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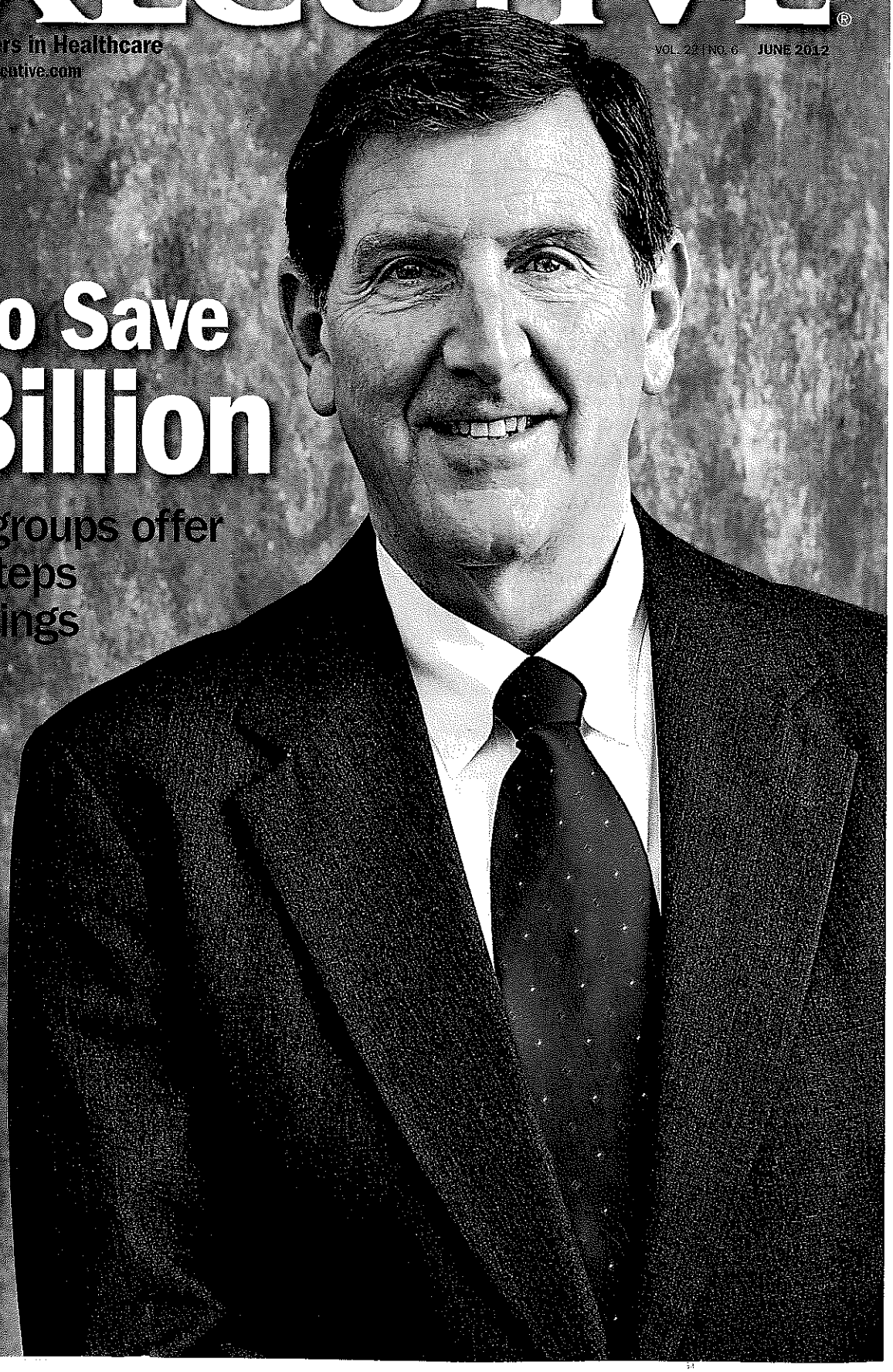

