted evaluation point for Medicare demonstration programs.
- Cost-effectiveness is introduced progressively as a part of "science-based" or "evidence-based" decision making.

Case Study: EBM and Medicare Rx

Medicare Part D benefits will be administered through Private Drug Plans (PDPs).

PDPs use Prescription Benefit Managers (PBMs).

PBMs manage formularies & Preferred Drug Lists (PDLs).

PDL development draws on "evidence" such as

- Random control trials
- Outcome and observational studies
- Best and standard practice protocols
- Health care economics
- Price per unit and price per dose

The expanding definition of evidence will increasingly drive coverage and benefit decisions in Medicare and beyond.

EBM and Health Care Disparities: The Facts

- Hispanics are less likely to receive or use medications for asthma, heart disease, HIV/AIDS, mental illness and cancer.
- Hispanics in a Medicaid population received fewer of the more effective second generation antipsychotic agents than did non-Hispanic Whites.
- Low income Hispanic children with asthma are less likely than Whites and African Americans to take inhaled beta-antagonist medication before hospitalization.
- Coexisting conditions prevalent among Hispanics (diabetes, depression, asthma and heart disease) are often under treated.

EBM and Health Care Disparities: The Facts

African Americans, Hispanics and Asian Americans:

- Receive fewer vaccinations
- Receive less therapy for pain
- Get fewer antiretroviral drugs for HIV/AIDS
- Are prescribed fewer antidepressants

Low income Hispanic children with asthma are less likely than Whites and African Americans to take inhaled beta-antagonist medication before hospitalization

EBM and Health Care Disparities: The Evidence

Clinical studies have shown that:

- Black and White patients differ significantly in response to beta blockers and other treatments for hypertension.
- Chinese patients generally are more sensitive than Whites to the effects of beta blockers on heart rate and blood pressure.
- Some ACE inhibitors are more effective in lowering blood pressure in Whites than in Blacks
- Asian Americans are generally more likely to require lower dosages of medications such as antidepressants and antipsychotics.

EBM and Health Care Disparities: Purchasing Implications

Smoking-related diseases and mortality disproportionately affect African Americans:

- 45% of urban African Americans reported smoking vs. 25% for the general population.
- African Americans metabolize nicotine more slowly than do Whites and thus develop addiction at lower levels of smoking than do whites.

Smoking accelerates the metabolism of many medicines used to treat chronic conditions such as asthma and hypertension – common among African Americans, thus making such medicines less effective in heavy smokers.

Arbitrary coverage and benefits limits on certain medicines can negatively impact care and treatment for African American smokers.

EBM and Health Care Disparities: National Implications

Hispanics are the fasted growing ethnic group in America and have significant concentrations in several key states.

Hispanics on average are almost twice as likely to have diabetes than non-Hispanic Whites.

Diabetes prevalence among Mexican Americans and Puerto Ricans (the two largest Hispanic groups) is twice that of Cubans and non-Hispanic Whites.

The high rate of diabetes among Pima Indians (21%) and Navajos (23%) may explain the high rate in Mexican Americans who have a genetic ancestry drawn heavily from American Indians.

EBM and Health Care Disparities: National Implications

Diabetes, when not treated, is closely correlated to conditions of obesity, hypertension, depression and loss of limb.

Disease management programs can be effective in treating diabetes but such programs require significant literacy and compliance for the patient and family. Literacy and compliance can be barriers in effectively treating many Hispanic patients.

Insurers and purchasers must contract with the appropriate community based providers and agencies to effectively treat diabetes and other chronic conditions.

Developing effective provider networks and culturally competent disease management programs is at the center of every insurer and government payer serving a diverse patient population.

Caution: EBM and Racial Profiling

Race is an imprecise substitute measure of genetic differences among populations.

- Skin color, facial features have little to do with drug responses or progression of diseases such as diabetes and hypertension.
- Hispanics share some common culture but represent many diverse and often combined racial groups.
- General and historic trends cannot predict individual behavior, pathology or response.

Policy Implications

Elders, urban Americans, African Americans, Hispanics, those with mental conditions and those with chronic conditions disproportionately dependant on Medicaid and Medicare programs.

Government purchasers, therefore, are the foremost protectors of the health of these communities and their caregivers.

Because employers and insurers often follow Medicare practice, look for commercial insurance to become increasingly “evidence-based.”

My Recommendations

- When applying evidence-based principles for making coverage, pricing and benefit decisions, incorporate all the relevant and appropriate sources – including observational studies, standards of practice, the individual patient's values and preference.
- Understand and respect the drivers of health care disparities – cultural and biological – when designing disease management programs and making coverage decisions.
- Pay close attention to Medicare PDP coverage decisions as they develop over time. As the body of evidence broadens look for formularies to shift significantly.

My Recommendations

- Apply evidence-based outcomes evaluation criteria to care management programs and specialty provider networks.
- Begin modeling pricing structures that incorporate evidence-based (outcome) data. Pay for Performance will one day become the norm.
- Resist the urge to mix financial data with clinical evidence. Both are necessary elements for effective purchasing, but they are distinct.
- Understand that effective health care is driven by, and toward the individual. Purchasing decisions that enable appropriate care to the individual will have both clinical and financial integrity.

Recommended Reading

- Drugs vs. talk therapy, CR investigates Antidepressants. *Consumer Reports.* October, 2004:22-29
- Huskamp H. Managing Psychotropic Drug Costs: Will Formularies Work? *Health Affairs*. (Sept/Oct 2003):84-96
- Kroenke K, West S, Swindle R et al. Similar Effectiveness of Paroxetine, Fluoxetine, and Sertraline in Primary Care. *JAMA. 2001; 286:2947-2955*
- Hitchcock NP, Williams J, et al. Depression and Comorbid Illness in Elderly Primary Care Patients: Impact on Multiple Domains of Health Status and Well-Being. *Ann Fam Med.* 2004; 2(6):555-562
- Lin E, Katon W, Von Korff M, et al. Effect of Improving Depression Care on Pain and Functional Outcomes Among Older Adults with Arthritis. *JAMA.* 2003; 290(18):2428-2434

My Conclusion

- Appropriate use of evidence results in better purchasing, coverage and treatment decisions for all patients.
- Inappropriate use of evidence enables cost-driven decision making with dangerous consequences for the most vulnerable patients.
- The difference is critical.

Evidence Based Medicine and Insurance Coverage

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