TO: HASC Board, November 13, 2013, Agenda Item II

FROM: Jim Barber, President/CEO

SUBJECT: Most Appropriate Care Initiative

RECOMMENDED ACTION:

Direct staff to pursue funding for a Most Appropriate Care Initiative.

PRESENTATION:

A 20-minute presentation will be made by Laurence Wellikson, MD, CEO of the Society for Hospital Medicine (SHM) in response to an RFP we sent to them to help HASC and NHF create an initiative to address non-value added tests and procedures (see bio attached).

In summary, the SHM proposes a 2-part initiative co-sponsored by HASC and NHF:

Part 1 would have two objectives:

✔ Develop a *Quality Improvement Implementation Guide* for five non-value added tests or procedures which hold the most promise for successful implementation in hospitals. An advisory panel consisting of HASC members and SHM subject matter experts would make the selections.

✔ Create an online *Resource Room* where members can access a broad array of information and tools needed to lead in-house quality improvement (appropriateness) projects. Resources would include sample protocols, order sets, best practices from other facilities, teaching aids/slide decks, measurement tools and on-demand educational webinars.

Part 2 is an optional initiative for hospitals to use SHM consultants and their *Mentored Implementation* program to imbed Choosing Wisely recommendations into the various hospital clinical settings.

At this point, HASC is interested in a Part 1 initiative only. If the Board gives approval, staff will work with SHM and NHF to write grant applications to foundations which may be interested in funding the Part 1 quality improvement initiative. Health plans may also be potential funders.

If grant funding proves to be unsuccessful, we will come back to the Board in April with a request to fund Part 1 out of HASC reserves.
DISCUSSION QUESTIONS WITH DR. WELLIKSON’S RESPONSES:

✓ Is a HASC sponsored “Most Appropriate Care Initiative” a priority for hospitals relative to all the other mandated (such as CMS) and voluntary (such as Patient Safety First) quality and patient safety initiatives?

I think that waste is a key area in the current “bend the curve” environment. Waste is one of the areas that physicians can impact. It is an area where physicians can exert influence and protect autonomy – professionalism. Extra testing no longer leads to extra monies in emerging fiscal environment. Participating improves care and patient safety, reduces costs, and if done properly, engages patients in some of these decisions. Wins all around.

✓ Will an initiative be embraced by medical staff leadership, or will it be boycotted?

We can’t predict this perfectly, but suspect the evidence is compelling, and most of the waste involved is from habit and failures in systems, not from conflicting beliefs. Many sites have accomplished improvement in many of these areas without controversy or marked pushback. This is why the implementation is important. If it is top-down, it may be boycotted by medical staff. If it is bottom-up, mentored implementation it has a good chance of succeeding. The evidence for all of these is sound (next question) and most of the evidence is not new (I’m speaking about all the Choosing Wisely recommendations, not just the SHM recommendations). The recommendations are necessarily and purposefully non-specific which requires each practice environment to specifically define the elements of implementation. To increase the chances of success that definition and implementation needs to happen bottom-up. The only top-down caveat is that, once the definition is decided, all should be held accountable for reliable compliance.

✓ Is the scientific evidence behind Choosing Wisely recommendations compelling enough to changed long-held physician practices? Can science trump culture?

The recommendations and education surrounding them are just one stage in the Choosing Wisely initiative. The hope is that organizations will turn them into longer interventions (developing QI programs, detailed steps on how to implement, etc.). ABIM and Consumer Reports have also developed a series of videos and trainings for physicians on how to have the difficult conversations.

✓ Will your patients consider this a program to ration care? Will patient satisfaction and HCAPS scores take a hit? (See attached L.A. Times article.)

Perhaps, but we don’t think so.....patients aren’t clamoring for needless blood transfusions, extra blood sticks for lab work, or Foley catheters. I agree that this is a remote possibility, but the program is structured so that patients are engaged. This will not work without patient engagement. The Consumer Reports work in this area has been significant and offers doctors good tools to engage patients. The trickier areas are the non-SHM recommendations such as CT and MRI for low back pain and antibiotics for URI. In the end this is why Consumer Reports was brought on board. There is a whole
series of educational videos and handouts for patients about why certain tests and procedures are not needed. http://www.choosingwisely.org/doctor-patient-lists/

✓ When certain high tech ancillary utilization decreases, will hospitals and specialist physicians be financially harmed to the point of abandoning the initiative and going back to business-as-usual?

_It certainly is possible that some providers could see a lower volume of potential widgets after implementation of Choosing Wisely recommendations. Any provider that is still in a widget mentality likely isn’t going to last long anyway. Choosing Wisely certainly resides in the volume to value bucket. There will be less high end radiology to read, less cardiac caths, less stress echos, etc. For the SHM recommendations, this really isn’t an issue. One might say that lab directors could be upset by fewer studies and the makers of acid suppression therapy may see less volume, but it shouldn’t be an issue._

**BACKGROUND:**

Ample evidence suggests that unnecessary tests and procedures are ordered by physicians when better alternatives are available.

Most non-value added tests and procedures are low cost and low risk; but some are high cost and carry a measurable degree of actually doing harm.

Too much care could be as simple as daily blood draws for lab tests of little consequence. More serious overtreatment might include spine surgery when a physical therapy regime would suffice, imaging with more radiation than necessary, radiating at all when an ultrasound would do, or any number of invasive procedures (stents, open heart surgery) when medical management is shown to work just as well.

Some hospitals are further along than others in working with their medical staff on consistently delivering the most appropriate care. Hospitals have embedded Choosing Wisely care protocols into their computerized physician order entry systems. The protocols send up an alert to ordering physicians which are not hard stops, but if overridden by the physician the overrides will be reviewed.

The Society for Hospital Medicine is a leader in practical application of tools and programs which can be implemented in hospitals. Many hospitals already employ hospitalists who could be the facilitators of in-hospital initiatives. Other organizations including the Joint Commission and AHA are developing programs as well.

At our last Board meeting, we identified several possible areas of focus to start with: blood utilization, antibiotic protocols, ED imaging tests and respiratory therapy. These may or may not end up on our final list, but we will be looking to start with clinical tests and procedures where improvement in appropriateness has a positive clinical outcome, the outcomes are measurable, and the process has a good chance for success.
Dr. Wellikson, MD, a board certified specialist in internal medicine, joined the Society in January of 2000 and serves the Society as Chief Executive Officer. Prior to his current position, Dr. Wellikson practiced internal medicine and was the founder and senior manager of an integrated medical group, IPA, and management services organization in Southern California that managed the healthcare of 130,000 capitated lives and contracted with 570 physicians. He was also a founder and senior partner in MedQuest Partners, LLC, a national consulting practice specializing in physician group, hospital, and/or insurance company relationships.

Dr. Wellikson has served as a Trustee of the American Society of Internal Medicine and a regent of the American College of Physicians. He is an assistant professor of medicine at the University of California at Irvine Medical School. A featured speaker on the topics of hospital medicine, the hospital of the future, and physician empowerment, Dr. Wellikson has helped hospitals, physicians, medical groups, pharmaceutical companies and national organizations understand the current medical environment and fashion strategies for success.
In medicine, more care may not be better

Is keeping patients satisfied and delivering high-quality care the same thing? And more important, can patients tell if they are getting good care?