How to Save $7 Billion

Physician groups offer five easy steps to cost savings

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Long-term care identified as next market opportunity

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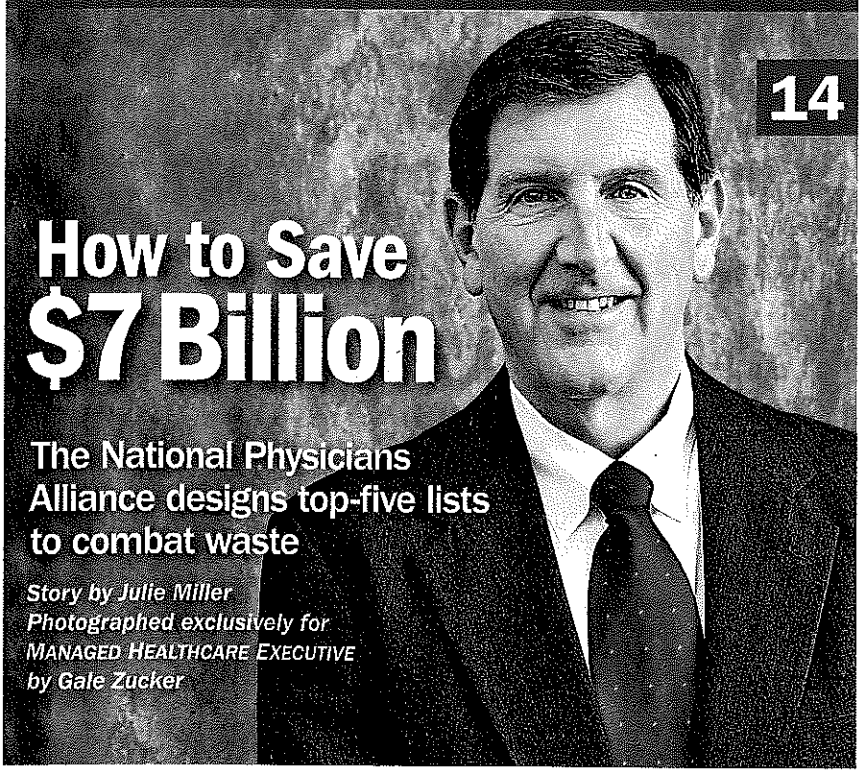

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Correction

May's News Analysis article, "PBM Market Retools After Mega-merger," should have reported the value of the Express Scripts acquisition of Medco as $29.1 billion.

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How to save $7 Billion

Good stewardship campaigns cut waste at the provider level

story | **Julie Miller** photography | **Gale Zucker**

Clinical providers are taking a new pledge. It's not the Hippocratic Oath exactly, but an ethical decision that extends *primum non nocere*—first, do no harm—into new territory.

Joining the industry's other stakeholders in practical cost-control solutions, providers are embracing the concept of waste reduction. Rather than shrugging their shoulders and passively watching costs escalate, physicians of all disciplines are committing to an attitude of stewardship, based on choosing *not* to deliver certain medical services in certain situations in which the care might be wasteful or harmful. The services are outlined in fairly simple top-five lists.

While the rationale comes from clinical best practices, the end result will be lower costs.

For example, radiologists are recommending against imaging for patients with uncomplicated headache. Such imaging is usually unnecessary and can add thousands of dollars in costs per patient.

"We are arriving at this idea of good stewardship and, in our professional judgment, defining the things that we shouldn't be doing because it's not right for our patients," says Steven Smith, MD, Brown University professor and treasurer of the National Physicians Alliance (NPA).

The campaigns are a bold move because reducing waste ultimately means fewer services will be delivered, which translates to fewer claims and less cash in providers' pockets. In fact, the recommendations coming from various specialty societies arguably mark the first significant effort on the part of providers to control costs. Waste accounts for an estimated 30% of the nation's total healthcare bill, or $750 billion annually. Even a modest reduction could impact a practitioner's bottom line.

