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Prescriptions for Excellence in HEALTH CARE

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Reducing Waste and Overuse: A National Priorities Partnership Recommendation

By Louis H. Diamond, MB, ChB

The triple threat of covering the uninsured, closing the quality gap, and slowing the rate of the projected cost escalation continues to haunt the US health care delivery system. The National Priorities Partnership (NPP) has made a valuable contribution by

galvanizing coordinated national action to attack 2 of these threats - quality improvement and cost reduction. The Partners have agreed on 6 National Priorities, one of which is to attack waste and overuse.

The importance of highlighting waste and overuse cannot be overemphasized. Prior and current efforts to reform health care delivery have focused on underuse and misuse, both of which have financial implications. The correction of misuse

Table 1. NPP Recommended Areas of Focus to Reduce Overuse While Ensuring Appropriate Patient Care

<p>1. Inappropriate Medication Use</p> <ul style="list-style-type: none"> • Antibiotics • Polypharmacy <ul style="list-style-type: none"> - Multiple chronic conditions - Antipsychotics 	<ul style="list-style-type: none"> • Bone or joint X-ray prior to conservative therapy without red flags • Chest X-ray, preoperative, on admission, or routine monitoring • Endoscopy 	<p>8. Preventable emergency department (ED) visits and hospitalizations:</p> <ul style="list-style-type: none"> • Potentially preventable ED visits • Hospital admissions lasting <24 hours • Ambulatory care-sensitive conditions
<p>2. Unnecessary Laboratory Tests:</p> <ul style="list-style-type: none"> • Panels (eg, thyroid, metabolic [SMA20]) • Special tests, such as Lyme disease, with regional considerations 	<p>5. Inappropriate nonpalliative services at end of life:</p> <ul style="list-style-type: none"> • Chemotherapy in the last 14 days of life • Aggressive interventional procedures • More than 1 emergency department visit in the last 30 days of life 	<p>9. Potentially harmful preventive services with no benefit:</p> <ul style="list-style-type: none"> • BRCA mutation testing for breast and ovarian cancer for women at low risk for these cancers • Coronary heart disease screening using electrocardiography, exercise treadmill test, electron beam computer tomography for adults at low risk for heart disease • Carotid artery stenosis screening for the general adult population • Cervical cancer screening for women older than age 65, those at average risk, and those post hysterectomy • Prostate cancer screening for men older than age 75
<p>3. Unwarranted maternity care interventions:</p> <ul style="list-style-type: none"> • Cesarean section 	<p>6. Unwarranted procedures:</p> <ul style="list-style-type: none"> • Spine surgery • Percutaneous transluminal coronary angioplasty/stent • Knee/hip replacement • Coronary artery bypass graft • Hysterectomy • Prostatectomy 	
<p>4. Unwarranted diagnostics, testing:</p> <ul style="list-style-type: none"> • Cardiac computed tomography (CT) (non-invasive coronary angiography and coronary calcium scoring) • Lumbar spine magnetic resonance imaging prior to conservative therapy without red flags • Chest/thorax CT for screening, uncomplicated 	<p>7. Unnecessary consultations</p>	

(continued on page 2)

often has an immediate and easily measurable cost-saving impact. Underuse is more complicated, often requiring a long-term view and consideration of the more general impact on health and productivity management. Highlighting waste and overuse addresses costs directly, while bringing into play complex issues of uncertainty, professional judgment, and patient preference.

The NPP's approach focused directly on waste and overuse, relying heavily on a study conducted by the New England Healthcare Institute¹ and a survey of the leadership of national specialty societies. The latter focused on answering the question, "What services and procedures do you think are being overused?"² Nine categories of waste and overuse are included in the NPP recommendations (Table 1).

The NPP approach took a focused, clinical view of the problem. Other areas of waste and overuse were not dealt with explicitly. For instance, administrative issues, such as the transaction costs that result from the

need for providers to deal with multiple public and private sectors payers, all of which utilize non-standardized procedures, is wasteful and an enormous cost driver. Similarly, the NPP did not deal directly with documented variation in care, expensive inputs, fraud and abuse, or defensive medicine.

There is evidence and a literature base supporting all areas included in the NPP categories. An example is the preventable readmission problem. Medicare costs in 2004 for readmissions were estimated to be \$17.4 billion. Jencks et al reported a 20% readmission rate within 30 days and a 34% readmission rate within 90 days for Medicare beneficiaries.³ Medical conditions accounted for 67% and surgical conditions for 51% of the index and initial admissions, whereas 70% of readmissions among surgical patients were driven by medical problems. Variation in readmission rates was documented as well (eg, 13% in Idaho, 23% in Washington). No bill was found for a physician service in half of the readmissions within 30 days of a medical discharge, highlighting a potential lack of coordination and

providing clues to correct the problem of preventable rehospitalization.

As a plan of attack is developed, a number of issues must be faced – among them, the nature of the evidence available to support an overuse definition. There is a paucity of evidence generation focused on these issues, as well as a failure to convert evidence into clinical practice guidelines and actionable applications (eg, rules and alerts, order sets).

Both the science and the application of shared decision making are in their infancy. The latter is essential to facilitate informed decision making by the patient, the physician, and members of the health care professional team. With the exception of those in large group practices that have mature information systems, physicians lack knowledge of their own practice patterns. Further, the reimbursement system is not designed to improve quality and reasonably contain costs.

Going forward, an action plan must include the elements in Figure 1.

Figure 1. Action Plan Elements

1. Create a robust effort to evaluate and understand the nature and magnitude of overuse. This will require literature review and an analysis of actual data of current experience. Both efforts must be ongoing.
2. Commit to an information-driven approach. Information about costs and trends must be generated. Physicians must receive information regarding their practice patterns as compared with their colleagues. Performance measures must be created and deployed. Point-of-care decision-support tools must be made available to support shared decision making.
3. Inform, educate, and "activate" patients. These efforts should include a public education campaign about overuse generally, along with some specific examples.
4. Engage the top clinical and administrative leadership, the "C suite" level, to lead from the top and make the right tools available to patient and health care professionals.
5. Realign financial incentives in the payment systems for hospitals and physicians.
6. Take steps to redesign the delivery system by supporting organizational systems such as the medical home and accountable care entities.
7. Create a research agenda that covers the many issues that impact waste and overuse. Topics should include evidence generation and the standardization of clinical practice guidelines. New approaches to performance measures are needed, and tools should be developed to support shared decision making and patient activation at the point of care. Issues regarding the health information infrastructure and the payment systems required to support these activities would round out a partial research agenda.

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