By Haider Javed Warraich

October 10, 2013

The dull whir of the computer running in the background seemed to have gotten louder as the patient fell quiet. She was a young woman, a primary-care patient of mine, seeking a referral to yet another gastroenterologist. Her abdominal pain had already been checked out by two of the city's most renowned gastroenterologists with invasive testing, CAT scans and endoscopic procedures. But she wasn't satisfied with her diagnosis — irritable bowel syndrome — or the recommended treatment and wanted a third opinion. I tried to reason with her but failed to convince her otherwise. Even when I acquiesced and gave her the referral, she walked out visibly unhappy. I sat there listening to the whirring, feeling disappointed.

Physicians love being liked. They also love doing their jobs well. With other incentives, such as monetary returns, dwindling, the elation we get from satisfying a patient as well as providing them good care is what still makes being a doctor special. But is keeping patients satisfied and delivering high-quality care the same thing? And more important, can patients tell if they are getting good care?

Policymakers certainly think so. In fact, under the Affordable Care Act, Medicare and Medicaid hospital reimbursements are now being tied to patient satisfaction numbers. But the association between patient satisfaction and the quality of care is far from straightforward, and its validity as a measure of quality is unclear.

In fact, a study published in April and conducted by surgeons at the Johns Hopkins School of Medicine showed that patient satisfaction was not related to the quality of surgical care. And a 2006 study found that patients' perception of their care had no relationship to the actual technical quality of care they received. Furthermore, a 2012 UC Davis study found that patients with higher satisfaction scores are likely to have more physician visits, longer hospital stays and higher mortality. All this data may indicate that patients are equating more care with better care.

Although patients and their physicians generally have similar goals, that is not always the case. As a resident, who is not paid on a per-service basis, I have no incentive to order extra testing or additional procedures for my patients if they're not warranted. But one study found that physicians who are paid on a fee-for-service basis and therefore have an incentive to deliver services — needed or not — are more likely to deliver these services (such as an MRI for routine back pain).
On top of that, as another study found, they also are more liked by their patients. It is no wonder then that the number of patients with back pain, one of the most common reasons for physician visits, are increasingly being overmanaged with MRIs and narcotic pain medications.

Consumer satisfaction is a metric that has been used extensively in other industries, and its increasing integration in healthcare may represent a desire to model medicine on industries that lead in efficiency, such as the technology, automobile or airline industries. But healthcare remains fundamentally different.

Consider Medicare's initiative to have hospitals publicly report their patient outcomes and satisfaction data and have consumers compare them a la computers or SUVs. Of the 13 teaching hospitals within five miles of my apartment, the relationship between the quality of care and patient satisfaction was unclear. Within these hospitals, hospital mortality outcomes did not correlate with satisfaction ratings.

I'm a physician and I had difficulty making sense of the data, so how can we expect everyday people to use them in a meaningful way? Would they prefer a place where they or their relatives are likely to live longer, have a lower risk of readmission and have fewer infections, or a place where their pain would be better managed, their nurses more responsive and their bathrooms cleaner? Although ideally hospitals would score highly in both sets of measures, data suggest that is not necessarily always the case.

Patient visits can sometimes be like family dinners. They are probably not the best occasions to talk about Dad's smoking habit or Mom's Xanax addiction. But to maintain shared decision-making, clear and honest communication is vital. And in critical situations, most data suggests that patients want their physicians to be upfront about bleak issues such as life expectancy.

Yet a 2012 study by investigators in the Dana-Farber Cancer Institute found that patients who were better informed about the grim nature of their cancer and the goals of their treatment were less satisfied with their physicians. Such findings put a physician in a quandary: a more informed patient or a more satisfied one?

Emphasizing patient satisfaction and offering incentives to hospitals and physicians to keep their patients satisfied are laudable. But trying to transform patient satisfaction into a catch-all quality metric may not be the right approach. What is really needed is for physicians to take the time to help patients identify the things they need, not just what they want.

My patient with belly pain saw the third gastroenterologist, who thought she would benefit from a stent to her pancreatic duct. Just the fact that someone appeared to be taking her symptoms more seriously gave her hope, and she went ahead with the procedure. But the procedure gave her little relief, and soon after, she developed inflammation in her pancreas, a common complication of this procedure.

Today, medical schools, residency training programs and professional societies are beginning to teach physicians not just how to be better doctors but also to value the outcomes of their care, rather than the volume of their services. Although retraining all physicians to think this way is hard, fundamentally changing how patients view value in healthcare may be even more difficult.

Haider Javed Warraich is a resident in internal medicine at the Beth Israel Deaconess Medical Center, Harvard Medical School.

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Collaborating to Improve Care

HASC
November 13, 2013

Larry Wellikson, MD SFHM
CEO, Society of Hospital Medicine
lwellikson@hospitalmedicine.org
What We Will Talk About

• A Little Bit about Hospitalists
• Why Partner with SHM?
• Why Choosing Wisely?
• Specifics of the Proposal
• Discussion
The Hospital Medicine “Movement”

The fastest growing medical specialty in history

- Approximately 40,000 hospitalists
- Presence at almost 70% of US hospitals
- Attending/consulting MDs for 65% of Medicare medical-surgical discharges

SHM has access to the front line physicians that deliver much of the inpatient care in the US
The SHM “Philosophy”

A different type of physician; a different type of medical society

- SHM has positioned the specialty to play a leadership role in Quality Improvement.

- Rather than focusing on guidelines, SHM focuses on IMPLEMENTATION, recognizing that every hospital is different.

- In addition to patient care, an important role of a hospitalist is as a “change agent.”
The Eisenberg Award, presented by The JointCommission and NationalQuality Forum, recognizesmajor achievements ofindividuals and organizationsin improving patient safety andhealth care quality, consistentwith the aims of the NationalQuality Strategy - better care,healthy people and communities and affordablecare.
## Examples of HASC Involvement

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<th>Hospital:</th>
<th>City:</th>
<th>SHM Program:</th>
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<td>Kaiser Permanente Hospital West Los Angeles</td>
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Successful Collaborations

Working with Partners is one of SHM’s core competencies

- **Payers**: BCBS (IL, MI), Medicaid plans
- **Hospital Associations**: HENs, PA, Carolinas
- **Medical Societies**: SCCM (Sepsis)
- **Industry**: Pharma, Device companies
- **EMR Vendors**: EPIC, Cerner, Siemens
- **Physician Resources**: QuantiaMD.com
Measurable Results

Tracking process and outcome metrics is part of SHM’s approach

Before: 14% of sites at 60%+
After: 100% of sites at 60%+
(74% at 80%+)

Reduced readmission rate at pilot sites 21% (from 14.2% to 11.2%)

Highest performance: Reduced uncontrolled hyperglycemia from 55% to 36%
What Is Choosing Wisely?

Is the Scientific Evidence Behind Choosing Wisely Recommendations Compelling Enough?

