

NATIONAL PRIORITY: OVERUSE

Eliminate overuse while ensuring the delivery of appropriate care

OUR VISION: We envision healthcare that promotes better health and more affordable care by continually and safely reducing the burden of unscientific, inappropriate, and excessive care, including tests, drugs, procedures, visits, and hospital stays.

Why is Overuse a National Priority?

A significant amount of attention on healthcare focuses on the care that Americans do *not* receive, but there is growing evidence that a significant portion of the care we receive is actually redundant and unwarranted—and beyond that, in some cases, even harmful.

Since the problem of overuse was defined more than 10 years ago—as when “the potential for harm exceeds the possible benefits of care”—a growing body of evidence has emerged documenting its pervasiveness and consequences.¹³⁴ Perhaps the most compelling evidence of this problem lies in the work of researchers at Dartmouth Medical School, who for many years have studied variation in healthcare service delivery and its relation to quality and costs. Their studies have shown that there is significant variation in healthcare spending between regions of the United States, only 40 percent of which can be attributed to different rates of illness and price. The remaining variation can be explained in part by practice variations that have little or nothing to do with evidence-based medicine, but rather with the capacity to provide healthcare, such as the number of hospitals, physicians, and physician specialists. Areas with more specialists have more consultations and consequently provide more surgeries and procedures and have higher

expenditures, regardless of whether such care is warranted.¹³⁵

The Partners identified targeted areas of potential waste, building on a broad evidence base, including recent work by the New England Health Institute,¹³⁶ which compiled a comprehensive compendium of evidence of overuse, underuse, and misuse from 1998 to 2006 that emphasizes high-value opportunities for tackling this problem. The Partners solicited and received important feedback from a broad array of stakeholder groups, including specialty societies, nursing organizations, hospital associations, and health plans.¹³⁷

Areas with more specialists have more consultations and consequently provide more surgeries and procedures and have higher expenditures, regardless of whether such care is warranted.

The resulting list of nine targeted areas encompasses multiple Priorities, care settings, and target populations and builds on the momentum of growing public and media attention to the issue.

The idea that “more does not necessarily mean better” is starting to resonate outside of the quality community and is entering into broader public consciousness. In the past year, a best-selling book on the topic was read by millions,¹³⁸ and reputable news outlets and national consumer organizations, including the *New York Times*, *U.S. News & World Report*, the *Wall Street Journal*, AARP, and Consumers Union, all ran articles that have increased public awareness of this issue.¹³⁹

The time is right to tackle this area, particularly given the potential for savings amidst the dire financial situation of our healthcare system and the number of under- and uninsured. It is important to emphasize, however, that for all of the identified target areas,

there are patients for whom these tests and procedures are absolutely appropriate and necessary. This goal is therefore not limited just to reducing overuse, but one that equally stresses the provision of appropriate care for each and every patient. Importantly, the other five Priorities explicitly focus on underuse and ensuring that safe, effective, and culturally sensitive care is delivered.

The idea that “more does not necessarily mean better” is starting to resonate outside of the quality community and is entering into broader public consciousness.

Americans.¹⁴⁰ Inappropriate use of antibiotics contributes to the emergence of antibiotic-resistant bacteria, making all of us more susceptible to infections and leaving us with fewer options to combat them.¹⁴¹ Such antibiotic use also puts

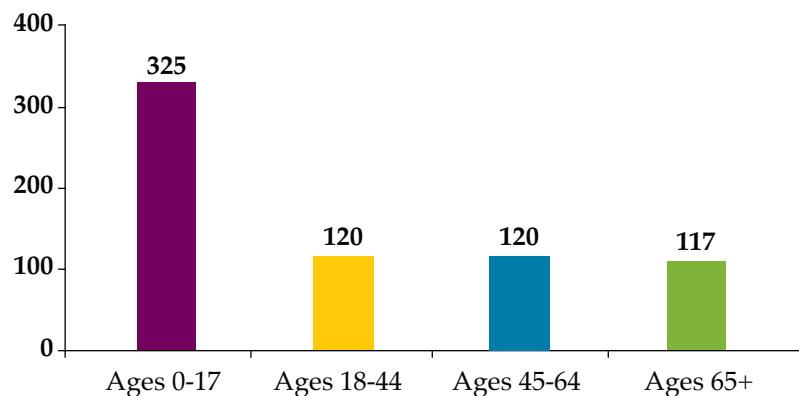
patients at unnecessary risk for adverse drug reactions, yet many patients, particularly children, are still inappropriately prescribed antibiotics for the common cold (see Chart 7).¹⁴² Unwarranted surgeries and procedures present opportunities for medical errors and serious adverse events, including surgical errors and infections, yet many women still receive unwarranted cesarean sections (c-sections)¹⁴³ and hysterectomies,¹⁴⁴ and patients with stable coronary disease receive coronary revascularization procedures when pharmacologic therapy may suffice.¹⁴⁵ Unnecessary testing exposes patients to additional risks as well—inappropriate imaging exposes patients unnecessarily to radiation, unwarranted endoscopies increase a patient’s risk of internal injuries, and unnecessary

