MEDPAGE TODAY AT 10
Progress and new goals

MEDPAGE TODAY AT 10 05.26.2015 9 COMMENTS

'Less Is More': The Next Big Thing for Medicine

— If the doctor just says no, what does the patient hear?

by Joan Stephenson PhD
Contributing Writer

When billionaire-entrepreneur-Dallas Mavericks owner Mark Cuban lobbed a Tweet in early April advising his followers to have their blood tested "for every thing available" every 3 months, he probably didn't expect to unleash a Twitterspheric debate on medical overuse.

Scores of health journalists and clinicians jumped on this ill-advised tweet, explaining that such overtesting can result in false positives, further testing, unneeded treatment, patient stress, and considerable costs.

Although it's unlikely that the furor swayed opinions on either side, it reflects a larger, thoughtful conversation within the healthcare community. That discussion is the "less is more" movement to reduce overuse of "low-value" services such as screening, diagnostic tests, or treatments that are unlikely to help patients and pose risk of harm.

Proponents of less-is-more medicine stress that its focus is avoiding harm rather than mere cost-cutting, which consumers fear might reduce access to necessary care. But it's also clear that targeting tests and procedures that offer little or no value, involve unnecessary risks to patients, and result in avoidable downstream care will indeed reduce wasteful healthcare spending.

Researchers have suggested the cost of wasted healthcare dollars, including from overuse of low-value services, makes up a third of the nation's $2.8 trillion healthcare bill. Despite this hefty price tag, U.S. healthcare ranks last overall compared with 10 high-income countries, as well for three other health indicators: infant mortality, mortality from conditions amenable to treatment, and healthy life expectancy at age 60.

Choosing Wisely

The less-is-more movement has percolated against this backdrop over the past decade, gaining traction with the 2012 launch of the Choosing Wisely campaign by the American Board of Internal Medicine (ABIM) Foundation. The campaign enlisted clinician groups to help galvanize change by naming an evidence-based top 5 list of tests and procedures that physicians and patients should question because they offer little or no benefit and may cause harm.

To date, more than 70 specialty societies have joined the campaign, each offering a top 5 list (some later updated to a top 10 or 15 list). ***Consumer Reports*** and other consumer groups have also signed on to help educate patients about how more medicine can be harmful.

In addition, major medical journals are highlighting research findings that provide data illuminating low-value care, including the ***JAMA Internal Medicine*** Less is More series and the ***BMJ***'s Too Much Medicine campaign. Annual conferences, such as Preventing Overdiagnosis and the Lown Institute-sponsored RightCare Conference, are raising the medical community's consciousness about medical overuse.

Bold vs. Timid Choices

Some specialty groups embraced the challenge, and despite potential effects on their members' financial bottom lines, presented top 5 lists that included services often performed within their own specialty that could be considered low value.

For example, the Society of General Internal Medicine advised against the routine annual physical, and the American College of Radiology listed five imaging tests to avoid under certain circumstances, such as admission or preoperative chest x-rays for ambulatory patients without specific findings from the physical exam and history.

But in an analysis reported last year, researchers at Dartmouth and Harvard pointed out that most of the tests and procedures selected by medical groups, especially "proceduralist societies," for their top 5 lists are either rarely done or are typically performed by clinicians in other fields.

"One of the interpretations of this was that specialty societies weren't choosing things that affected their own revenue streams, they were choosing things that affected others' revenue streams," said Carrie H. Colla, PhD, one of the Dartmouth researchers who co-authored the analysis.

For example, the American Academy of Orthopedic Surgeons' top 5 list included three items related to patients with knee osteoarthritis: use of chondroitin and glucosamine supplements, a rarely performed procedure called needle lavage, and use of lateral wedge insoles.

Noticeably absent from the list were some commonly performed orthopedic procedures that evidence shows are unlikely to help many of the patients who undergo them, explained orthopedic surgeon James Rickert, MD, president of the Society for Patient Centered Orthopedics.

To take one example, each year 700,000 U.S. patients with knee osteoarthritis and degenerative meniscal tears undergo arthroscopic surgery, despite evidence from a 2002 randomized, controlled trial that found the procedure was no better than sham surgery in relieving pain or improving function in such patients.

