From the Editor

The $14,000 Office Visit

An effective primary care office visit can prevent an admission and save costs. But the real value is better care for our patients.

It's a late summer evening as I write this. The sun is lazily sliding toward the horizon in a beautiful salmon-colored sky almost as if in penance for the atmospheric oven it created, baking us until we are crisp. And it's a Monday, which means the heat of the day magnifies the exhaustion of seeing patients for hours. It's been a good day, nonetheless. Exhaustion and satisfaction are not mutually exclusive.

Although today was busy, it had moments of success interspersed regularly enough to make it bearable. One bright spot was my last patient of the day, a 37-year-old female with Down syndrome, who looked at her mom, pointed to me, and said "I like this guy!" If I had to choose between winning the Powerball lottery or that moment, well, she will always be my winning ticket!

As I collapse back into my chair and reflect on the day (another way of saying "procrastinate my preparations for tomorrow"), another patient comes to mind. She's an 86-year-old female who has heart failure with preserved ejection fraction, among other comorbidities. You know this patient — always a little dyspneic but never quite decompensated, puffy all over but not necessarily volume overloaded, a good candidate for SGLT2s and an ARNI-ARB combo pill but they're out of the question due to cost, and consuming an adequate diet but loves her sodium-laden processed foods.

I started seeing her acutely last month for an overall malaise, which means either she's got nothing more serious than a hangnail or she's moments away from the ICU. It seems there's often no in-between. After initial evaluation, she looked a little volume overloaded on exam. Her B-type natriuretic peptide (BNP) was elevated slightly, although she does have stage 3 chronic kidney disease, which was, not surprisingly, worsened as well. I wish I could say I heard a soft S3 gallop, but that unicorn has never pranced past my tympanic membranes. (And pardon me for being pedantic, but it's heart failure [HF], not congestive heart failure [CHF]. CHF is no longer favored, as not all heart failure is congestive.[1])

Over the next few weeks, I ordered labs, adjusted medications, repeated her echocardiogram, plugged her in to care management, and reevaluated her in the office weekly. All of this culminated in today's visit, where she reported she was feeling much better. This was surprising, considering she only lost about four pounds, but hey, I'll take the victory, right?

I think the real victory, though, was this: I kept her out of the hospital. Not just me, of course. This was a team win — from the scheduler who recognized the severity of her symptoms to the nurse care manager who educated her to the medical assistant who called her umpteen times to check on her. We all worked to keep her out of the hospital.

The average cost for an HF-specific admission in a patient with comorbidities is $14,015.[2] And you know what would have happened if this patient had ended up in the emergency department? She would have been admitted. Now, before the torches and pitchforks come out, clearly if she needs admission then she needs admission. But if we have a high-touch model that prevents unnecessary admission, I'm all for it. By preventing this HF admission, essentially each office visit was worth $14,000.

We are healers, not accountants. I get it. Why should we worry about the cost of an admission when we have no control over that cost? Well, it's not just about the cost of the admission. It's also about rethinking the care model to prevent the admission in the first place. After all, who wants to be in the hospital? Without even considering health care economics, reducing avoidable admissions is better care for our patients.

These are my midsummer musings. The sun is down now, and a cool breeze is finally trying to weave its way through what's left of the day's thick, hot air. I'm going to mark today in the "good" column, turn off the computer, and decompress for the rest of the evening. Tomorrow is already standing at the door, ready to come in. FPM

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1. 2022 AHA/ACC/HFSA guideline for the management of heart failure: a report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *Circulation*. 2022;145(18):e895-e1032.

2. Patel J. Heart failure population health considerations. *Am J Manag Care*. 2021;27(suppl 9):S191-S195.