- www.choosingwisely.org

- Some slides from Weingarten from Cedars Sinai
Opportunity to Reduce Costs While Providing Excellent Quality of Care

Overtreatment

“subjecting patients to care that, according to sound science and the patients’ own preferences, cannot possibly help them”

$248 billion per year

10% of health care expense


- From Weingarten, Cedars Sinai
Choosing Wisely

• 120 tests that do not benefit patients
• 150 more over next 9 months
• 35 subspecialty societies
• Representing > 500,000 physicians
• 79% of AMA physicians agreed that they should adhere to guidelines that say do not perform marginally beneficial care

-from Weingarten, Cedars Sinai
Choosing Wisely

- Benefits of reducing inappropriate utilization*
  - Up to 19-times greater false-positive rate than true-positive rate
- No improvement in patient worry, anxiety, symptoms
- Elimination of 5 of 90 “Choosing Wisely”-type tests would reduce costs by $5 billion per year**

**Arch Intern Med. 2011;171(20):1858-1859
- From Weingarten, Cedars Sinai
Don’t do” imaging studies for chronic isolated headache

• Potential harms
  – Kaiser Permanente Woodland Hills
  – 1990, 100,800 adults
  – 15 to 27 month follow-up period
  – No CT scans for chronic isolated headache yielded new and important information
  – CT brain radiation exposure may cause 4,000 additional cases of cancer per year in US
  – Model based on National Research Council’s “Biological Effects of Ionizing Radiation”
  – False positives, one led to unnecessary brain biopsy.

»Arch Intern Med. 2009 Dec 14;169(22):2071-7
SHM and *Choosing Wisely*

- Working group formulated list employing staged methodology  
  - surveys, literature review, Delphi panel
- Common issues with suboptimal management
- Amenable to remediation via application of EBP
- High potential for improved care and reduced cost
- Many practical strategies for implementation formulated at SHM QI Pre-course
SHM Choosing Wisely Selections

Opportunities to Reduce:

• Inappropriate use of urinary catheters
• Prescribing of meds for stress ulcer prophylaxis in patients at low risk for stress ulcers
• RBC transfusions in patients who don’t benefit from them
  – AHA Initiative to be Announced Soon
• Excessive telemetry monitoring
• Repetitive routine lab testing in stable patients
Why should this initiative be considered a strategic priority given all the other quality/patient safety/efficiency initiatives already at work in hospitals?

• Bend the Curve Environment
• Reducing Waste
• Professionalism
• More Tests May Not = Greater Revenue
• Can Improve Safety
• Can Reduce Costs
• Patient Engagement
Will this initiative be embraced by medical staff leadership?

- Most Waste comes from Habits and Poor Systems not Self Interest or Beliefs
- Need Bottom Up Leadership from Frontline Physicians and Hospital Staff
- Need Local Interpretation and Ownership
- Mentored Implementation Works This Way
Will patients consider this a program to ration care?

• Patients Don’t Want Unnecessary Tests, Transfusions, or Catheters
• Need Active Patient Engagement
• Consumer Reports Involvement Specifically Directed to Patients
Will Physicians Fight This Because of Loss of Autonomy or Revenue?

- SHM’s Bucket of Recommendations Don’t Affect Physician Revenue
- Trend is Moving from Volume to Value
- Reality—There Will Be Less:
  - Echos
  - Caths
  - Expensive Radiology Testing
SHM Proposal

• Phase One
  – Goal: Increase Implementation of 5 SHM Choosing Wisely Recommendations
  – Convene Expert Advisory Board
    • Develop Best Practice Interventions
  – Create Implementation Guide

• Phase Two
  – Web Based Resource Room
    • Repository of Key Information on Choosing Wisely
    • Strategies for Hospitals to Implement Change

• Potential Future Approaches
  – Mentored Implementation
Implementation Guides / Resource Rooms

• Using a Proven QI Framework
  – QI fundamentals
  – Building a team
  – Metrics and evaluation
  – Gaining institutional support
  – Process mapping and needs assessment
  – Topic-specific interventions
  – Spreading Improvement

• Tools, links, annotated bibliographies, slide decks, etc.

Overview

The BOOSTing (Better Outcomes by Optimizing Safe Transitions) Care Transitions resource room provides a wealth of materials to help you optimize the discharge process at your institution. We developed this through support from the John A. Hartford Foundation. (Read more about Project BOOST and the BOOST mentoring program.) We based the approach and tools on principles of quality improvement, evidence based medicine as well as personal and institutional experiences. Of note, we are piloting the contents at multiple hospitals and will be constantly revising the resource room based on this invaluable experience.

- Download the BOOST Fact Sheet
- Read more about BOOST and the BOOST Mentoring Program
- BOOST In The Media
- BOOST Case Studies:
  - Read about Piedmont Hospital, "BOOSTing a Team Approach to Patient Care"
  - Read about SSM St. Mary’s Medical Center, "Reducing Readmissions and So Much More"

This resource room will help you to:

- Analyze current workflow processes
- Select effective interventions
- Redesign work flow and implement interventions
- Educate your team on best practices
- Promote a team approach to safe and effective discharges
- Evaluate your progress and modify your interventions accordingly

Each section of this resource is described below.

How to Use:

The BOOSTing (Better Outcomes by Optimizing Safe Transitions) Care Transitions Resource Room is the online version of the Care Transitions Implementation Guide. The suggested approach is based on 8 essential elements for improving the discharge process.

The resource room will walk you through each step of designing, implementing and evaluating your intervention. We recommend that you go through each section, in the order presented in the yellow portion of the navigation bar at the top of each page. However, if you are already familiar with the content of a particular section, skip ahead.

The resource room also includes a wealth of other resources, (within the blue portion of the navigation bar at the top of each page) including Educational Resources (review of key literature, teaching slide sets, patient education and more) and Clinical Tools. Finally, for a refresher on Quality Improvement basic principles, visit QI Basics.
The Mentored Implementation Model

• Based upon model pioneered by Center to Advance Palliative Care
• Physician coaches with expertise and experience in effective implementation and QI, as well as topical expertise
• Mentoring occurs via monthly one-to-one calls, site visits and ad hoc communications
• Timely guidance, advice, and feedback
• Written summaries, ‘to do’ tasks, timelines
• “Mentor University” training
The Mentors

- Hospital Medicine All Stars
- Topical Expertise
- QI and Implementation Expertise
- Communication and Mentoring Skills
- Provide ‘just in time’ feedback and advice
- Disseminate ‘pearls’ from enrolled sites
Questions and Next Steps
TO: HASC Board, July 24, 2013, Agenda Item III.E.
FROM: Jim Barber, President/CEO
SUJBECT: Non-Value Added Treatments

RECOMMENDED ACTION:
Determine the potential member value of HASC launching a peer-to-peer program similar to Patient Safety First for the purpose of eliminating (reducing) non-value added treatments in hospitals.

PREFACE
In 2012, Don Berwick, M.D. and Andrew Hackbarth, M.Phil., published an article in the Journal of the American Medical Association highlighting the amount of non-value-added health care provided in the United States, building on the work of The Dartmouth Atlas of Healthcare and others. As they state, “The opportunity is immense. In just 6 categories … – overtreatment, failures of care coordination, failures in execution of care processes, administrative complexity, pricing failures, and fraud and abuse – the sum of the lowest available estimates exceeds 20% of total health care expenditures.”

