



Promote Making Informed Decisions, Reducing Waste, and Improving Outcomes

Cynthia D. Smith, MD, FACP
Steven Peskin, MD, FACP
1/22/2014



Disclosures

Cynthia Smith is salaried by the American College of Physicians (ACP), a nonprofit membership organization (137,000 physicians) with a mission is to enhance the quality and effectiveness of health care by fostering excellence and professionalism in the practice of medicine.

Cynthia Smith owns stock and stock options in Merck and Company where her husband is employed.

Disclosures

Steven Peskin is salaried by Horizon Blue Cross Blue Shield of New Jersey. Horizon Blue Cross Blue Shield of New Jersey, the state's oldest and largest health insurer, is a tax-paying, not-for-profit health services corporation, providing a wide array of medical, dental, and prescription insurance products and services. Horizon BCBSNJ is an independent licensee of the Blue Cross and Blue Shield Association, serving 3.7 million members with headquarters in Newark, NJ and offices in Wall, Mt. Laurel, and West Trenton. Horizon BCBSNJ has a number of patient-centered programs, including Patient-Centered Medical Homes, Accountable Care Organizations and programs focused on Episodes of Care. More than 500,000 Horizon BCBSNJ members are benefiting from Horizon BCBSNJ's patient-centered programs that are working to improve patient care while controlling costs.

Learning Objectives

- Define high value care (HVC)
- Understand provider-driven sources of excessive health care costs
- Explain the framework and guiding principles behind the High Value Care Initiative
- Identify care that provides no benefit and may be harmful
- Overcome some of the barriers to high value care (patient expectations, malpractice concerns, patient access, marketing)

Outline

- Introduce the HVC Initiative
- Show the Online High Value Cases video
- Demonstrate a sample HVC Case
- Review pilot feedback
- Plans for the future

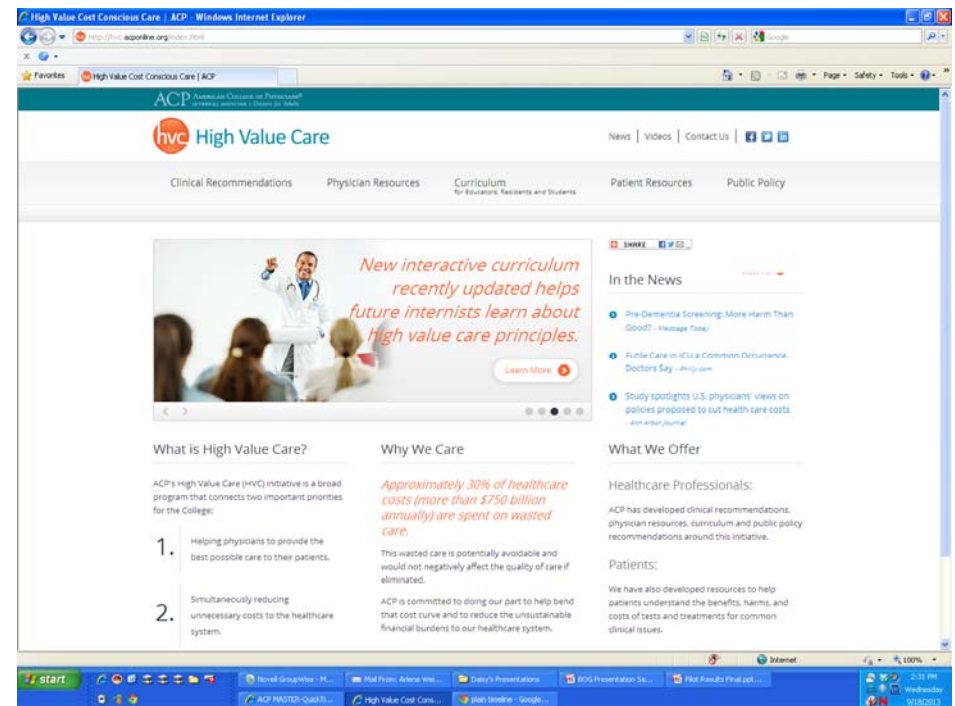
High Value Care Definition

Care that balances clinical benefit with cost and harms with the goal of improving patient outcomes