The orthopedic surgeons also didn't discuss spinal fusion, which has increased six-fold in the U.S. over the last 2 decades and is done much more frequently than in Canada, Europe, Australia, and New Zealand. Spinal fusion was also absent from the North American Spine Society's top 5 list. The spine surgeons did advise against performing elective spinal injections, such as steroid injections, without imaging guidance.

What's problematic about the latter recommendation is that it doesn't specify that studies have found epidural steroid injections offer little benefit for the many patients

who have back pain without sciatica who undergo this procedure, said Richard Deyo, MD, MPH, an expert in low back pain management at Oregon Health and Science University.

"These injections have increased several hundred percent over the last 15 to 20 years, and it's hard to justify," said Deyo. Although epidural steroid injections are considered relatively safe, a 2012 outbreak of spinal meningitis caused by contaminated steroid injections underscored that rare, potentially serious complications do occur.

Similarly, the American College of Cardiology, passed over a major -- and profitable -- overused intervention: stents in patients who have stable angina.

"It's estimated from the cardiovascular data registry that 30% or possibly more of people who are getting stents are asymptomatic, and there has not been any benefit shown for cardiac stents over medical therapies in people who don't have symptoms and questionable benefit in people who do," said Rita Redberg, MD, MSc, of the University of California San Francisco (UCSF), and editor of ***JAMA Internal Medicine***.

A Bird in the Hand ...

Even though critics have appropriately pointed out that some of the societies "went easy on themselves," it's more important at this point that the profession has started to engage with the issue, said John Santa, MD, medical director, ***Consumer Reports Health.***

Santa makes the case that small steps could lead to more significant changes down the line. "It was quite the accomplishment that [the ABIM Foundation] got all those doctor associations to admit they're overusing products and services," he said.

"This is a new kind of activity for us all, and I think we're going to get better," said Daniel Wolfson, MHSA, executive vice president and chief operating officer at the ABIM Foundation. "People will be developing new lists, with better evidence, and I think there will be bolder recommendations coming down the pike."

With the campaign's clout growing, "now is the time for professional societies to be bolder in identifying common interventions that add little value to our medical care," Redberg wrote in an April editorial in ***JAMA Internal Medicine***.

Impact of Efforts

Even with a lack of boldness in some of the specialty societies' Choosing Wisely top 5 choices, emerging evidence suggests that the less-is-more movement is indeed gaining traction.

As a sign the overtreatment tide is turning, H. Gilbert Welch, MD, of Dartmouth Medical School and a long-time critic of medical overuse, points to the 2014 recommendation by health experts to raise the threshold for beginning drug treatment for hypertension from 140/90 to 150/90 for people 60 or older. "It was the first time in my career that the guideline has called for a higher threshold, so I think we are seeing the beginning of a rebalancing," Welch said.

"It's become legitimate to talk about overuse and not get accused of being a lackey for the insurance industry, an out-of-touch doctor, or -- dare I say it? -- a member of a 'death panel,'" said Santa.

A national survey of primary-care and specialist physicians commissioned for the ABIM Foundation found that nearly three in four physicians said that unnecessary tests and procedures are a serious problem and 72% said the average physician prescribes an unnecessary test or procedure at least once a week. When asked about their own practice, nearly half said patients ask for an unnecessary test or procedure at least once weekly, and 30% said they get such requests at least several times a week.

The surveyed physicians conceded that they sometimes order an unnecessary test or procedure for a host of reasons, including malpractice concerns, a desire "just to be safe" and obtain information to reassure themselves, patient insistence on a test, and not having enough time to spend with patients. Compared with physicians who didn't recall exposure to the Choosing Wisely campaign, those who did said they were less likely to suggest a "low-value" test or procedure (62% versus 45%).

Institutional Buy-In

Some academic medical centers have spearheaded initiatives that tackle specific examples of medical overuse and are seeing positive results. For example, after a team of physicians at Mount Sinai Hospital in New York launched a "Lose the Tube" campaign to address the inappropriate use of urinary catheters in five hospitalist medicine units, catheter use and associated urinary tract infection rates dropped sharply.

