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Introducing Choosing Wisely®: Next Steps in Improving Healthcare Value

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In this issue of the Journal of Hospital Medicine, we introduce a new recurring feature, "Choosing Wisely®: Next Steps in Improving Healthcare Value," sponsored by the American Board of Internal Medicine Foundation. The Choosing Wisely® campaign is a collaborative initiative led by the American Board of Internal Medicine Foundation in which specialty societies develop priority lists of activities that physicians should question routinely doing. The program has been broadly embraced by both patient and provider stakeholder groups. More than 35 specialty societies have contributed 26 published lists, including the Society of Hospital Medicine (SHM), which published two lists, one for adults and one for pediatrics. These included suggestions such as avoiding urinary catheters for convenience or monitoring of output, avoiding stress ulcer prophylaxis for low to medium risk patients, and avoiding routine daily laboratory testing in clinically stable patients. A recent study estimated that up to $5 billion might be saved if just the primary care-related recommendations were implemented.[1]

The need for change

The Choosing Wisely campaign has so far focused primarily on identifying individual treatments that are not beneficial and potentially harmful to patients. At the Journal of Hospital Medicine, we believe the discipline of hospital medicine is well-positioned to advance the broader discussion about achieving the "triple aim": better healthcare, better health, and better value. Inpatient care represents only 7% of US health care encounters but 29% of healthcare expenditures (over $375 billion annually).[2] Patients aged 65 and over account for 41% of all hospital costs and 34% of all hospital stays. Accordingly, without a change in current utilization patterns, the aging of the baby boomer generation will have a marked impact on expenditures for hospital care. Healthcare costs are increasingly edging out discretionary Federal and municipal spending on critical services such as education and

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scientific research. Historically, Federal discretionary spending has averaged 8.3% of GDP. In 2014, it dropped to 7.2% and is projected to decline to 5.1% in 2024. By comparison, Federal spending for Medicare, Medicaid and health insurance subsidies was 2.1% in 1990[3] but in 2014 is estimated at 4.8% of GDP, rising to 5.7% by 2024.[4]

In conjunction with the deleterious consequences of unchecked growth in health care costs on national fiscal health, hospitals are feeling intense and increasing pressure to improve quality and value. In fiscal year 2015, hospitals will be at risk for up to 5.5% of Medicare payments under the parameters of the Hospital Readmission Reduction Program (maximum penalty 3% of base DRG payments), Value-Based Purchasing (maximum withholding 1.5% of base DRG payments), and the Hospital Acquired Conditions Program (maximum penalty 1% of all payments). Simultaneously, long-standing subsidies are being phased out, including payments to teaching hospitals or for disproportionate share of care delivered to uninsured populations. The challenge for hospital medicine will be to take a leadership role in defining national priorities for change, organizing and guiding a pivot towards lower-intensity care settings and services, and most importantly, promoting innovation in hospital-based healthcare delivery.

Existing innovations

The passage of the Affordable Care Act gave the Centers for Medicare & Medicaid Services (CMS) a platform for spurring innovation in healthcare delivery. In addition to deploying the payment penalty programs described above, the CMS Center for Medicare & Medicaid Innovation has a $10 billion budget to test alternate models of care. Demonstration projects to date include Accountable Care Organization pilots (ACOs, encouraging hospitals to join with community clinicians to provide integrated and coordinated care), the Bundled Payment program (paying providers a lump fee for an extended episode of care rather than service volume), a Comprehensive End Stage Renal Disease Care Initiative, and a variety of other tests of novel delivery and payment models that directly involve hospital medicine.[5] Private insurers are following suit, with an increasing proportion of hospital contracts involving shared savings or risk.