But health plans, hospitals and pharmaceutical companies offered their cost-control pledges years ago—generally in support of the Patient Protection and Affordable Care Act. In the case of health plans, they acquiesced to medical-loss ratio policies, knowing the profit loss would be counterbalanced somewhat by the promise of increased membership.

Providers, on the other hand, have historically been reluctant to acknowledge the systemwide overuse of services. New payment models will likely become the counterbalance they need to ease their financial concerns.

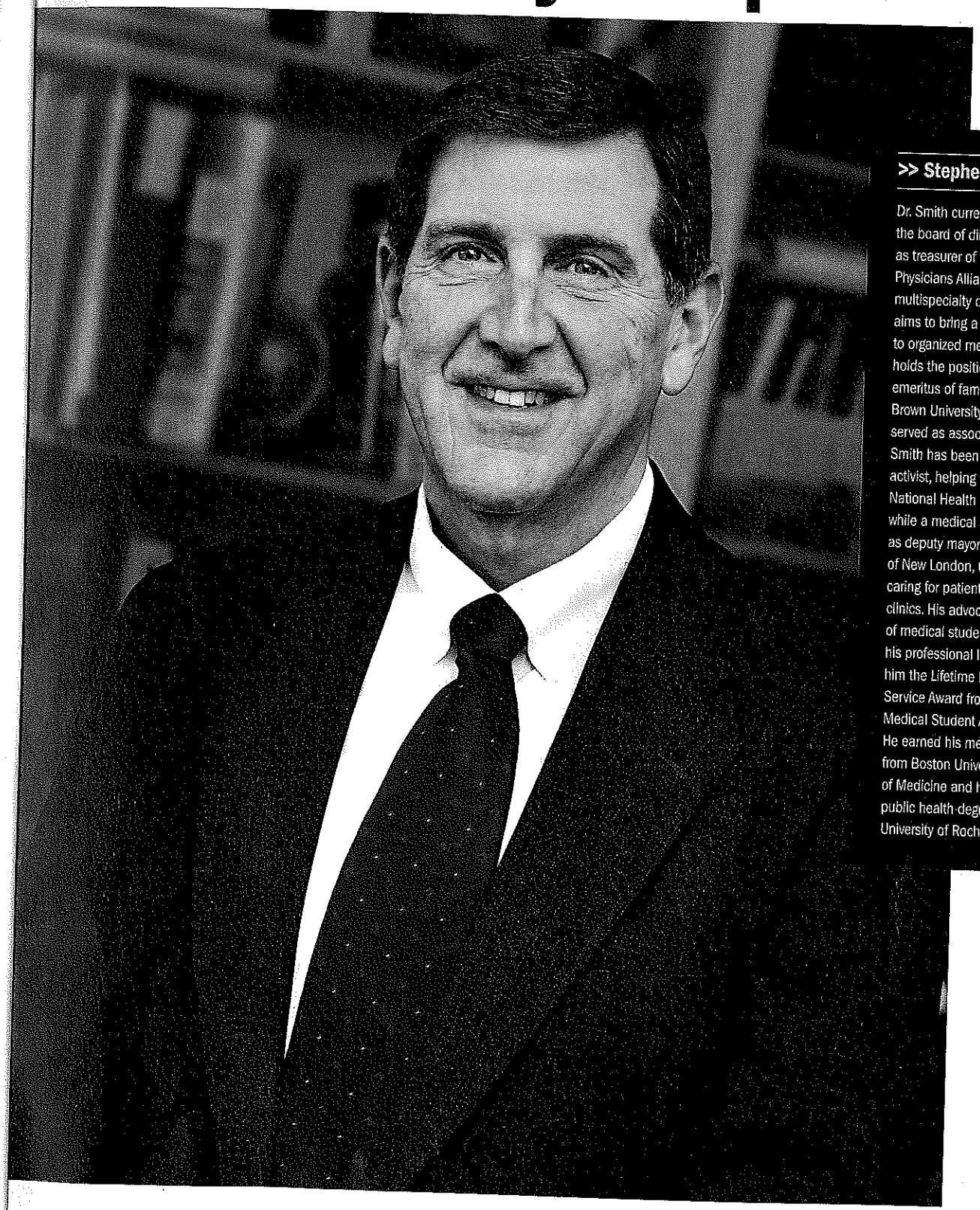
Societies identify top five

National initiatives have recently emerged as evidence of the good-stewardship trend among providers.

- In April, the American Board of Internal Medicine (ABIM) Foundation launched its Choosing Wisely campaign with a series of top-five lists. The lists, compiled by specialty, identify 45 common clinical activities where changes in practice could lead to better care and better use of resources. Each list outlines activities that physicians should avoid because they would be contrary to best practices and, most likely, would be considered waste. Nine societies have contributed thus far.
- As a precursor to Choosing Wisely, NPA used a grant from ABIM in 2009 to develop top-five lists for family practice, internal medicine and pediatrics, under what it calls the Good Stewardship project (See page 23). Thanks to a second grant, the recommendations are now being implemented and tracked for effectiveness in three practice organizations.

The Good Stewardship project was a springboard that helped inspire ABIM to create the larger Choosing Wisely program and invite the medical community's specialty societies to develop their own top-five lists of overused or unnecessary services. Dr. Smith, who is the principle researcher for Good Stewardship, says the avoidable activities outlined on the lists aren't as important as the fact that culture of medicine is changing.

in five easy steps



>> Stephen Smith, MD