Making Overuse a National Priority Will:

REDUCE HARM. The inappropriate use, misuse, or overuse of medical interventions poses many serious threats to our population. Beyond the negative impact of wasted resources that we can ill afford, the areas of inappropriate use identified may cause unnecessary harm to millions of

Chart 7

Rate that Antibiotics Were Prescribed at Outpatient Visits with Diagnosis of Common Cold (per 10,000 Population), by Age Group, 2001-2002



Data: National Ambulatory Medical Care Survey and National Hospital Ambulatory Medical Care Survey (Agency for Healthcare Research and Quality, 2006).

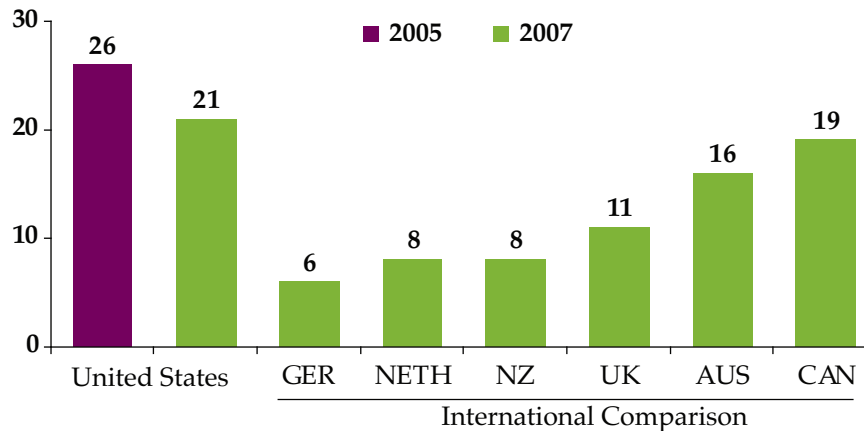
Source: McCarthy and Leatherman, *Performance Snapshots*, 2006. www.cmwf.org/snapshots.

Chart 8

EFFICIENCY

Went to Emergency Room for Condition That Could Have Been Treated by Regular Doctor, Among Sicker Adults

Percent of adults who went to emergency room in past two years for condition that could have been treated by regular doctor if available



AUS = Australia; CAN = Canada; GER = Germany; NETH = Netherlands; NZ = New Zealand; UK = United Kingdom.
Data: 2005 and 2007 Commonwealth Fund International Health Policy Survey.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

laboratory tests may induce more testing or exploratory procedures exposing patients to further potential harms.

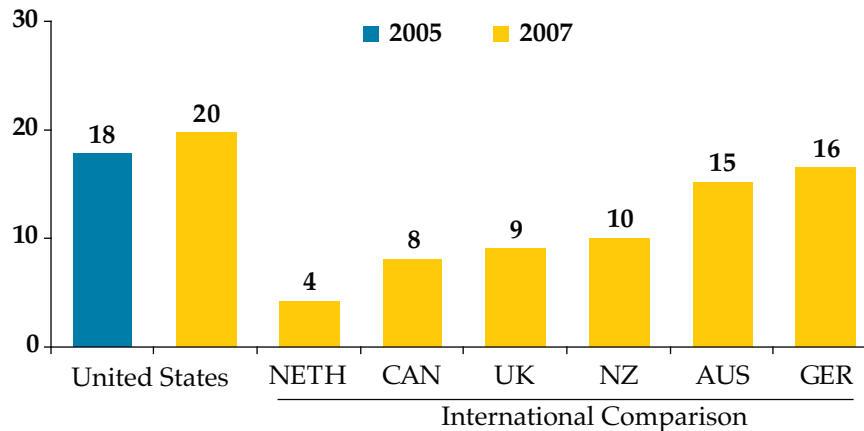
REDUCE DISPARITIES. Effectively addressing the burden of unnecessary care is one way to remedy the problem of disparities in how care is and is not provided. The discussion of healthcare disparities typically focuses around the lack of access to healthcare services and the lack of appropriate care; however, assuring access to appropriate healthcare services early on can also help to reduce more costly utilization downstream. Studies indicate that the overutilization of emergency departments and unnecessary hospitalizations, which have been associated with poor access to primary care, are more common in minority populations.¹⁴⁶ A study of neonates seen in an urban emergency room found that 60 percent of all emergency department visits were nonurgent and that patients of younger maternal age, patients with Medicaid, and patients of nonwhite race all had more frequent nonurgent emergency department use.¹⁴⁷ Separate research indicates, however, that 50 percent of hospitalizations for children who are admitted for any one of six