HVC Timeline

- 2010 ACP introduced the HVC initiative
- 2012 AAIM/ACP released a FREE HVC curriculum for Internal Medicine Residents
- 2013 ACP launched HVC website <http://hvc.acponline.org>
- 2014 ACP launches Online High Value Care Cases



Introductory Video

<https://vimeo.com/72985394>

Online High Value Care Cases for Clinicians

- Introductory video
 - Five modules (30-60 minutes each)
 - Take-home tools with each module to help provider incorporate modules into practice
1. Avoid Unnecessary Testing
 2. Use Emergency and Hospital-Level Care Judiciously
 3. Improve Outcomes with Health Promotion and Prevention
 4. Prescribe Medications Safely and Cost Effectively
 5. Overcome Barriers to High Value Care

Topic 1: Avoid Unnecessary Testing

- Use validated decision support tools to increase accuracy and diagnostic efficiency
- Estimate the harms and costs associated with common tests
- Balance benefits with harms and costs of testing

Michelle Barrow

59-yr woman 3 days s/p lap chole who complains of acute onset shoulder pain and SOB.

On PE, she is diaphoretic, afebrile, BP 110/78 mm Hg, P 115/min, RR 20/min, O2 sat 82% on ambient air. Lungs- crackles at bases that clear with cough, Cardiac-tachy, no m/r/g. Abd- nontender, incision C/D/I, ext- no edema.

Portable CXR shows atelectasis.



Michelle Barrow

You think that she might have had a pulmonary embolism (PE), and you calculate her pretest probability using the Wells score.

Her score is 6, which means she has a 16% to 20% chance of having a PE.



Question #1

Given Ms. Barrow's high pretest probability, which of the following tests is the most cost-effective for diagnosing pulmonary embolism?

- A. D-Dimer assay
- B. Lower-extremity Doppler ultrasonography
- C. Pulmonary CT angiography
- D. Transthoracic echocardiogram
- E. Ventilation/perfusion scan

Question #1- Answer

Given Ms. Barrow's high pretest probability, which of the following tests is the most cost-effective for diagnosing pulmonary embolism?

- A. D-Dimer assay
- B. Lower-extremity Doppler ultrasonography
- C. Pulmonary CT angiography**
- D. Transthoracic echocardiogram
- E. Ventilation/perfusion scan

Question #1 Key Point

- In patients with high pretest probability of pulmonary embolism like Ms. Barrow, pulmonary CT angiography is the most cost-effective diagnostic test.

Use Validated Risk Scores to Guide Testing

- The Wells prediction score helps tailor diagnostic testing to the specific patient and prevent unnecessary testing.
- Ms. Barrow's Wells score of 6 equates with high pretest probability and makes a D-dimer study unnecessary as a positive result would not rule in the disease and a negative result would not exclude the diagnosis.
- Patients with the combination of high pretest probability and a normal D-dimer (quantitative rapid ELISA test) have between a 19% and 28% chance of having an acute PE.
- D-dimer testing is most useful for excluding disease in patients at low or intermediate risk.

Value Cost of the Test

- High Value Care is not always choosing the least expensive test
- High Value Care is making the correct diagnosis as efficiently as possible and avoiding unnecessary testing and delaying treatment
- Lower extremity ultrasound and V/Q scanning may make the diagnosis but are not first line choices in this high probability patient with an abnormal chest x-ray, as they are as likely to be indeterminant and lead to further testing as they are to make the diagnosis.

Michelle Barrow cont.