In 2008, the then Director of the Congressional Budget Office testified before the House Budget Committee indicating that “Researchers have estimated that nearly 30 percent of Medicare’s costs could be saved without negatively affecting health outcomes … With health care spending currently representing 16 percent of GDP, that estimate would suggest that nearly 5 percent of GDP – or roughly $700 billion each year – goes to health care spending that cannot be shown to improve health outcomes.”

BACKGROUND:
Eliminating the costs, wasted resources and clinical complications associated with non-value added treatments requires health care leaders to face significant system-embedded opposition, not the least of which includes:

- **Patient demand for the “latest and greatest.”** Often patient demand is the result of internet research, influential television personalities, and incessant direct-to-customer advertising by pharmaceutical companies, providers of specialty procedures and diagnostic equipment manufacturers.

- **Provider income** in a fee-for-service world can often trump effectiveness research. New financial incentives throughout the health system must be implemented that reward providers for doing less. When hospitals partner with doctors and together make the switch to capitation, case rates and full risk, the incentives will be more aligned.
Clinical knowledge doubles every two years. There is no way on earth that physicians can keep up with all the new studies and recommended clinical protocols, so they must rely on what’s worked for them in the past.

Defensive medicine. The fear of a lawsuit remains a very real factor in clinical decision making. Even with California’s MICRA limits on patient pain and suffering, physician pain and suffering during the trial of a non-meritorious lawsuit is enough to “leave no stone unturned.”

Non-coordinated care results in duplication of tests and procedures. It is not unusual for physician B to repeat lab tests because he/she doesn’t trust the lab of physician A; or physician B has no information and therefore no way of knowing about physician A’s workup of the patient.

The system in general does not reward being careful stewards of limited health care resources. The “best care” is still considered synonymous with the most aggressive care.

Actions to reduce non-value added treatments must be based on the premise that the fundamental issue is not provider greed, nor is it about deliberately (fraudulently) churning out unnecessary tests or unnecessary consultations. There may be bad apples in the barrel, and individual problem people must be held to account for their abnormal ordering practices, but for our purposes we must address the issue from a broad system-level perspective.

It is only through such an approach that the really big cost avoidance outcomes can be achieved. We must also recognize that:

Physician leaders and medical executive committees must be 100 percent on board. Hospital administrators cannot change physician behavior without physician champions, especially if it results in lower physician income.

There are medical staff utilization review and peer review structures already in place at hospitals, but chart review to determine appropriateness of any given procedure is a time consuming and subjective process. The physician reviewing charts may happen to be the hospital’s biggest offender!

Health care financial incentives prevent many hospitals from getting excited about attacking non-value added treatments. Taking out 20 percent of a hospital’s ancillary revenue and 20 percent of a hospital’s occupancy closes the doors. Yeah for us for reducing early elective deliveries, but C-section revenues and NICU revenues suffer. Health plans and capitated medical groups and self-insured employers gain, but hospitals lose. When hospitals assume insurance (financial) risk for patient populations, then a 20 percent cost savings will not only look very attractive, it will become an essential strategic imperative. Payment reform may not be too far off in the future, but until it actually happens, lowering ancillary utilization will be a tough sell.
VARIOUS APPROACHES

The American Hospital Association led a discussion on non-value added treatments at the summer round of Regional Policy Boards. A draft white paper was presented to the participants outlining the issue (see Attachment A).

Breakout sessions produced the following suggestions of how hospitals could play a meaningful role:

1. Provide the medical staff with appropriate and relevant education around comparative effectiveness data, evidence-based clinical protocols, and benchmark comparative utilization data (aggregated) for the clinicians practicing in the hospital’s community.

2. Engage physicians and staff responsible for measuring and improving hospital quality in the discussion of non-value added treatments and align quality, patient safety and appropriate utilization goals and objectives.

3. Promote specialty society guidelines at medical staff department meetings; encourage discussion and debate.

4. Lead the development of community-wide electronic health record systems to increase care coordination and reduce duplicative testing. Begin with the ability to share imaging test results among community hospitals, imaging centers and physician offices.

5. Get the community involved in raising the collective conscience on non-value added treatments. Talk to the community about the issues of quality, safety and appropriateness and enable individuals to watch out for test redundancy in the same way they should watch out for hand washing when they are a patient in the hospital. An informed public could be our advocates in the fight to eliminate non-value added treatments!

I concluded from this discussion that HASC could initiate a “campaign” to eliminate non-value added treatments such as we have done with Patient Safety First by developing peer-to-peer learning opportunities, distributing sample policies and procedures, possibly developing benchmarks and measures of performance for hospitals to use, and collecting and distributing data from hospitals (aggregated) on progress toward goals. We would have to start small, with selected non-value added treatments that are more inpatient oriented than physician office oriented.

As a start, the AHA Committee on Clinical Leadership created a “top five” list for hospitals to consider:

☑ Reducing inpatient admissions for ambulatory-sensitive conditions (i.e., low back pain, asthma, uncomplicated pneumonia)¹
☑ Appropriate blood management inpatient services
☑ Appropriate use of elective percutaneous coronary intervention²

¹ Several medical societies have included references in their lists to treating low back pain less aggressively.
² The Society for Vascular Medicine’s list suggested refraining from percutaneous or surgical revascularization of peripheral artery stenosis in patients without claudication or critical limb ischemia. The American College of
● Appropriate antimicrobial stewardship

● Reducing the use of ICU for life-threatening terminal illness (including encouraging early intervention and discussion around advanced illness management)

CONCLUSION

Equipping physicians and patients with information to make better, more cost-effective decisions will be a major undertaking. But as health care moves toward a payment system based on fixed and at-risk payments, hospitals cannot afford to ignore a potential 20 percent reduction in costs with no adverse patient care impact.

If hospital executives have been minding the store, most of the obvious excess operating costs have already been removed from their organizations. Lean, six sigma, staffing/productivity, purchasing/materials management, scheduling, etc., have all been addressed by now. There is always room for improvement in operating efficiency, but incremental improvements will not suffice to save hospitals if more reimbursement cuts are in our future.

Eliminating non-value added treatments represents a huge opportunity to eliminate costs without sacrificing quality, safety or patient experience. It may be the “next big thing” for the association to help address with the membership.

Cardiology list suggested not stenting non-culprit lesions during PCI for uncomplicated hemodynamically stable ST-segment elevation myocardial infarction (STEMI).

3 American Geriatrics Society recommended against antimicrobials to treat bacteriuria in older adults unless specific urinary tract systems are present. Several other societies also referenced reducing antibiotic use.

4 The American Academy of Hospice and Palliative Care Medicine list included urging to not delay palliative care for a patient with serious illness who has physical, psychological, social or spiritual distress because they are pursuing disease-directed treatment.
Tough to beat care in health system

DAVID LAZARUS

The healthcare system, like the government, is easy to criticize until you need it. And then it's indispensable.

I've devoted my fair share of ink and edits to talking about what's wrong with healthcare in the United States. I wrote last week about yet another example of loony billing practices.

Today, let's appreciate some of the things that make our system extraordinary — maybe not the best in the world, as conservatives are fond of gushing, but pretty darn impressive.

My wife had a seizure a couple of weeks ago after the sodium level in her blood dropped dangerously low. She's now home after spending eight nights in the intensive care unit at UCLA Medical Center.