Although professional societies can provide leadership, as U.S. medicine moves toward paying for the quality and effectiveness of care rather than the sheer volume of services, some interventions to reduce low-value care need to be taken on at the physician group level, said Colla. "Risk-sharing and moving away from fee-for-service allow physician groups to make decisions that would work best for their group to control utilization of low-value services, through things such as clinical decision support [such as reminders embedded in an electronic health records (EHR) system], physician education, and feedback."

Some institutions are also embracing the effort and embedding the campaign's lists into clinical settings. When Christiana Care Health System in Delaware focused on reducing inappropriate use of continuous telemetry monitoring outside of intensive care units, an item on the Society of Hospital Medicine's Choosing Wisely campaign, it resulted in a 70% reduction in telemetry use overall without any negative effects on patient safety.

In a more comprehensive effort, Cedars-Sinai Health System in Los Angeles has incorporated Choosing Wisely recommendations into its electronic health records system to provide alerts to help physicians avoid ordering potentially problematic tests or treatments.

After an alert was set up to warn against use of benzodiazepines or other sedative-hypnotics in older adults as first choice for insomnia, agitation, or delirium, such use decreased 30%, said Scott Weingarten, MD, MPH, senior vice president and chief clinical transformation officer at Cedars-Sinai. (Weingarten is chairman of the board of Stanson Health, which markets the clinical decision support software being used at Cedars-Sinai.)

"Long-acting benzodiazepines can cause patients to fall, develop hip fracture, and get into motor vehicle accidents. They're actually associated with increased death," said Weingarten.

When an alert is triggered, the system displays links to citations provided by the specialty society that made the recommendation. Physicians can still override alerts if they wish,

but the process makes it more likely they will consider the information provided before reflexively issuing an order.

Reviews of medical records indicate that orders have dropped about 20% on average for items linked to soft stops (which don't require an explanation to place an order) and by about 40% for medium stops (which do require physicians to say why they are making the order), said Weingarten. So far, this reduction translates into an annualized savings of about $4 million, he said.

Each alert also links to the ***Consumer Reports*** patient information that explains why the test or procedure may not be appropriate, which the physician can share with a patient who is pressing for it. "Our hope is that physicians use this opportunity as an opportunity to talk to patients," Weingarten said.

Educating Patients

But physicians have limited time to talk with patients to help them understand that more medicine isn't necessarily better medicine, an important message in light of direct-to-consumer advertising of medical products and services that stokes consumer demand. Santa points to the hundreds of millions of advertising dollars fueling an increase in prescriptions of testosterone replacement therapy, from 1.3 million patients in 2009 to 2.3 million patients in 2013, despite warnings about the possible risk of heart attack and stroke.

Even when advertising isn't an issue, it's important to educate patients about practices that should be avoided altogether, said Harlan Krumholz, MD, SM, director of the Center for Outcome Research at Yale University School of Medicine. But, if possible, patients also need to be engaged in shared decision-making with physicians, to ensure that risks, benefits, and the patient's preference are weighed.

"For the vast majority of tests and procedures, there's a fair amount of uncertainty, and physicians often don't disclose these uncertainties," said Krumholz.

There is evidence, however, that decision aids can clarify for patients the benefits, limitations, and potential harms of tests and procedures, so they can have better-informed discussions with their physicians.

"Decision aids are a practical solution to the problem that doctors don't have enough time to get into nuances," Deyo said. "They also have an important role in the gray areas of medicine, where reasonable people might make different choices." A 2014 review of studies of decision aids found that many patients who use them are more likely to choose less-aggressive or no treatment after learning about potential benefits and risks.

Doctors in the trenches have their own ideas about what will help foster a less-is-more culture. In the ABIM Foundation's survey, 91% said malpractice reform; 85% said specific, evidence-based recommendations that a physician can use with patients; 78% said having more time with patients to discuss alternatives; and 61% said changing the system of financial rewards some physicians receive for ordering tests or procedures.

What's needed, given these various pressures, is likely to be "a multifactorial approach" to reducing low-value care, said Colla, who described a range of "supply-side" interventions (targeting healthcare providers) and "demand-side" interventions (aimed at patients) in a recent article.

Payment reform can play a substantial role in reducing low-value care, Colla added.

"Through accountable care organizations, for example, the physician group would be responsible for the total cost of care," she said. That responsibility provides an incentive to doctors to think through with patients the value of services they are providing.