Dr. Smith currently serves on the board of directors and as treasurer of the National Physicians Alliance—a multispecialty organization that aims to bring a different voice to organized medicine. He also holds the position of professor emeritus of family medicine at Brown University and formerly served as associate dean. Dr. Smith has been a long-time activist, helping to create the National Health Service Corps while a medical student, serving as deputy mayor in his hometown of New London, Conn., and caring for patients at community clinics. His advocacy on behalf of medical students throughout his professional life earned him the Lifetime Distinguished Service Award from the American Medical Student Assn. in 2005. He earned his medical degree from Boston University School of Medicine and his master of public health degree from the University of Rochester.

"Our hope originally was that our Good Stewardship project lead would result in other specialties taking up the cause and making their own top-five lists."

Thirty percent waste

Prevailing pressure on physicians often compels them to lean toward doing more for their patients rather than doing less. Their clinical orders translate to more of everything from prescription drugs to imaging scans to surgical procedures.

It's clear that the fee-for-service model tempts physicians to increase the quantity of services. However, quality programs also reward providers financially for increasing the delivery of certain elements, such as cholesterol tests or diabetes screenings. At the same time, patients often demand more prescriptions, scans and procedures because they believe quantity equals quality.

Under such circumstances, it's no wonder expert data analysis shows that at least 30% of healthcare spending is wasted on interventions that don't provide benefits.

"If we're talking about 30% waste in our current system—that's $750 billion—now you're talking about real money," says Dr. Smith. "Our hope originally was that our Good Stewardship project lead would result in other specialties taking up the cause and making their own top-five lists. The initial movement in that direction and now the Choosing Wisely campaign are really gaining momentum."

According to Daniel B. Wolfson, executive vice president and COO of the ABIM Foundation, in addition to the nine specialty societies that contributed lists of services they advise against, 11 more societies are scheduled to participate in Choosing Wisely by the end of the year. Wolfson says NPA's Good Stewardship top-five lists for primary care were a compelling influence for the larger campaign.

