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**Jon Baron**

jbaron@coalition4evidence.org  
202-380-3570

900 19<sup>th</sup> Street, NW

Suite 400

Washington, DC 20006

www.coalition4evidence.org

## Overlooked Strategies To Reduce Health Care Costs

In the urgent policy discussions on the cost of health care reform, some simple, proven strategies to cut costs have been overlooked that, if incorporated into the reforms, could produce tens of billions of dollars in savings annually. What distinguishes these strategies from the vast majority of ideas for reducing cost is that these have been proven effective in rigorous randomized controlled trials that meet the evidence standards of the National Academy of Sciences and Food and Drug Administration, and therefore would likely meet the Congressional Budget Office's criteria for scoring savings in health care reform legislation. By contrast, most other proposed cost-reduction strategies are plausible-sounding ideas that, experience shows, are often found not to work if rigorously evaluated.

Consider first some examples of the proven strategies. One is an electronic decision support tool for doctors, which uses clinical data from a patient's insurance claims to identify potential errors in the patient's care, and then alerts his or her doctor via email. This system, which costs approximately \$1 per patient per month, has been shown in a large randomized trial in a managed care setting to reduce hospitalizations by 9%, and health care costs by \$10-\$20 per patient per month, compared to the control group. This suggests potential annual savings of \$20 billion or more if implemented nationally.

The second example is a brief educational program for low-income hospital patients about to be discharged. A nurse provides the patient with a clear plan for avoiding health complications after discharge, including contact information for the patient's medical providers, dates for appointments and tests, a medication schedule, and related items. After discharge, a pharmacist phones the patient periodically to help ensure adherence to the plan. This low-cost program -- \$100-\$150 per patient -- has been shown in a large randomized trial to reduce rehospitalizations by 30%, and average health care costs by about 25%, during the 30 days after patient discharge, compared to the control group. This suggests potential annual savings of \$10 billion or more if implemented nationally.

Wouldn't it be great if there were many of these proven cost-saving strategies? Unfortunately, there aren't -- not yet. This is because randomized controlled trials -- the widely-used "gold standard" for evaluating the effectiveness of health care *treatments* -- have only recently been applied to evaluate health care delivery *systems*. Meanwhile, the less-rigorous studies that are often used to evaluate systems have been shown in careful investigations to produce erroneous conclusions in many cases. Thus, for the most part, policymakers are operating in a vacuum of knowledge about which strategies to reduce costs can truly make a difference.

That is why it is important for health care reform not only to expand the few proven strategies to reduce cost, such as those above, but also to use rigorous evaluations to build additional knowledge about what works -- and what does not work -- to reduce cost. Two recent examples show the way. In 1995, the Department of Health and Human Services launched a rigorous randomized evaluation to test prospective payment of Medicare home health agencies -- i.e., paying such agencies a lump sum per patient -- against the usual cost-reimbursement approach. The evaluation found that prospective payment reduced costs to Medicare by 20% over five years, compared to cost-reimbursement, with no negative effects on patient health. This finding was a key factor leading to Medicare's nationwide implementation of prospective payment for home health agencies starting in 2000, generating major national cost savings.

The federal government's Medicare Coordinated Care Demonstration has used a similar knowledge-building approach, with much different -- but still valuable -- results. Launched in 2002, the Demonstration is rigorously evaluating 15 promising cost-reduction strategies for Medicare patients with chronic conditions, aimed at coordinating care among their many physicians, fostering adherence to their doctor's prescribed care, and encouraging preventive care. The Demonstration includes a randomized evaluation which, thus far, has found that none of the 15 strategies reduced Medicare costs enough to pay for the strategy, and most have had little impact on the quality of care. Although the Demonstration is still ongoing, the initial results follow a well-known pattern: highly-promising policy ideas are often found not to work as promised when properly evaluated.

Such a knowledge-building approach could be applied to many aspects of health care reform as it goes forward, enabling us to replace the current guesswork about how to reduce costs with the valid evidence needed to ensure success. If coupled with a plan for wide implementation of proven strategies as they are developed, the result could be a critical new dynamic for evidence-driven reductions in the cost of American health care.