- Ms. Barrow is stabilized and transferred to the intensive care unit.
- Pulmonary CT angiography confirms the diagnosis of pulmonary embolism, and she is given intravenous heparin. Her subsequent course is uncomplicated.



Ms. Barrow's Hospital Bill

BNP \$233.73
Prothrombin Time × 4 (34.35) \$137.40
PTT × 13 (\$54.02) \$702.26
D-Dimer \$83.79
CBC with diff × 5 \$168.30
ABG \$308.97
Troponin × 3 \$549.03
Electrolytes, BUN/Cr × 5 (\$60.35) \$301.75
Live chemistry tests \$69.43
Hypercoagulable panel \$2553.12
Blood type and crossmatch \$26.46
ECG \$206.02

Acetaminophen × multiple (\$0.10) \$2.00
Warfarin (\$0.14) \$1.40
IV Heparin × multiple (\$20.25) \$243.00

Portable CXR \$409.61
CT Chest with Contrast \$1462.55
Duplex Ultrasound Lower Ext \$1089.15
Echocardiogram \$2201.03

Physician fees × 5 days (\$200 × 5) \$1,000
PT Evaluation \$319.09
Semi-Private Bed × 5 days (\$3250 × 5) \$16,250

Total \$28,318

Question #2

Which of the following categories of services that Ms. Barrow received contributed the most to her charges with the least clinical benefit?

- A. Imaging studies
- B. Laboratory testing
- C. Pharmacy charges
- D. Physician charges

Question #2- Answer

Which of the following categories of services that Ms. Barrow received contributed the most to her charges with the least clinical benefit?

- A. Imaging studies**
- B. Laboratory testing
- C. Pharmacy charges
- D. Physician charges

Question #2 Key Point

- Diagnostic testing should be tailored to the individual patient and focused on making an accurate diagnosis as efficiently as possible.

\$6,000 in Unnecessary Testing!

- Unnecessary imaging studies contributed the most to Ms. Barrow's hospital charges; unnecessary laboratory testing also significantly contributed to the bill.
- She had a straightforward diagnosis of pulmonary embolism (PE) that was identified and treated quickly.
- Despite this, she underwent an extensive work-up that included several tests that were unlikely to change her management plan significantly.
- Studies should be selected based on the information needed to diagnose and treat the patient effectively, not based on habit or routine.
- High value care is customized, prioritized care—not one-size-fits-all medicine.