I'll keep details of this family matter private. But what I want to share are some observations based on having been at my wife's bedside for much of her hospital stay.

First, it's hard to imagine any other healthcare system in the world that can marshal as many resources as ours. From highly skilled doctors and nurses to every possible medical device and drug, our system is second to none in its capabilities.

No wonder that when foreign leaders fall sick, they often seek treatment here and not at home.

Moreover, once you've gained access to the higher levels of the system — admittedly, no small feat — there's seemingly no limit to efforts that will be made to help you. Every possible test will be run. Every expert opinion will be sought.

This is undoubtedly wasteful. But when it's a loved one with his or her life on the line, is there anyone who would seriously cut corners if given a choice?

Ah, but there it is. None of this remarkable care comes cheap. And it's how we price and bill for such services that makes our healthcare system, for all its merits, unworkable and unsustainable.

"We get what we pay for, and we have a payment system that pays for more," said Stuart Guterman, vice president of Commonwealth Fund, a healthcare policy organization. "So we get more."

Here's an example: My wife told her nurse that she was having trouble going to the bathroom. The nurse didn't hesitate. She wheeled in a fancy-looking gadget and did an ultrasound on my wife's bladder to see whether there was any fluid in there. There wasn't.

It's unquestionably a good thing to know for sure whether a patient's plumbing is functioning. It's the difference between understanding whether she's experiencing minor discomfort or a major medical issue.

But was the test necessary? Would it have sufficed to just wait and see? I have no idea.

How much did the test cost? Again, I have no idea. One hundred dollars? Five hundred? A thousand? Was it fully covered by our insurer? Partially covered? Not covered at all?

No clue.

As I sat in the ICU watching all the activity in my wife's and other patients' rooms, I wondered what it would be like if every treatment came with a price tag prominently displayed, as in any other retail environment.

What if that ultrasound bore a big sign declaring it to be a $500 exam? What if the MRI machine announced itself as a $4,000 experience?

What if the mild sedative my wife requested to help her sleep was revealed to cost $100?

Would that change anything?

Perhaps there are some people who would forgo this or that treatment when presented with an actual price. But I think most people wouldn't hesitate to
Care is not among faults of health system

accept whatever was offered, especially if your doctor believed it was in your best interest.

That’s what makes healthcare so unlike any other consumer product available. The typical shopper is fully capable of making informed decisions about whether to buy Nike or Converse sneakers, or which brand of jeans to wear, or what kind of car to drive.

But is there anyone without medical training who feels qualified to say, “No thanks, we’ll skip that bladder ultrasound and see what happens?”

“Consumers are the last people to make these decisions,” said David Dranove, a healthcare economist at Northwestern University’s Kellogg School of Management. “Nobody should try to play doctor.”

It’s crazy to think that patients will ever be in a position to be equal partners in the healthcare equation. This is the one product in which we have to trust others to be looking out for us.

Yet, along with being caregivers, those others are representatives of financial interests that are mindful of how people’s medical treatment will affect their bottom line.

That’s not to say hospitals, drug companies, medical device makers and even insurers aren’t having a positive effect on society. They are. But they’re also businesses. They measure their overall success not in lives saved but in dollars earned.

As such, it’s important that our healthcare system have the transparency and oversight required to keep patients, not profits, front and center.

The healthcare marketplace doesn’t foster the same economic forces that keep other markets in line. Consumers aren’t making free decisions. Medical businesses exploit their unfair advantage in the form of arbitrary and hidden prices.

Americans pay twice what people in other developed countries pay for healthcare. Yes, we have the best tools. Yes, we have the best medical practitioners.

And yes, I wouldn’t want my wife to have been treated anywhere else.

But I live in fear of the bill that’s coming down the pike.

It will almost certainly run in the six figures. My out-of-pocket costs could run to five figures.

More than 60% of personal bankruptcies in this country are caused by medical bills, according to researchers at Harvard Medical School. And of those who file for bankruptcy, 78% have health insurance.

I’m grateful for the exceptional care my wife received.

Our healthcare system is truly a marvel.

Yet I have to ask: What’s the good of having the best tools if no one can afford to use them?

David Lazarus’ column runs Tuesdays and Fridays. He also can be seen daily on KTLA-TV Channel and followed on Twitter @DavidLaz. Send your tips or feedback to david.lazarus@latimes.com.
American Hospital Association  
Draft White Paper  
Delivering Appropriate Medical Care  
May 2013

Driving Factors for Overuse  
Years of financial incentives, increased information availability, malpractice concerns, and a societal desire to “try everything” have helped drive the levels of procedure-based intervention and treatment we see today. While providers have historically been incentivized to deliver more rather than less care, fee-for-service structures will continue to recede and the move from volume-based to value-based reimbursement will require shifts in care provision and payment incentives.

Payment incentives  
Financial incentives helped shape the delivery of preventive care. For decades preventive medicine has advocated for annual physicals, testing at specific intervals, and interventions to prevent or slow disease. This focus on specific interventions has driven volume and in some cases resulted in identifying disease processes that might have little effect on patient outcomes. Rather than the intervention focus of the past, some primary care providers have begun to shift to engaging patients in discussions around lifestyle management to curb the potential for disease.

Discomfort with ambiguity  
In today’s fast-paced, instant information environment, we have grown increasingly uncomfortable with ambiguity, but is knowing the answer always helpful? With medical websites offering diagnoses in a few clicks, categorizing symptoms into specific illnesses occurs despite the absence of clear clinical disease. Follow up testing and interventions often follow, rather than active surveillance, turning the asymptomatic information-seeking consumer into a patient. Evidence has shown that physicians with less than ten years experience have 13 percent higher overall costs than their more experienced colleagues. While some of the difference may reflect younger physicians’ familiarity with newer and potentially more costly procedures, some of the cost differential may be due to inexperience and driven by uncertainty and a desire to treat more aggressively.\(^4\) Something the care system does not discourage, and is in fact financially incentivized to encourage under the current payment structure. It is too early to tell if this trend is one that will dissipate as younger physicians gain more experience, or if the societal shift towards more information and desire for action might continue to drive higher costs. It is important that as health care becomes more complex and technology driven, that we not fall under the spell of treating those things that have little clinical consequence and might benefit from watchful waiting or less aggressive interventions.

Liability concerns  
Another factor driving the levels of testing and procedures is the concern around possible malpractice actions. As a recent study indicated, physicians spend as much as 11 percent of their careers with an open, unresolved malpractice claim, so it is not surprising it can color ordering patterns to ensure providers leave “no stone unturned.”\(^5\) This, in the context of a fractured health care delivery system, can lead to duplication of efforts and higher costs.

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Utilization management

In the 1990s utilization management, a strong tool to guide the appropriate use of medical care became synonymous with cost cutting and denials of coverage. Unfortunately, what was a systematic review and discussion to determine evidence-based guidelines and protocols to ensure that patients received the most appropriate care became tainted with the denials of managed care. At the same time, quality and patient safety efforts began to move to the forefront, driven in part by the release of the Institute of Medicine’s To Err is Human: Building a Safer Health System, shifting the discussion to a greater focus on quality and patient safety. While work on clinical practice guidelines and protocols has never stopped, it has only recently begun to reach the same level of attention and discussion as previously.