Hospitals are already responding to this new era of cost sharing and cross-continuum accountability in a variety of creative ways. The University of Utah has developed an award-winning cost accounting system that integrates highly detailed patient-level cost data with clinical information to create a “value driven outcomes” tool that enables the hospital to consider costs as they relate to the results of care delivery. In this way the hospital can justify maintaining high cost/better outcome activities, while targeting high cost/worse outcome practices for improvement.[6] Boston Children’s Hospital is leading a group of healthcare systems in the development and application of a series of Standardized Clinical Assessment and Management Plans (SCAMPs), designed to improve patient care while decreasing unnecessary utilization (particularly in cases where existing evidence or guidelines are insufficient or outdated). Unlike traditional clinical care pathways or clinical guidelines, SCAMPs are developed iteratively based on actual internal practices, especially deviations from the standard plan, and their relationship to outcomes.[7,8]

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Local innovations, however, are of limited national importance in "bending the cost curve" unless broadly disseminated. The last decade has brought a new degree of cross-institution collaboration to hospital care. Regional consortiums to improve care have existed for years, often prompted by CMS-funded Quality Improvement Organizations and demonstration projects.[9,10] CMS's Partnership for Patients program has aimed to reduce hospital-acquired conditions and readmissions by enrolling hospitals in 26 regional Hospital Engagement Networks.[11] Increasingly, however, hospitals are voluntarily engaging in collaboratives to improve the quality and value of their care. Over 500 US hospitals participate in the American College of Surgeons National Surgical Quality Improvement Program to improve surgical outcomes, nearly 1,000 joined the Door-to-Balloon Alliance to improve percutaneous catheterization outcomes, and over 1,000 joined the Hospital2Home collaborative to improve care transitions.[12–14] In 2008, the Premier hospital alliance formed QUEST, a collaborative of approximately 350 members committed to improving a wide range of outcomes, from cost and efficiency to safety and mortality. Most recently, the High Value Healthcare Collaborative was formed, encompassing 19 large health care delivery organizations and over 70 million patients, with the central objective of creating a true learning healthcare system. In principle, these boundary-spanning collaboratives should accelerate change nationally and serve as transformational agents. In practice, outcomes from these efforts have been variable, largely depending on the degree to which hospitals are able to share data, evaluate outcomes and identify generalizable improvement interventions that can be reliably adopted.

Lastly, the focus of hospital care has already begun to extend beyond inpatient care. Hospitals already care for more outpatients than they do inpatients, and that trend is expected to continue. In 2012 hospitals treated 34.4 million inpatient admissions, but cared for nearly 675 million outpatient visits, only a fraction of which were emergency department visits or observation stays. From 2011 to 2012, outpatient visits to hospitals increased 2.9%, while inpatient admissions declined 1.2%.[15] Hospitals are buying up outpatient practices, creating infusion centers to provide intravenous-based therapy to outpatients, establishing post-discharge clinics to transition their discharged patients, chartering their own visiting nurse agencies, and testing a host of other outpatient-focused activities. Combined with an enhanced focus on post-acute transitions following an inpatient admission as part of the care continuum, this broadening reach of "hospital" medicine brings a host of new opportunities for innovation in care delivery and payment models.

Choosing Wisely®: Next Steps in Improving Healthcare Value

This series will consider a wide range of ways in which hospital medicine can help drive improvements in healthcare value, both from a conceptual standpoint (*what to do and why?*), as well as demonstration of practical application of these principles (*how?*). A companion series, Choosing Wisely®: Things We Do For No Reason, will focus more explicitly on services such as blood transfusions or diagnostic tests such as creatinine kinase that are commonly overutilized. Example topics of interest for Next Steps include:

- Best methodologies for improvement science in hospital settings, including Lean healthcare, behavioral economics, human factors engineering.

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- Strategies for reconciling system-level standardization with the delivery of personalized, patient-centered care.
- Impacts of national policies on hospital-based improvement efforts: how do ACOs, bundled payments and medical homes alter hospital practice?
- Reports on creative new ideas to help achieve value: changes in clinical workflow or care pathways, radical physical plant redesign, electronic medical record innovations, payment incentives, provider accountability and more.
- Results of models that move the reach of hospital medicine "beyond the walls" as an integrated part of the care continuum.

We also welcome unsolicited proposals for series topics, submitted as a 500 word precis to: nextsteps@jhm.org.

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