diagnoses, including asthma, dehydration, and skin infections, may be avoidable through better parent education and follow-up clinical care.¹⁴⁸ Minority populations may also suffer more from certain unnecessary procedures than nonminority patients. In a phone survey of women in seven different U.S. cities, the highest rates of hysterectomy were found in disadvantaged African American and Hispanic subgroups, which could not be explained by known risk factors.¹⁴⁹

REDUCE DISEASE BURDEN. The rising number of cesarean sections can have long-term unintended consequences for women and their offspring. For example, women who have c-sections are at increased risk for chronic pelvic pain or even bowel obstruction as a result of abdominal adhesions. Subsequent pregnancies following a c-section introduce dual risks for mother and child, including placenta previa, uterine rupture, low birth weight, preterm birth, stillbirth, and admissions to neonatal intensive care units. Babies that do not experience vaginal delivery may be at increased risk of respiratory problems such as allergies and asthma.¹⁵⁰

Duplicate Medical Tests, Among Sicker Adults

Percent reporting that doctor ordered test that had already been done in past two years



AUS = Australia; CAN = Canada; GER = Germany; NETH = Netherlands; NZ = New Zealand; UK = United Kingdom.
Data: 2005 and 2007 Commonwealth Fund International Health Policy Survey.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

On the other end of the spectrum, approximately 20 percent of patients are given chemotherapy in the last 14 days of life,¹⁵¹ at which point the disease has progressed to such an extent that the chemotherapy has essentially no chance of helping. Receiving chemotherapy at this point can be detrimental to incurable patients, who may still suffer the negative side effects of the medication and who may forego limited opportunities for spiritual growth, quality family time, and an easier transition to death.¹⁵²

REDUCE WASTE. Drawing on the Dartmouth research, individuals who live in “high-spending” areas receive approximately 60 percent more in services than those who live in “low-spending” areas, which is at least in part attributed to differences in the supply of healthcare providers in the area as well as practice variation. Furthermore,

and contrary to intuition, the low-spending regions perform as well or better on a range of quality indicators.¹⁵³ This “over spending” is substantial. In fact, one report indicates that Medicare spending would decrease by 29 percent if spending in medium- and high-spending regions reached the level of that in low-spending regions.¹⁵⁴ Evidence shows that Americans are more likely to be seen in an emergency department for a condition that is treatable by a primary care professional than in six other developed countries (see Chart 8).¹⁵⁵ Reducing preventable hospitalizations by 5 percent for ambulatory care-sensitive conditions could result in savings of more than \$1.3 billion.¹⁵⁶ The waste of healthcare resources also can be attributed to such things as duplicate testing that could be remedied by systems that allow better tracking of ordered tests and results (see Chart 9).¹⁵⁷

In collaboration with medical groups, HealthPartners, a Minnesota insurer, has developed a “decision support” tool that medical groups can embed in their electronic medical records. The tool allows physicians to enter a planned diagnostic procedure, such as a CT scan, into the computer while a patient is in the exam room and receive immediate feedback regarding whether that particular procedure makes sense; if not, alternatives are suggested. HealthPartners emphasizes that it will pay for the diagnostic procedure even if the physician does not follow its recommendation. Still, the company says its efforts have helped it avoid some 7,000 inappropriate scans.¹⁵⁸

