Choosing Wisely: How We Can Improve Value in Health Care

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Overview

- Our cost problem and its causes
- How we can improve health care value
- ACP targets for Choosing Wisely
- Other targets to consider
- "Overuse" quality measures
- Federal initiatives addressing value
  - Physician Quality Reporting System and Physician Compare
  - Value-Based Payment Modifier

Learning Objectives

- Understand the sources of health care cost problems in the US
- Incorporate the tenets of high-value and low-value care into everyday practice

Health Spending per Capita, 2011
Adjusted for Differences in Cost of Living

International Comparison of Spending on Health, 1980–2010

Average spending on health per capita ($US PPP) and total health expenditures as percent of GDP.


Diagnostic Imaging in Select OECD Countries

Higher utilization

Source: OECD: Organisation for Economic Co-operation and Development

Pharmaceutical Spending per Capita, 2009

Adjusted for Differences in Cost of Living


Drug Prices in Select OECD Countries

Prices for 30 most commonly prescribed drugs, 2006-07 (U.S. set at 1.00)


Volume of Knee and Hip Replacements, 2009


Physician Fee for Hip Replacement, 2008

Adjusted for Differences in Cost of Living

### Hospital Spending per Discharge, 2009

Adjusted for Differences in Cost of Living

![Graph showing hospital spending per discharge](source: OECD Health Data 2011 (Nov. 2011). http://www.oecd.org/els/health-systems/health-data.htm)

### Out-of-Pocket Spending and Problems Paying Medical Bills in Past Year

- More than US$1,000 in out-of-pocket costs
- Serious problems paying or unable to pay medical bills

![Graph showing out-of-pocket spending and problems paying medical bills](2011 Commonwealth Fund International Health Policy Survey of Sicker Adults in Eleven Countries. www.commonwealthfund.org)

### Since 2003, the Proportion of Adults with High Deductibles Has More Than Tripled

<table>
<thead>
<tr>
<th>Percent of Insured adults ages 19-64*</th>
<th>2003</th>
<th>2005</th>
<th>2010</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>No deductible</td>
<td>47%</td>
<td>46%</td>
<td>43%</td>
<td>25%</td>
</tr>
<tr>
<td>$1–$499</td>
<td>35%</td>
<td>33%</td>
<td>30%</td>
<td>26%</td>
</tr>
<tr>
<td>$500–$999</td>
<td>12%</td>
<td>12%</td>
<td>12%</td>
<td>10%</td>
</tr>
<tr>
<td>$1,000 or more</td>
<td>7%</td>
<td>10%</td>
<td>12%</td>
<td>25%</td>
</tr>
</tbody>
</table>


### High-Value and Low-Value Care

- ACP High Value Cost-Conscious Health Care defines value as benefits relative to costs
- Advocates cost-effectiveness analysis
- Two categories of low-value care
  - Services with minimal or no value
  - Benefits small relative to the costs
- Ultimately, “low value” is a societal decision
- Using CEA is contentious, so focus up until now has been on services with minimal/no value


### Case 1

- 72-yo man with 50 pack-year tobacco use, emphysema, diverticulosis, and hypertension
- 4-day history of right leg pain radiating to the foot
- Some numbness on bottom of foot and some weakness when walking, walking with a limp
- Otherwise in usual state of health

### Case 1 - Exam

On exam:
- Afebrile, BP 160/84 mm Hg, P 91
- Motor: 5/5 except 4/5 R plantar flexion
- Sensory – slight decrease in R lateral foot and heel
- Reflexes symmetric x/ absent R Achilles
Early Imaging Not Recommended if No “Red Flags” Are Present

- Red Flags
  - Fever
  - History of cancer, sickle cell, intravenous drug use
  - Unexplained weight loss
  - Night pain or pain at rest
- Clinical Course
  - Treated with PT and naproxen, hydrocodone
  - Pain persisted, started gabapentin; improved
  - Pain recurred, MRI showed mild central and moderate foraminal stenosis. Central disc protrusion at L5-S1.
  - Pain improved (therapeutic MRI?) over next month

Case 2

- 47-yo man with obesity, diabetes, and chronic low back pain who presents with marked worsening of his back pain with radiation down the left leg for 2 days.
  - Pain is on the top, side, and back of the leg.
  - It is difficult for him to walk because of the pain. His lower leg and foot feel numb.

Early Imaging High Value in Some Cases

- Red Flags:
  - Fever
  - History of cancer, sickle cell, intravenous drug use
  - Unexplained weight loss
  - Night pain or pain at rest
  - Anything else that is profoundly atypical, such as in this patient who had sx/sg at L5 and S1
  - MRI showed a left psoas abscess and L5 vertebral osteomyelitis

Case 2 - Exam

On exam:

- Afebrile, BP 146/72 mm Hg, P 84
- Motor: 5/5 hip flexion and knee flexion & extension, 4/5 plantar and dorsiflexion of the foot
- Decreased sensation to pinprick in L5 and S1 dermatomes

Choosing Wisely:
An ABIM Foundation Initiative

- Based on the “Medical Professionalism in the New Millennium: A Physician Charter”
  - Principles of patient welfare, autonomy, & justice
  - We must advocate for just and cost-effective distribution of finite resources
- 65 Specialty Societies are now partners
- Each identified 5 tests, treatments, or services that should be scrutinized (“rarely be used”)
- Partnership with Consumer Reports

Choosing Wisely: Services Clinicians “Should Question”

- Don’t obtain screening exercise ECG in patients who are asymptomatic and low risk for CHD
- Don’t obtain imaging studies in patients with non-specific back pain
- Don’t obtain brain imaging in patients with syncope and normal neurological examination
- In patients with low probability of VTE (Wells criteria), use D-dimer as initial diagnostic test
- Don’t obtain pre-operative CXR if no suspicion of intrathoracic pathology
**Recommendations from Other Organizations**

ACCP  For patients discharged on home oxygen after acute illness, don’t renew unless ongoing hypoxemia.