Moving away from payment systems that reward volume to those that reward value -- which is what Medicare is rolling out in the post-SGR era -- may also help accelerate investment in clinical decision support linked to EHRs to reduce low-value care.

"Right now, there is no financial reason for a physician group to invest in that kind of technology," said Colla. "Risk-sharing arrangements such as accountable care organizations may create an impetus for physician organizations to put things in place like what Cedars-Sinai is doing, providing financial reasons to invest, on top of the motivation to improve quality of care."

Whatever changes are needed to move the less-is-more movement forward, the idea has staked its claim in the culture of medicine. "What's been accomplished," said Santa, "is a cultural sea change, a cultural wave around safety issues and a cultural wave about overuse."

Joan Stephenson, PhD, is an award-winning science and medical writer and editor based in Chicago. A former director of medical news for JAMA, ***she has been writing about science and medicine for newspapers, magazines, and online for more than 25 years.***

Deyo, Krumholz, Redberg, Rickert, Santa, Weingarten, and Welch showed no relevant financial payments from industry.

LAST UPDATED 05.28.2015

9 COMMENTS

MEDPAGE TODAY AT 10 SPECIAL REPORT

Progress and new goals

MEDPAGE TODAY AT 10 05.28.2015 3 COMMENTS

Patients Resist 'Less Is More,' a MedPage Today Survey

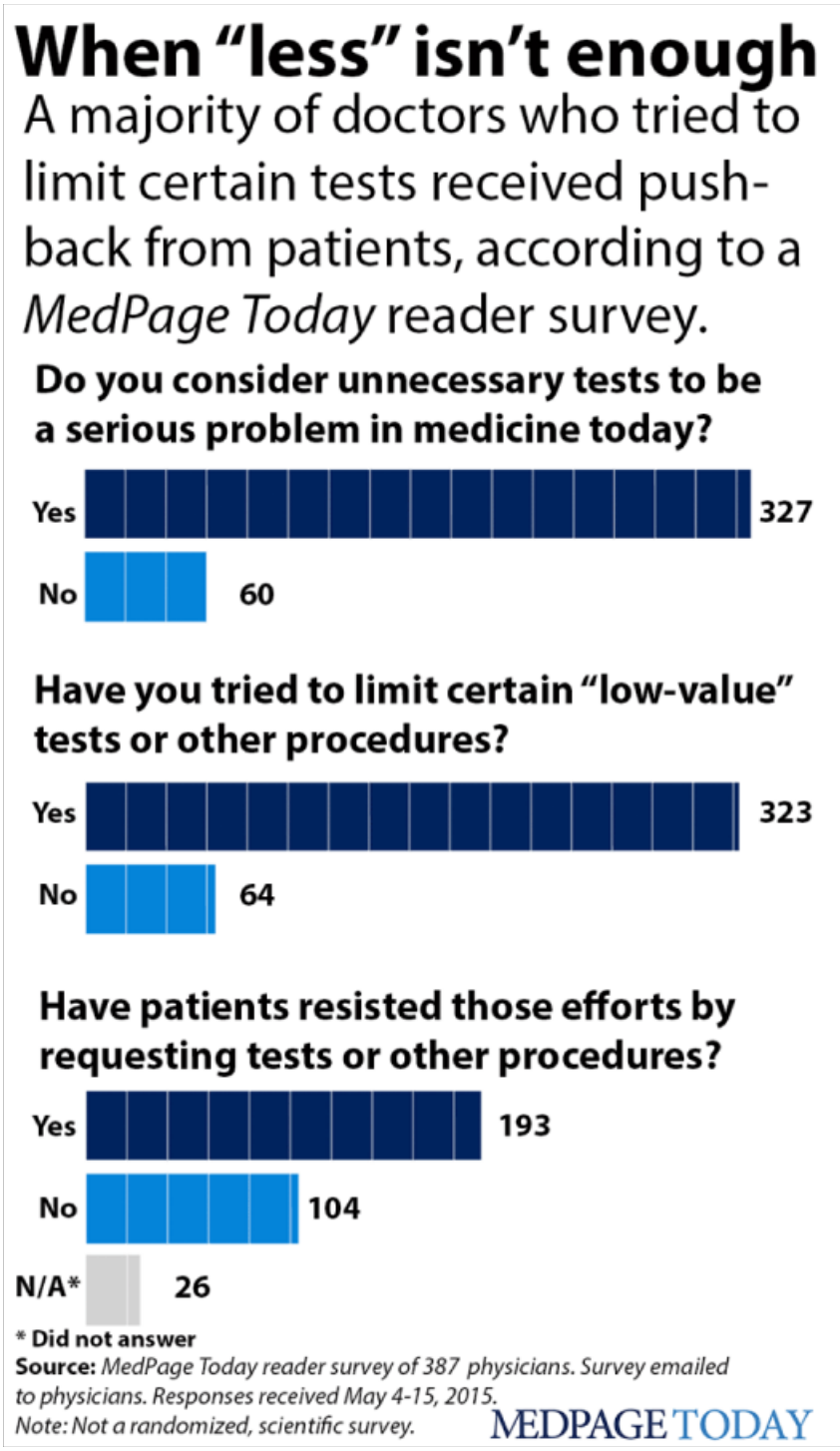
— Physicians limiting 'low-value' tests find patients need extra explanation