HVC Cases Pilot Methodology

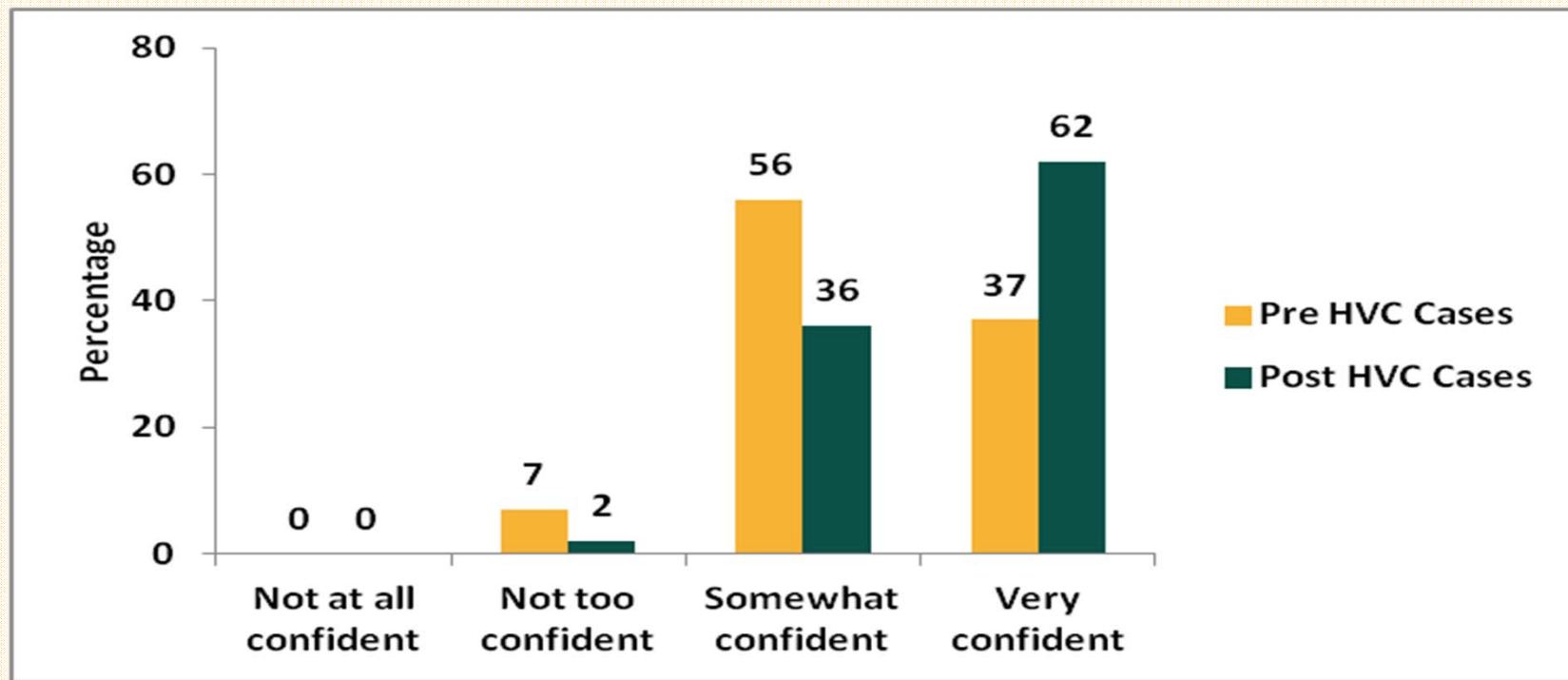
- 662 eligible (>50% of time in clinical practice) from the ACP Research Panel invited
- 189 (29%) agreed to participate
- 123 (65%) completed all 5 topics
- 118 (96%) completed all 5 topics and the survey