UnitedHealth’s “advanced notification,” program requires many of its physicians to notify United before proceeding with a nonurgent scan. The company then reviews the case in advance to make sure the test makes sense. Although it sounds like prior authorization, the company says the distinction is that doctors risk not being paid only if they do not provide the notification. Once they have done that, it does not matter for payment purposes whether the doctor follows the company’s advice. United says that doctors have changed what test they have ordered 3 percent of the time, and 9 percent of the time they have canceled the order altogether.¹⁵⁹

The home health community has been targeting preventable hospitalizations and emergency department visits through the Centers for Medicare & Medicaid Services’ QIO Program. Many home health agencies have implemented interventions such as telemonitoring to better keep an eye on a high- or moderate-risk patient’s medical condition, especially when the patient is first discharged home from the hospital. Others are emphasizing better education for patients that historically have higher rehospitalization rates or emergency department visits to help them understand when a condition is a true emergency as opposed to when it is more appropriate to call the home care agency for assistance.¹⁶⁰

AARP has been informing its membership about the issue of overuse and about the potential dangers of inappropriate medical care. An article in the Health section of its magazine, “Why Does Health Care Cost So Much?,” provided an overview of the problem as well as some of the potential causes. AARP went one step further to speak to this issue by including five tips for consumers of things to do now to lessen the risk of receiving care they do not need.¹⁶¹

HOW WILL WE GET THERE?

The Partners will work together to ensure that:

Goal: All healthcare organizations will continually strive to improve the delivery of appropriate patient care and substantially and measurably reduce extraneous service(s) and/or treatment(s).

The recommended areas of concentration are as follows:

↑ Inappropriate medication use, targeting:

- Antibiotic use
- Polypharmacy (for multiple chronic conditions; of antipsychotics)

↑ Unnecessary laboratory tests, targeting:

- Panels (e.g., thyroid, SMA 20)
- Special testing (e.g., Lyme Disease with regional considerations)

↑ Unwarranted maternity care interventions, targeting:

- Cesarean section

↑ Unwarranted diagnostic procedures, targeting:

- Cardiac computed tomography (noninvasive coronary angiography and coronary calcium scoring)
- Lumbar spine magnetic resonance imaging prior to conservative therapy, without red flags
- Uncomplicated chest/thorax computed tomography screening
- Bone or joint x-ray prior to conservative therapy, without red flags
- Chest x-ray, preoperative, on admission, or routine monitoring
- Endoscopy

↑ Inappropriate nonpalliative services at end of life, targeting:

- Chemotherapy in the last 14 days of life
- Aggressive interventional procedures
- More than one emergency department visit in the last 30 days of life

↑ Unwarranted procedures, targeting:

- Spine surgery
- Percutaneous transluminal coronary angioplasty (PTCA)/Stent
- Knee/hip replacement
- Coronary artery bypass graft (CABG)
- Hysterectomy
- Prostatectomy

↑ Unnecessary consultations

↑ Preventable emergency department visits and hospitalizations, targeting:

- Potentially preventable emergency department visits
- Hospital admissions lasting less than 24 hours
- Ambulatory care-sensitive conditions

↑ Potentially harmful preventive services with no benefit, targeting:

- BRCA mutation testing for breast and ovarian cancer – female, low risk
- Coronary heart disease screening using electrocardiography (ECG), exercise treadmill test (ETT), electron-beam computed tomography (EBCT) – adults, low risk
- Carotid artery stenosis screening – general adult population
- Cervical cancer screening – female over 65, average risk and female, posthysterectomy
- Prostate cancer screening – male over 75

(See U.S. Preventive Services Task Force D Recommendations List at www.ahrq.gov/clinic/prevenix.htm)

To get there, we will continue to pursue a collaborative, multidisciplinary approach with the healthcare organizations and healthcare professionals who played a major role in the development of the targeted areas. We will work with the practicing and academic professional communities and the medical specialty societies to identify strategies to achieve this goal (e.g., embedding performance measurement in the maintenance of certification requirements). We will engage all key stakeholders, including patients, payers, employers, suppliers, and the media to promote an understanding of the nine targeted areas. We will support patient shared decisionmaking to ensure that the patient's needs are met, ensure that there are evidence-based resources for the targeted areas, and assist in the development of payment and consumer information processes to discourage inappropriate and unnecessary care. We will provide tools for successful implementation where possible and appropriate. We will develop metrics to measure successful implementation and outcomes and publicly report this data on a timely basis.