He also cites a powerful call to responsibility in an editorial published in the *New England Journal of Medicine* on Jan. 28, 2010. (Howard Brody, MD, the author of the piece, specifically challenged specialty panels to create top-five lists of overused services.)

"The most important thing about the campaign is who is saying this—it's their specialty society," Wolfson says.

Recommendations coming from the heart of the medical profession make a difference, he says. All the items on the top-five lists were vetted to ensure they were actionable in practice and supported by evidence.

For example, in the Choosing Wisely list from the American Gastroenterological Assn., experts recommend physicians do not repeat colorectal cancer screening (by any method) for 10 years after a high-quality colonoscopy is negative in average-risk individuals.

"The message is about overuse and appropriate use—not cost per se," Wolfson says.

ABIM has not quantified the potential cost savings from any of the lists and has no plans to do so, he says. Conversations among physicians and between physicians and patients about appropriate use and optimal care remain the goal of Choosing Wisely, instead of specific cost savings. Besides, tracking the effect of physicians not ordering certain tests or procedures could be impossible.

"These lists are not 'never do' lists," Wolfson says. "There are exceptions to the rule. They list what's usually not necessary, but that's not for all cases. That complicates data collection."

Saving $7 billion

NPA's Good Stewardship project is willing to offer some savings projections, however. According to research, the top-five lists created for family practice, internal medicine and pediatrics could yield somewhere in the neighborhood of $7 billion in savings per year. Even that large figure only represents less than 1% of national healthcare expenditures.

"That's for primary care," Dr. Smith says. "That's small potatoes compared to a $2.5 trillion healthcare budget, but it's something."

Researchers were able to quantify specific costs associated with list items. The most impressive savings could come from physicians simply adhering to recommendations for prescribing low-cost generic statins when initiating cholesterol-lowering treatment. Resulting savings could reach $5.8 billion.

Other savings are difficult to pinpoint but intuitively could reach into the billions. For example, the societies recommend that family physicians avoid prescribing antibiotics for acute, mild-to-moderate sinusitis (lasting less than seven days or absent worsening symptoms), noting that sinusitis accounts for 16 million office visit and $5.8 billion in annual healthcare costs.

Despite the evidence and ongoing awareness campaigns alerting physicians to the best practice, antibiotics are still prescribed in more than 80% of outpatient visits for sinusitis. Although a single antibiotic prescription might only cost a few dollars, when multiplied by the number of annual fills, the costs add up quickly. And the spending isn't directed toward a helpful treatment for sinusitis.

"They're mostly viruses, and whenever you treat anybody with an antibiotic, you are posing potential harm and risk to the patients," Dr. Smith says. "In fact, more than 25% of patients you give an antibiotic to get sick from the antibiotic."

Because it is difficult to quantify, treatment of mild-to-moderate sinusitis was not included in NPA's total, and researchers note savings could go well beyond the conservative $7 billion estimate. Adoption in clinical practice will be the key to achieving the ultimate savings for all the measures.

Dr. Smith believes each physician can and will deliver optimal care to each patient while putting the top-five lists into practice. He says the evidence supports the 'do not deliver' recommendations, so by not delivering certain services, physicians are truly offering the best treatment plans.

"When you start talking about things that will affect people's income—like not doing imaging—this is really about the culture of medicine," he says. "Yes, I believe that we do need to do something to change the mechanisms and so on, but I think that's secondary. That follows the aligned values and beliefs in medicine."

Let physicians move forward

Other cost-saving forces at work across the industry include accountable-care models, pay-for-quality and bundled payments. Each model chips away at the financial incentives in care delivery, and each one is championed by public and private payers hoping to control costs. Choosing Wisely and Good Stewardship are different because they leverage evidence to address clinical practice directly.

"The data are irrefutable," says Dr. Smith. "We had a culture, a set of beliefs in medicine, which was fine for most of the 20th century. But it's unsustainable, and it's not providing us with the benefits of more assurance of good health for our patients and our society. So, when the data no longer fit, you've got to shift the model. And, I think all these other things—the ACOs and bundled payments—are all reflecting the need to rethink the model of care that we have."