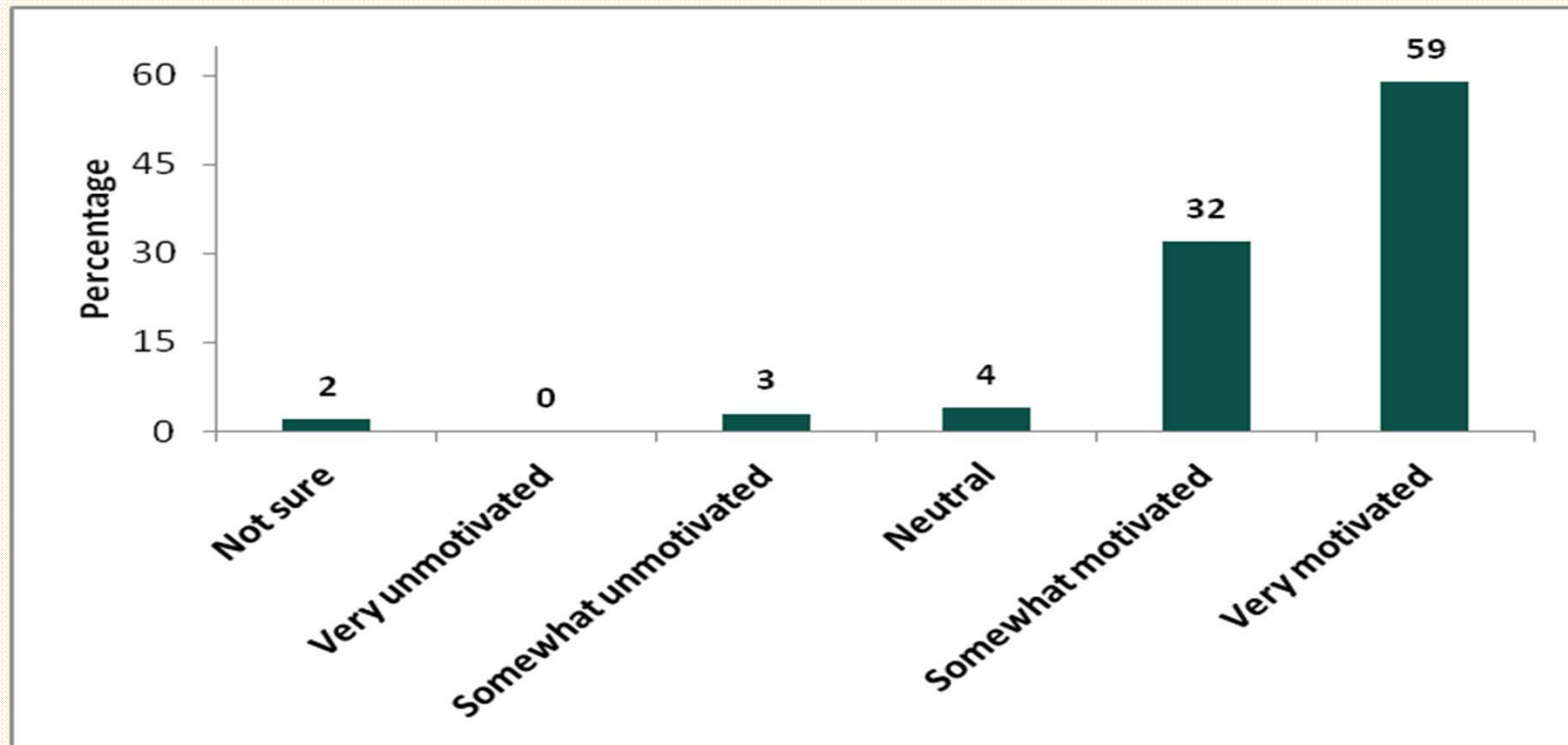
The HVC Cases significantly impacted physicians' reported behavior

- Increased frequency of discussing the risks and benefits of tests and treatments with patients.
- Increased frequency of discussing relative costs of tests and treatments with patients when generating a plan.
- **Decreased frequency of ordering unnecessary tests and treatments because they were requested by patients.**
- Increased frequency of offering patients alternatives to tests and treatments that consider the risks, benefits, patient preference and costs.
- **Decreased frequency of ordering tests and treatments out of fear of malpractice.**

Confidence in One's Ability to Communicate with Patients as to Why Tests Are Not Necessary



Impact of the HVC Cases on One's Motivation to Incorporate Principles into Daily Practice



Engage Patients

- Patient empowerment expo on High Value Care in San Francisco, April 2013
- 450 patients from the Bay Area; rich discussion -- patients are ready and eager to talk about these issues
- Next patient empowerment expo on HVC: April 2014 in Orlando

Patient Education Materials

- Partnerships with Consumer Reports and AHRQ -- to provide patient educational materials
- New ACP center for patient partnership and engagement, materials on website as they are developed
- Consistent message between provider and patient educational materials
- Resident Curriculum and Online Cases include patient education materials you can start using now!