Appropriate setting

Utilization management also encompasses the use of the most appropriate setting for care delivery. As higher cost settings, emergency department and inpatient hospital care need to be carefully monitored to ensure the most appropriate use. Significant research has shown that for several “ambulatory sensitive conditions” access to primary care, urgent care clinics, outpatient services, and other sub-acute settings can reduce hospital admissions and readmissions, lower costs and improve patient outcomes. Ambulatory sensitive conditions are defined as hospital admissions due to those medical conditions that could be avoided by provision of adequate primary care.6

In addition, the use of intensive care units (ICU) for patients with terminal illnesses has risen significantly over the last decade. While the use of hospice and palliative care has increased, a recent study highlights that it too often follows on the heels of overly aggressive care, including ICU stays. While hospice care increased from 21 percent to 42 percent from 2000 to 2009, the usage of ICUs for those at the end of life also increased from 24 percent to 29 percent. So while hospice use has increased, 40 percent those entering hospice are often doing so for very short periods and as referrals from an ICU stay within the last month of life.7

As the health care delivery system moves towards reform, all participants will need ensure that finite resources are not used for interventions that do not add value and focus care resources to settings where they can provide the greatest benefit to patients. However, care needs to be taken to preserve clinical judgment on the most appropriate use of testing, intervention, and care setting.

Increased Scrutiny

While health care reform efforts are shining a light on the issue of appropriate use of medical care, federal and state regulators are watching closely to curb the rising costs of the Medicare and Medicaid programs. The appropriate use of medical care sits squarely at the intersection of

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medical judgment and the oversight and regulation of payment, leading to conflicts around medical decision making and the need to be careful stewards of limited health care resources.

Several issues have risen to legal scrutiny over the last years, including increases in imaging studies and lawmakers have put measures in place to curb excessive use. The Medicare Payment Advisory Commission recommended that Medicare require pre-approval for advanced imaging services for those physicians deemed to have high utilization as an attempt to curb usage.\(^8\) Imaging represents one of the fastest growing costs for Medicare patients and one study indicated that “20% to 50% of all “high-tech” imaging provide no useful information and may be unnecessary.”\(^9\)

In several states, inquiries by regulatory agencies regarding the “medical necessity” of certain procedures, including the use of cardiac stents, have been initiated and some have become the subject of Senate committee investigations and lawsuits for “unnecessary” care. In addition, scrutiny has increased around the use of observation status versus inpatient admission. While this scrutiny exists for certain procedures with more evidence-based guidelines, many other issues have not been as clear cut. Given the relatively narrow list of existing evidence-based protocols, clinical judgment as to the most appropriate use of care resources is essential. While some interventions and testing may not directly improve patient outcomes, they may be the most reasonable course of action at the time of treatment.

**Clinical Evidence for Change**

While the payment realm is looking to curb costs and the health care field is adopting a more value-based focus, studies are emerging showing not only the increase in diagnosis of disease due to more sensitive diagnostics, but the potential for increased harm through unneeded treatment. But how do we determine what care is truly unneeded? Clinical evidence and disease treatment protocols exist for a just a subset of care needs and many care decisions are not easily categorized into existing protocols. There are, however, clear areas where over-diagnosis, reduced value for certain tests, procedures, and interventions, and inappropriate use of higher cost settings are emerging.\(^10\)

*Increased screening and over-diagnosis of disease*

As recent studies have shown, while the incidence of several cancer diagnoses has increased, there hasn’t been a corresponding drop in their mortality. More people are living with a cancer diagnosis and more importantly receiving treatment that may not impact their survival but could reduce their quality of life. For years, the war on cancer has focused on earlier detection, under the assumption that if we could detect the disease process early enough, we could stop it.\(^11\) Unfortunately, as the following studies conclude, while we have become extremely adept at identifying cancer earlier and earlier, for some we have not been able to stem the disease progression, begging the question of whether earlier treatment is warranted.

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\(^8\) Carey, MA, Serafini, MW. Doctors Balk at Proposal to Cut Medicare’s Use of Imaging. Physicians News Digest, June 15, 2011.


Studies of lung, ovarian, and breast cancer screenings for low-risk populations have shown little impact on mortality rates. While more sensitive testing has increased the rate of diagnosis through earlier identification of disease, there has been little to no corresponding reduction in mortality. In addition, the increased sensitivity of testing has resulted in more false positive diagnoses which require additional interventions which could cause harm. As the authors of a 2007 study regarding computed tomography screening for lung cancer concluded, “Until more conclusive data are available, asymptomatic individuals should not be screened.”\textsuperscript{12} To highlight the need for clear protocols and clinical judgment, results such as these cannot be extrapolated beyond their scope – for example, lung cancer screening for high-risk populations has decreased their mortality rates, but did not correlate to the general population. A recent update confirmed that annual screenings for low-risk populations did not reduce lung cancer mortality as compared with usual care.\textsuperscript{13}

The New England Journal of Medicine recently published a review of data from 1976 through 2008 of mammography screening indicating a significant over-diagnosis of breast cancer. “Despite substantial increases in the number of cases of early-stage breast cancer detected, screening mammography has only marginally reduced the rate at which women present with advanced cancer. … The imbalance suggests that there is substantial over-diagnosis, accounting for nearly a third of all newly diagnosed breast cancers, and that screening is having, at best, only a small effect on the rate of death from breast cancer.”\textsuperscript{14} These earlier diagnoses are leading to longer survival rates since many are diagnosed before symptoms appear, but mortality rates have not significantly changed. So while a patient might live with cancer for 10 years instead of 5, a doubling of the survival rate, early detection has not slowed the disease progress and only subjected the patient to additional, possibly unnecessary treatment. Similar results have been found for ovarian cancer, where screening has not reduced mortality and the diagnostic follow up for false-positives has been associated with complications.\textsuperscript{15}

These studies are appearing in the mainstream media and recent news reports, for example, highlighted recommendations by the U.S. Preventive Services Task Force against the use of prostate screening exams because evidence suggests “that screening of asymptomatic men often leads to the over-diagnosis and over-treatment of prostatic tumors that will not cause illness or death.”\textsuperscript{16} While studies found that screening slightly reduced mortality, it was also associated with a high risk of over-diagnosis which might lead to complications.\textsuperscript{17,18} In addition to over-diagnosis, prostate cancer has involved more aggressive treatment than might be warranted given the associated morbidity. A study in 2009 highlighted the improved quality of life for those

\textsuperscript{12} Bach, PB, et. al. Computed Tomography Screening and Lung Cancer Outcomes. JAMA; 297(9):953-961.
\textsuperscript{15} Buys, SS, et. al. Effect of Screening on Ovarian Cancer Mortality: the Prostate, Lung, Colorectal and Ovarian (PLCO) Cancer Screening Randomized Controlled Trial. JAMA;305(22):2295-2303.
\textsuperscript{17} Schroeder, FH, et.al. Screening and Prostate Cancer Mortality in a Randomized European Study. N Engl J Med; 360:1320-1328.
undergoing active surveillance versus several treatment options for low risk, localized prostate cancer, concluding that active surveillance is a reasonable approach.19