Clinicians have responded positively to the top-five lists, he says, and the payer community is only too willing to support the initiative. NPA does not accept funding from payers or pharmaceutical companies, so payer support, ironically, should be focused on letting the physicians move forward on their own.

"Let the profession of medicine take the lead on this because patients will trust their doctors," he says. "We're not trying to hold back care that's going to help. We're trying to not do things that will be hurtful to patients. Having heard it from a doctor will convince patients that this is not just to make money or to provide dividends to stockholders. This really is the best care. I would urge insurers not to get too far ahead of what the profession's trying to do."

Supporters believe Choosing Wisely is going to cause a pardigm shift across the healthcare system.

"There's a sense of relief that we can talk about this," says ABIM Foundation's Wolfram. "We can now have a rational conversation about overuse."

"This is a fight for the hearts and minds of physicians. And, it's really about the culture change."

Now convince the consumers

Even as payers and providers embrace the issue of overuse and take practical steps to reduce waste, patients won't be so easily convinced. In fact, Dr. Smith has recorded a number of patient-facing You Tube videos that can be used as education tools in primary care offices. The videos are meant to change the patients' mindset that more care equals better care.

Wolfram says Consumers Union and AARP are among the partners endorsing the Choosing Wisely project. *Consumer Reports* has committed to providing resources for consumers and physicians to engage in conversations about the overuse or misuse of medical tests and procedures that provide little benefit or might cause harm. The magazine and its Web site reach millions of Americans in its role as the "consumer communicator" in the campaign.

In addition, the ubiquitous Wikipedia has committed to offering a "Wikipedian in residence" who will connect Choosing Wisely with the dedicated volunteer community that has produced 23,000 medical articles on the Wikipedia Web site.

"You can provide physicians and providers with communication skills so that they feel empowered when they're in front of a patient who says, 'I really want the antibiotic,'" Dr. Smith says.

He says more study is warranted to find out why clinicians still persist in performing services that are unnecessary, such as overuse of antibiotics or imaging. Many believe physicians are simply responding to patient insistence, while others believe it's a case of defensive medicine.

"Doctors say they do it to avoid getting sued," Dr. Smith says. "I hear it, but I really don't believe it. It may play a little bit of a role but not a large role. I think a lot of it has to do with the way we train doctors."

He hopes professional society meetings, workshops and medical journals will bring the top-five lists into everyday practice. In fact, the *Archives of Internal Medicine* will publish separate articles on each of the three primary-care lists created by the Good Stewardship project. What's more, as an educator himself, Dr. Smith hopes to drive the new culture deeper through medical school education.

"We then should be pushing on the policy side and thinking about how we can align the structure of healthcare and its financing to be consistent with this new model," he says. "It will work even without that, but it would certainly be a lot better if we could work in an environment where everything is aligned."

He says the top-five lists all come from ideas healthcare leaders have had all along, but the ideas "always end up on bookshelves and haven't had any real impact." NPA has a $20,000 grant to put the primary-care top-five lists into practice, which includes development of measurement tools and chart audits to determine the impact of the care guidelines.

"This is not a quality assurance project," Dr. Smith says. "This is a fight for the hearts and minds of physicians. And, it's really about the culture change, the paradigm shift. Once we do that, everything else will follow." **MHE**