Visit the HVC Website

- Visit the ACP HVC website to view clinical recommendations and download free physician and patient resources including the curriculum and videos:

<http://hvc.acponline.org>

Current Focus

- Focus now on the “low-hanging fruit”:
Interventions with **low or no benefit**
- Goal: Reduce inappropriate care that does not help (or even harms) patients
- Ultimate outcomes: Better patient care, reduced cost



Slide used with permission from Dr. Chris Moriates, UCSF

ABIM Foundation's Choosing Wisely Campaign

- 52 medical societies have published lists of five things physicians and patients should question
- All lists are publically available www.choosingwisely.org
- Collaboration with consumer reports to create companion patient education materials



American Gastroenterological Association



Five Things Physicians and Patients Should Question

- 1 For pharmacological treatment of patients with gastroesophageal reflux disease (GERD), long-term acid suppression therapy (proton pump inhibitors or histamine2 receptor antagonists) should be titrated to the lowest effective dose needed to achieve therapeutic goals.**
The main identifiable risk associated with reducing or discontinuing acid suppression therapy is an increased symptom burden. It follows that the decision regarding the need for (and dosage of) maintenance therapy is driven by the impact of those residual symptoms on the patient's quality of life rather than as a disease control measure.
- 2 Do not repeat colorectal cancer screening (by any method) for 10 years after a high-quality colonoscopy is negative in average-risk individuals.**
A screening colonoscopy every 10 years is the recommended interval for adults without increased risk for colorectal cancer, beginning at age 50 years. Published studies indicate the risk of cancer is low for 10 years after a high-quality colonoscopy fails to detect neoplasia in this population. Therefore, following a high-quality colonoscopy with normal results the next interval for any colorectal screening should be 10 years following that normal colonoscopy.
- 3 Do not repeat colonoscopy for at least five years for patients who have one or two small (< 1 cm) adenomatous polyps, without high-grade dysplasia, completely removed via a high-quality colonoscopy.**
The timing of a follow-up surveillance colonoscopy should be determined based on the results of a previous high-quality colonoscopy. Evidence-based (published) guidelines provide recommendations that patients with one or two small tubular adenomas with low grade dysplasia have surveillance colonoscopy five to 10 years after initial polypectomy. "The precise timing within this interval should be based on other clinical factors (such as prior colonoscopy findings, family history, and the preferences of the patient and judgment of the physician)."
- 4 For a patient who is diagnosed with Barrett's esophagus, who has undergone a second endoscopy that confirms the absence of dysplasia on biopsy, a follow-up surveillance examination should not be performed in less than three years as per published guidelines.**
In patients with Barrett's esophagus without dysplasia (cellular changes) the risk of cancer is very low. In these patients, it is appropriate and safe to exam the esophagus and check for dysplasia no more often than every three years because if these cellular changes occur, they do so very slowly.
- 5 For a patient with functional abdominal pain syndrome (as per ROME III criteria) computed tomography (CT) scans should not be repeated.**

Expansion of the High Value Care Initiative

- Medical students: Adapt high value care content onto the MedU platform that supports individual, online learning -- these reach 97% of students in the nation
- Beyond internal medicine: Adapt curriculum to other specialties, current work underway with obstetrics and gynecology, family medicine, and surgery; pediatrics and psychiatry also interested; collaboration with ACGME Resident/Fellow Council to expand beyond IM

Future Challenges

- End of life care
- Over-pricing
- Price transparency
- Defensive medicine
- Improved reimbursement for care coordination
- Alignment of financial incentives
- Physician financial conflict of interest

In Summary: What Can We Do?

- ACP has developed a library of FREE tools for providers and patients to engage them in the high value care initiative
- We need your help get the word out to providers to use these tools
- Let's work together to motivate providers and patients to eliminate health care waste while improving outcomes



Patient Care in New Jersey Must Improve

Current state



Jim
(NJ citizen)

According to Dartmouth Atlas:

- Receives **quality of care that ranks 42nd in the U.S.**
- Receives **value of care that ranks 48th in the U.S.**
- Will face the highest Medicare cost in the last two years of life (compared to all other states)



Dr. Smith
(NJ PCP)

- Receives \$20-30K less per year than the average PCP in U.S. (Bureau of Labor Statistics)
- Has difficulty finding a younger physician to work in practice
- Considering using EMR, but not using it currently
- Gets little information from hospitals and ERs about patients