Over-treatment and the incidentaloma
While cancer has garnered a large amount of the study around over-diagnosis due to the invasive and debilitating effects of unneeded treatment, there are numerous other investigations into the over-diagnosis and over-treatment of less life-threatening conditions. For example, ear infections are often over-treated with antibiotics when watchful waiting would suffice, or antibiotics are inappropriately used to treat a viral condition that does not involve ear disease. Unfortunately, the overuse of antibiotics not only leads to public health concerns around antibiotic-resistant infections, it also brings side effects which might end up more debilitating than the initial disease.20 The American Academy of Pediatrics recently updated their guidelines to stricter diagnostic criteria and broader use of observation for ear infections.21 Similarly, a study in the British Medical Journal concluded that the use of tympanostomy tubes in children with recurrent ear infections varied widely from recommended guidelines and likely represented an overuse of surgery.22

Over-treatment with antibiotics has risen to national prominence with news stories of deaths due to antibiotic resistant strains and concerns around the over-prescription of antibiotics. Antimicrobial stewardship programs, which are “coordinated interventions designed to improve and measure the appropriate use of antimicrobials by promoting the selection of the optimal antimicrobial drug regimen, dose, duration of therapy, and route of administration,”23 have seen an increase in recent years. The Society for Healthcare Epidemiology of America, the Infectious Diseases Society of America, and the Pediatric Infectious Diseases Society issued a policy statement in 2012 calling for the development and broad dissemination of antimicrobial stewardship programs stating that “antimicrobial stewardship must be a fiduciary responsibility for all healthcare institutions across the continuum of care.”24

In addition, the inappropriate use of blood and blood products has drawn some attention. The cost of blood and blood products continues to rise as additional testing is needed to ensure safety coupled with a decreasing pool of donors.25 Blood management programs have also increased in recent years to ensure the safety of the blood supply and ensure proper usage. Blood management programs involve the “implementation of evidence-based transfusion guidelines to reduce variability in transfusion practice, and the employment of multidisciplinary teams to

23 Society for Healthcare Epidemiology of America; Infectious Diseases Society of America; Pediatric Infectious Diseases Society, Infection Control and Hospital Epidemiology , Vol. 33, No. 4, Special Topic Issue: Antimicrobial Stewardship (April 2012), pp. 322-327
24 Ibid. p. 322.
study, implement, and monitor local blood management strategies." The AABB (formerly, the American Association of Blood Banks) has developed guidelines around proper use of red blood cell transfusions, which the Society for Hospital Medicine has included in their Choosing Wisely list for adult inpatient care.

Percutaneous coronary interventions have also come under review for appropriate use. The Department of Justice recently conducted inquiries regarding the "medical necessity" of certain interventional cardiology procedures. Cardiac stent usage became the subject of a Senate Committee on Finance investigation which ultimately resulted in several lawsuits for "unnecessary" care. The American College of Cardiology Foundation, in partnership with others, released revised guidelines outlining standards for cardiac catheterization labs in 2012.

The drive for increased information has also affected the use of many healthcare technologies, particularly scanning technology such as ultrasound, computed tomography (CT), and magnetic resonance imaging (MRI) scans. These tests, which provide incredibly detailed and useful clinical data, are also able to show anomalies that have no clinical significance. Unfortunately, once discovered, many require additional testing and may represent a potential diagnosis pitfall. In three separate studies looking at imaging of asymptomatic patients, findings included: 10 percent had gallstones present, 40 percent had damaged meniscal cartilage, and 50 percent had bulging lumbar discs. These three studies highlight the difficulty in using scans for diagnosis given the prevalence of these findings in asymptomatic patients. Concerns are also emerging regarding the increased exposure to excessive radiation, not to mention the potential harm from diagnostic and therapeutic interventions that follow the finding of a non-clinically relevant anomaly.

**Appropriate setting**

Overuse potential exists in many areas of the health care delivery system and inappropriate use of hospital care can quickly result in high costs. For example, lack of coordination of care across settings has led to the increased potential for hospital readmissions. While experts agree optimum management of chronic disease should happen outside of the hospital, lack of coordination, coupled with potential gaps in primary care access may result in increased use of hospital care. Efforts, however, are underway to ensure that patients are treated in the most appropriate setting for their needs and work underway by hospitals to reduce readmissions in particular is showing some positive results. Appropriate use of care also needs to be monitored for the intensive care unit, where use in terminal cases may not be warranted. It is

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essential that providers and patients discuss the patient’s wishes, the options around palliative and hospice care, and the level of aggressive treatment preferred.

Lowering of threshold values
Another aspect to overuse of care is through the lowering of threshold values. Several chronic conditions have seen a lowering of threshold numbers, such as what constitutes hypertension or diabetes, turning more of the population into patients. While the thresholds serve to head off the more severe complications associated with chronic conditions, lowering them exposes much larger numbers of people to risks from treatment side effects. According to Dr. Gilbert Welch, Professor of Medicine at The Dartmouth Institute and of Community & Family Medicine and on the medical staff at the White River Junction Veterans Affairs Medical Center, in his book Overdiagnosed: Making People Sick in the Pursuit of Health, changes in thresholds for diabetes, hypertension, hyperlipidemia, and osteoporosis have resulted in over 64 million new cases of the four diseases, with 42 million alone diagnosed with high cholesterol. While there are many reasons to control these chronic conditions early, the lowering of the thresholds, he argues, exposes vastly larger numbers of people to becoming patients, with all the attendant side effects and long-term implications of medication regimens. There are conditions where lowering of thresholds is warranted, for example with co-morbid conditions, but caution needs to be used in applying those lowered thresholds in initial diagnosis of the general population.

Medicalization of aging
In addition to the issues of potential over-treatment, there has been a growing movement towards the medicalization of aging, with medication utilization for aging-related conditions increasing between 18 and 32 percent in a recent study by Express Scripts. From their analysis of pharmacy claims data from 2006-2011, use of medications for aging-related conditions (e.g., urinary incontinence, hormone replacement therapy, mental alertness/memory issues, etc.) increased 18 percent for privately insured patients of all ages and 32 percent for Medicare patients. While utilization increased, Medicare costs did not, but private insurance costs rose over 45 percent, leading to concerns that resources may be focused on mitigating the aging process and creating a cost burden similar to chronic condition management.

We must, however, be careful to not swing the pendulum too far in the other direction. Many screening and diagnostic tests, such as colonoscopies, have been extremely effective in detecting and reducing cancer mortality. While focused effort is needed to reduce lower-value treatments, we must ensure that high-value interventions with strong clinical evidence of efficacy are broadly adopted.

Approaches Underway to Curb Overuse
As the February 2013 Health Affairs highlights in several studies, there is growing evidence that patient involvement and engagement in their health care results in a better patient experience,

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lower costs, and improved outcomes. Empowering patients with greater knowledge of their options and stimulating a more honest dialogue about their desired outcomes helps minimize discomfort and potential harm from overuse of services while providing truly patient-centered care. In addition, others are working to reduce overuse of certain medical services through increased coordination of care and awareness campaigns about the most appropriate use of health care resources.