ACC  Don’t perform annual echocardiogram in patients with native valve disease and no change in signs/symptoms.
    Don’t do annual stress imaging tests in asymptomatic patients with CAD.

AAFP  Don’t prescribe antibiotics for mild-moderate sinusitis unless > 7 days or worsening symptoms.
    Don’t screen for osteoporosis in women < 65 years or men < 70 year w/o risk factors.

**Personal Favorite Low-Value Targets**

**Cervical Cancer Screening**
- NOT if post hysterectomy
- NOT if > 65 years old (if previously normal)
- NOT if < 21 years old
- NOT if 21-65 years and Pap negative in last 3 years or Pap/HPV negative in last 5 years
- Do not screen women < 30 years for HPV (AAFP)
- Overuse remains a large problem

**Pap Overuse in Northwestern GIM Clinic**

Eligible for extended interval (n=1705) ➔ No Pap test sooner than recommended (n=585)

Pap test performed sooner than recommended (n=1209)
- Number of Pap Smears in 2008: 839
- Number of Pap Smears in 2008: 712

Excluded after manual chart review (n=2*)

Received colposcopy after Pap test performed sooner than recommended (n=21)
- Number of colposcopies in 2008: 10
- Number of colposcopies in 2009: 11

**Emphasize Risk when Discussing with Patients**
- Value argument often not accepted
- May be especially true for prevention
- Need to emphasize risks (Dr. John Santa, Consumer Reports)
  - Pap – colposcopy, discomfort
  - Mammogram – biopsies, “over-diagnosis”
  - Colonoscopy – perforations

**Colon Cancer Screening**
- Value of colonoscopy = quality/cost
  - Adenoma detection rate of 15% F, 25% M
  - Huge variation in cost
- Also scrutinize high rate of “normal” biopsies and/or high rate of “inadequate” colon prep
- Adhere to guidelines for surveillance
- Stop “routine” screening age 76 – 85 years
- Stop all screening at age > 85 years (USPSTF – D)

**Case 3**
- 82-yo man with well-controlled diabetes, CLL, post-polio syndrome and multiple other medical problems.
- Generally good functional status, CLL in remission for 2 years.
- Has had at least two colonoscopies in the past with no polyps.
Case 3 - Follow-up

- On routine follow up, he asks when he should get another colonoscopy. He says an oncologist he knows said he “sees colon cancer all the time” and he should be screened again.

- Should he have a colonoscopy? Should he have fecal occult blood testing or fecal DNA testing?

Breast Cancer Screening

- USPSTF recommends biennial screening in women 50-74 years old
- I tell women that they should have screening every 1 to 2 years
- Discuss the small additional benefits and the risk of more false positives with annual test
- “It’s very reasonable to get a mammogram every two years instead of every year”
- About one quarter opt for biennial screening


Other Targets

- Repeat DEXA for osteoporosis screening based on T-score
- Do not repeat pneumococcal vaccine unless indicated
- Stop routine home glucose monitoring for stable type 2 diabetics who are not using insulin
- Expand use of home BP monitoring, ambulatory BP monitoring, or automated in-office BP measurement to dx & manage HTN

DEXA = dual-energy x-ray absorptiometry

American College of Immunization Professionals National Institute for Health and Care Excellence

More Challenging Strategies to Improve Value

- Expand office hours to prevent emergency department visits and hospitalization
- Develop team-based care within medical home
- Use remote monitoring, telephone, e-visits
- Promote decision-making around end-of-life care, including do-not-hospitalize orders
- BUT, we need fundamental change in payment

Overuse Measures

- Analogous to process of care quality measures
  - No Pap in low risk patients
  - Appropriate interval for CRC screening
  - Lack of imaging for low back pain
- Two types
  - Direct – based on individual patient characteristics
  - Indirect – utilization rates with overuse defined arbitrarily based on norms/medians


Examples of Overuse Measures

- Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery
- Prostate Cancer: Avoidance of Overuse Measure – Bone scan for staging low-risk patients
- Sinusitis: Computerized Tomography for Acute Sinusitis
- Central line-utilization ratio (CLUR): number of central line-days per patient-days in adult intensive care unit (Indirect Measure)

Medicare Initiatives to Promote Value

- Physician Quality Reporting System
  - Incentive payment 0.5% in 2013 and 2014
  - 1.5% penalty in 2015, 2% after that
- Physician Value-Based Purchasing
  - 2014 data will be used for 2016 payment adjustment for groups of 10 or more providers
  - Plan to include composite of cost measures
- Physician Compare
  - Plan to have quality measures included by 2015


Medicare's Quality Incentive Programs

Conclusions

- Physicians need to lead efforts to control health care costs
- There are many “low value” services that we can greatly decrease
- Larger changes will require payment reform
- Federal government is not going to wait: strong pressure from consumer groups to profile physicians on value/cost

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