TOP 5 LISTS

Top 5 list in pediatrics

1. **Don't prescribe antibiotics for pharyngitis unless the patient tests positive for *streptococcus***
   - Most cases of pharyngitis are viral and will not respond to antibiotics, yet antibiotics are prescribed more than half the time
   - Antibiotic use has potential risks to the patient, increases bacterial antibiotic resistance and adds to healthcare expenses
   - Confirmation of *streptococcus* infection is definitely necessary before antibiotic use can be justified
2. **Don't obtain diagnostic images for minor head injuries without loss of consciousness or other risk factors**
   - Imaging low-risk patients rarely detects traumatic abnormalities, and of the abnormalities detected, few, if any, require surgery
   - Early exposure to radiation poses a significant risk of radiation-attributed cancers—as high as one case in 1,400 among infants exposed to cranial CT
3. **Don't refer otitis media with effusion (earache and pressure) early in the course of the problem**
   - Many cases of OME resolve spontaneously within three months with no adverse consequences
   - Reasons for early referral include craniofacial or neurological abnormalities, language delay or learning problems, and when structural abnormalities of the eardrum or middle ear are suspected
4. **Advise patients not to use cough and cold medicines**
   - There is little evidence that over-the-counter cough and cold medications help, yet more than 10% of children use a cough and cold medicine every week
5. **Use inhaled corticosteroids to control asthma properly**
   - Use of controlling medication for persistent asthma reduces asthma exacerbations, emergency visits and hospital admissions
   - Inhaled corticosteroids are relatively safe and well-tolerated

Top 5 list in family medicine

1. **Don't do imaging for low back pain within the first six weeks unless red flags are present**
   - Imaging of lumbar spine before six weeks does not improve outcomes but does increase costs
   - Low back pain is the fifth most common reason for all physician visits
2. **Don't routinely prescribe antibiotics for acute mild to moderate sinusitis unless symptoms last for seven or more days or symptoms worsen after initial clinical improvement**
   - Most maxillary sinusitis in the ambulatory setting is due to viral infection that will resolve on its own
   - Despite consistent recommendations to the contrary, antibiotics are prescribed in more than 80% of outpatient visits for acute sinusitis
   - Sinusitis accounts for more than 16 million office visits and $5.8 billion in annual healthcare costs
3. **Don't order annual ECGs or any other cardiac screening for asymptomatic, low-risk patients**
   - There is little evidence that detection of coronary artery stenosis in asymptomatic patients at low risk for coronary heart disease improves health outcomes
   - False-positive tests are likely to lead to harm through unnecessary invasive procedures, overtreatment and misdiagnosis
4. **Don't perform Pap tests on patients younger than 21 years or in women post-hysterectomy for benign disease**
   - Most dysplasia in adolescents regresses spontaneously
   - Pap tests have low yield in women after hysterectomy (for benign disease), and there is poor evidence for improved outcomes
5. **Don't use bone density screening for osteoporosis in women under age 65 years or men under 70 years with no risk factors**
   - It is not cost-effective in younger, low-risk patients, but cost-effective in older patients

Top 5 list in internal medicine

1. **Don't do imaging for low back pain within the first six weeks unless red flags are present**
   - Imaging of lumbar spine before six weeks does not improve outcomes but does increase costs
   - Low back pain is the fifth most common reason for all physician visits
2. **Don't obtain blood chemistry panels or urinalyses for screening in asymptomatic, healthy adults**
   - Only lipid screening yielded significant numbers of positive results among asymptomatic patients
   - Screen for type 2 diabetes mellitus in asymptomatic adults with hypertension
3. **Don't order annual ECGs or any other cardiac screening for asymptomatic, low-risk patients**
   - There is little evidence that detection of coronary artery stenosis in asymptomatic patients at low risk for coronary heart disease improves health outcomes
   - False-positive tests are likely to lead to harm through unnecessary invasive procedures, overtreatment and misdiagnosis
4. **Use only generic statins when initiating lipid-lowering drug therapy**
   - All statins are effective in decreasing mortality, heart attacks and strokes
   - Switch to brand-name statins only if generic statins cause clinical reactions or do not achieve LDL cholesterol goals
5. **Don't use bone density screening for osteoporosis in women under age 65 years or men under 70 years with no risk factors**
   - It is not cost-effective in younger, low-risk patients, but cost-effective in older patients