Patient engagement
Several studies published recently examine the tools and methods used to reach out to clinicians and patients to begin the dialogue around the appropriate use of health care resources. Shared decision-making, whether through national campaigns or more localized approaches, has been hailed as a strong tool in reducing costs and increasing engagement. The Affordable Care Act calls for Shared Decision-Making Resource Centers to help increase patient engagement and improve the use of shared decision-making as part of the clinical practice.  

Recent work by the American Institutes of Research proposed a framework for patient and family engagement that defines the levels of engagement and the steps across the continuum to help providers, hospitals, and health care delivery systems to develop tools to engage their patients. Informed Medical Decisions Foundation, which develops decisions aids, found through their demonstration project, several barriers to shared decision making including overworked and insufficiently trained providers and information systems not equipped to prompt providers about tools or track patient involvement. The authors concluded that the use of electronic medical record prompts and the involvement and training of clinicians beyond the treating physician might improve uptake. Another study looking at the use of enhanced decision-making support through contact with health coaches “found that patients who received enhanced support had 5.3 percent lower overall medical costs ... 12.5 percent fewer hospital admissions ... and 9.9 percent fewer preference-sensitive surgeries, including 20.9 percent fewer preference-sensitive heart surgeries,” strong evidence that remote intervention by phone and email can reduce costs. Another recent report highlights a “patient activation measure” that rates the level of patient engagement in their health care. Reviewing more than 30,000 patients, the study showed the patient activation score was a significant predictor of health care costs with those least engaged incurring the highest costs.

Example: Choosing Wisely
In early 2010, Howard Brody, M.D., Ph.D., director of the Institute of Medical Humanities at The University of Texas Medical Branch, challenged physician specialty societies via the New

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34 Ibid.
England Journal of Medicine to agree to a list “of five diagnostic tests or treatments that are very commonly ordered … that are among the most expensive services provided, and that have been shown… not to provide any meaningful benefit to at least some major categories of patients for whom they are commonly ordered.”

Dr. Brody felt that the best way to approach health care reform and the potential for cost cutting was to have physicians take the lead in identifying the places where reductions in cost would not adversely affect care delivery.

Several others took up the challenge, including an article series in the Archives of Internal Medicine entitled Less is More, which tried to dispel the myth that more care is always better. The U.S. National Physicians Alliance also took the challenge through its Promoting Good Stewardship in Clinical Practice project which outlined steps primary care physicians could take to promote more effective use of health care resources.

In April 2012, the American Board of Internal Medicine Foundation (ABIMF), as part of their ongoing work to help physicians become better stewards of finite health care resources, launched the Choosing Wisely campaign, lists of five common procedures or tests whose necessity should be discussed by patients and their physicians. The lists, outlined by several specialty societies, create a structure for patients and physicians to discuss the appropriateness of certain interventions. The specialty societies’ involvement provided credibility to this effort and provided “cover” and legitimacy for delivery systems to address resource use. ABIMF also partnered with Consumer Reports, an independent non-profit consumer organization, to help create consumer-friendly tools to provide a resource for patients to help them understand when more care is not better. ABIMF is also working with medical universities to develop tools for physicians to assist them in beginning these types of conversations with their patients.

In February 2013, 17 additional medical specialty societies joined the original nine, ABIMF, and Consumer Reports in releasing recommendations to bring the total to approximately 130 specific evidence-based recommendations that physicians and patients should consider as part of health care decisions. Currently there are over 42 specialty societies involved in the campaign.

Provider education

Educational offerings for providers around these issues are becoming more prevalent and showing positive results. At the same time, work is being done to determine the best ways to disseminate and broadly communicate comparative effectiveness research findings as clinical guidelines and protocols. One study found that academic detailing, “direct outreach education that gives clinicians an accurate and unbiased synthesis of the best evidence for practice in a given clinical area,” is proving to be an effective means of translating findings into actions. The study shows that the practice is improving patient outcomes, reducing costs, and is well received by clinicians. Several states have begun government-sponsored academic detailing programs and in Canada and Australia, professional societies provide these types of programs with support from the government.

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42 Ibid.
The American College of Physicians recently shared recommendations for use of evidence-based performance measures to assess the costs, benefits and potential harms of diagnostic and therapeutic treatments. Many measures to date have focused on the underuse of high-value services, but as more scrutiny is placed on the overuse of low-value services, the report provides some guidance on how measures of overuse can be applied in clinical practice. Additional focus on the use of quality measures for overuse would allow providers to analyze, track, and understand cases of overuse and design quality improvement efforts.

**Example: National Summit on Overuse**

In fall 2012, The Joint Commission and the American Medical Association-convened Physician Consortium for Performance Improvement held a National Summit on Overuse to begin a dialogue around the quality and patient concerns related to overuse of certain procedures. The session shared the work of five advisory panels, each focused on a different intervention, to review the existing evidence on overuse, discuss guidelines and quality measures, and identify strategies key stakeholders could adopt. The groups studied:

- Elective percutaneous coronary intervention,
- Typanostomy tubes for middle ear effusion of brief duration,
- Early term non-medically indicated elective delivery,
- Appropriate blood management, and
- Antibiotics for uncomplicated viral upper respiratory infection.

Related, the Society for Hospital Medicine, recognizing the importance of appropriate blood management to the inpatient hospital setting, included “Avoid transfusions of red blood cells for arbitrary hemoglobin or hematocrit thresholds and in the absence of symptoms of active coronary disease, heart failure or stroke” in their Choosing Wisely list for adult inpatient treatment, citing the recommendations of the AABB.

**Example: Safe Use of Medical Imaging**

The American Board of Radiology Foundation has held a series of national summits on the safe use of medical imaging to develop a systematic and patient-centered approach. The summits have involved representatives from key stakeholder groups including patients, regulators, imaging professionals, payers, manufacturers, and systems and facilities management staff. The participants are working to define steps for safe and appropriate use of medical imaging, identify gaps in the process, and agree on approaches to address the gaps. The programs hope to use a consensus approach to develop imaging decision making criteria for patients and physicians to determine the most safe and effective use of imaging studies.

**Use of measures**

A recently concluded study of ambulatory care services from 1999 to 2009 sought to determine the underuse, misuse, and overuse of 22 quality indicators. The authors found that while the measures for underuse (aspirin for patients with coronary artery disease, use of beta blockers,

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45 Society for Hospital Medicine, Choosing Wisely list, February 2013. (Accessed April 4, 2013)

statin use) improved for six of the nine measures, only two of the 11 overuse measures improved. While there was a decrease in cervical cancer screening for women over 65 and a decrease in the overuse of antibiotics for asthma, there was an increase in prostate screening in men older than 75. The authors argue that clinical practice guidelines have been focused on process measures and correcting for underuse rather than overuse. The study does indicate that underuse measures have been easier to track and thus develop more robust guidelines but they stressed the need to broaden the work around overuse. Reducing inappropriate care will require the same level of clinical guideline development that has thus far been focused on underuse. While the authors cite efforts by specialty societies to develop appropriateness criteria around specific procedures and tests, they argue that these have not been widely implemented.46 However, results are promising thus far on work done using the prevention quality indicators developed by the Agency for Healthcare Research and Quality, which look at admission rates for ambulatory-sensitive condition including diabetes, circulatory diseases, pneumonia, and others. From 2005 to 2010, reductions of over six percent for preventable admissions were recorded. 47