Future state through PCMH



Improved care quality, health outcomes and patient satisfaction



Material increase in primary care provider's revenue and take-home pay



PCMH processes and workflows that improve care coordination and management of high-risk patients

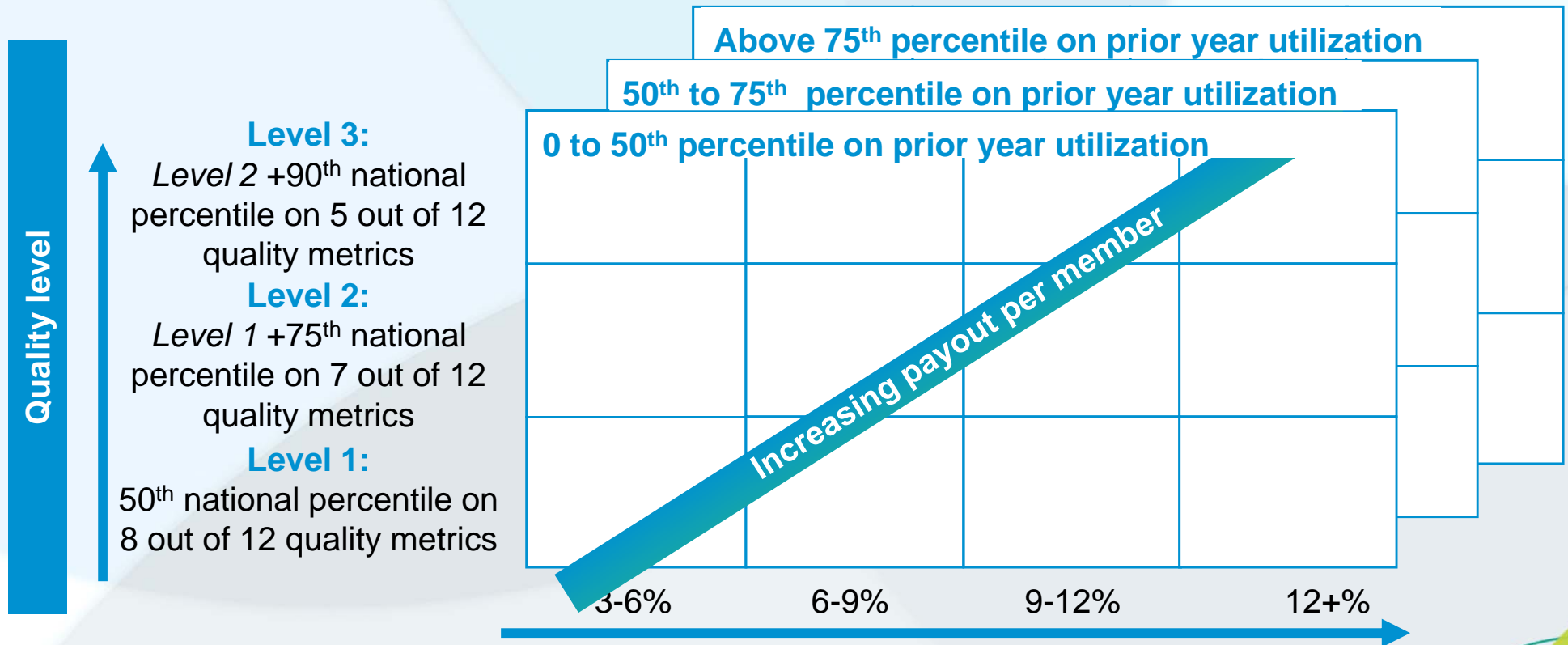


Meaningful reduction in utilization and significant total cost of care savings

Five Key Elements to Achieve Sustainable Results



Outcomes-based Payout Matrix for Years 1 & 2



Higher payout in each box for practice with better prior year utilization
(rewarding practices with higher starting levels of performance)