by Coulter Jones
MedPage Today Staff

Physicians trying a 'less is more' approach to clinical care by limiting "low-value" tests or procedures often received pushback from patients, according to a ***MedPage Today*** reader survey.

About two-thirds of the doctors surveyed said patients resisted their efforts and requested more tests or other procedures after initially being advised otherwise.

Nearly 390 doctors completed the survey, emailed to readers of ***MedPage Today*** from May 4 to 15. Although not necessarily representative of the medical community, the survey still shows how some physicans balance providing healthcare to patients who think they need certain procedures or tests.



Unnecessary testing is a serious problem in medicine, according to 85% of survey respondents. More than 80% of the physicians said they are trying to limit what they

view as "low-value" procedures. CT scans, MRIs and x-rays were the three the most common tests identified in the survey as providing low value for the costs or risk.

"I'd rather explain what is happening in my best estimation, rather than give a plethora of marginally linked tests," said Tom Bellinger, MD, of Michigan.

Bellinger, who practices family medicine said he tries to provide more explanatory workups, rather than labs. Stephanie Delbert, ARNP, a nurse practitioner in central Florida, follows similar protocol.

"They'll usually listen," she said of patients, "but sometimes I have to spend time explaining that the test likely won't show anything that I don't already know."

Knowing when a screenings are necessary can come down to experience said Michael Rothstein, MSN, FNP, who works at the New York College of Podiatric Medicine.

"I tell my students that 'you have to know when to limit so you're not doing the million-dollar workup unnecessarily," he said.

Unnecessary screenings are fairly common said John W. Thompson, MD, of Portland, Ore., who retired as an orthopedic surgeon. He also worked as an independent medical evaluator for the state of Oregon for 14 years and reviewed medical files of injured workers.

"It wasn't at all uncommon to find an injured worker who had three MRIs in the past year and no true evidence of the condition getting worse," he said. "The third wouldn't show anything different from the first one, but they still got all three."

Eric Udell, ND, M.Ed., of Tempe, Ariz., said that a push to limit certain screens has its limitations, particularly if it puts a doctor at risk for litigation.

"I think that it has become one of the major whipping posts or scapegoats and I'm not sure that's its solely deserving of that level of blame." he said. "It's a tradeoff that we have to be aware of. Simply starting to limit certain tests has tradeoffs that aren't often discussed. What about running a test for a peace of mind? You feel pretty sure that a test is not necessary, but the patient is going to continue to have some anxiety and stress about the issue until the test confirms it."

Douglas Ashinsky, MD, who practices internal medicine in New Jersey, said he thinks the "less is more" movement often oversimplifies the issue.

"Every person that I see in my office is not the same," he said. "Every one responds to different treatments, guidelines differently. Guidelines are just that -- guidelines."

Survey respondents were self-selected from ***MedPage Today***'s readership, and are not necessarily representative of all practicing physicians in the U.S. For example, more than two-thirds have practiced for at least 16 years and about 30% are in a solo practice, both of which are much higher than the general physician population. Only about 18% of physicians are in solo practice, according to the American Medical Association.

LAST UPDATED 05.28.2015

3 COMMENTS

NEXT ARTICLE