Part 2: The Value Mandate: What It Means for Your Organization

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This is the second in a four-part series examining emerging research and best practices to help health care providers get in front of the challenges and pressures of providing patient care in a post-reform era. Part I set the stage by examining what we now know about the improve quality/reduce costs value mandate. Part 2 discusses opportunities to reduce overall health care spending by lowering the utilization of high-cost, discretionary, and often unnecessary services.

Despite eight consecutive year-over-year declines in the rate of spending growth, the United States spends more on health care than any other country in the world. According to data compiled by the Organization for Economic Co-operation and Development (OECD), health care expenditures in the United States were 2 ½ times higher than in other developed nations in 2009. After adjusting for differences in per capita income between countries, the McKinsey Center for U.S. Health System Reform concluded that spending in the United States was 23 percent above expected levels.

Sources of the Spending

Some experts have estimated that as much as one third of health care costs in the United States can be attributed to unnecessary, ineffective, and sometimes harmful care. Expensive diagnostic tests and procedures of limited value to the patient, avoidable hospitalizations, or care provided in the last six months of life are leading examples. Several factors contribute to unnecessary utilization: defensive medicine to protect against malpractice lawsuits, poor management of chronic conditions, and the prevailing fee-for-service payment system that rewards providers for the quantity, not the quality, of the services they deliver.

Leading Change

A surprising acknowledgement by a broad spectrum of physicians that overutilization is a widespread problem, but one easily addressed by altering treatment standards, occurred on April 4, 2012 when nine medical specialty boards recommended that 45 common tests and procedures (five in each specialty) be performed less often. The recommendations, stemming from the Choosing Wisely campaign conducted under the auspices of the ABIM Foundation, included less frequent use of antibiotics for sinusitis, imaging for low back pain, screening colonoscopies, cardiac screening tests for asymptomatic low-risk patients, and CT scans for several different conditions.

Although some physicians and consumer advocates expressed concern that applying the Choosing

Wisely guidelines too broadly could result in undertreatment of patients, the prevailing view is that the specialty societies deserve praise for taking the lead to identify tests and procedures that provide little benefit at considerable cost. "Overuse is one of the most serious crises in American medicine," a recent *New York Times* article quoted Dr. Lawrence Smith, physician-in-chief at North Shore-LIJ Health System and dean of the Hofstra North Shore-LIJ School of Medicine, who described the recommendations as a "very powerful message."

Two other studies published in 2012 provide additional evidence that expensive procedures are performed far more often than medically necessary. A study presented at the annual meeting of the American Academy of Orthopaedic Surgeons estimated that the practice of defensive medicine by orthopedic surgeons led to $2 billion in unnecessary spending per year, with 24 percent of tests ordered defensively. A study of non-emergency angioplasties performed in hospitals in New York State in late 2009 and 2010 concluded that the procedure was inappropriate for 14 percent of the patients and fell into the uncertain category for 50 percent of the patients.

Medical leaders and management teams at several prominent hospitals and health systems have also taken aggressive action to eliminate unnecessary care and curtail unnecessary spending according to another recent *New York Times* article. Successes reported by Virginia Mason Medical Center in Seattle included reducing CT scans for sinus conditions by 27 percent and MRIs for headaches by 23 percent by requiring physicians to use a computerized check list of medical circumstances to justify that those tests were needed, and collaborating with Starbucks and Aetna to find less costly ways to treat Starbucks' employees with uncomplicated back pain.

Now that the constitutionality of the Affordable Care Act has been upheld by the Supreme Court, examples of individuals and organizations that are leading the transformation of health care delivery by being bold and executing change will become more common as the way care is provided and paid for in the near future changes dramatically. Providers, insurers, and government organizations all agree that the nation must take aggressive action to cut health care expenditures, not just slow the rate of growth.

Physician leaders and management executives must seize this opportunity and be better stewards of limited health care resources. And while there will be continued efforts to further reduce the unit cost of care, most of those gains have already been realized. Instead, far greater returns can be achieved by reducing the services provided per episode of care, and by coordinating care across the continuum of services, so that care is provided in the least costly manner and in the least costly settings.

We will examine the issue of care coordination in Part 3 of our *Survive and Thrive Under Health Care Reform* series.

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