«SMARTER MEDICINE» : QUO VADIS ?

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Prof. Dr. Jean-Michel Gaspoz

Département de Médecine communautaire, de premier recours et des urgences.

Co-président de la Société Suisse de Médecine Interne Générale
1. In 2009, harsh debates in the USA concerning the Health Care Reform « Patient Affordable Care Act » from Barack Obama.

2. Insurance companies, pharmaceutical manufacturers, medical device makers, hospitals: agreed to forego some future profits to show support for the reform efforts.

3. Medical societies: scepticism; refused to contemplate any measure they could take.
4. Proposition from Howard Brody in the NEJM that each medical society sets up a « Top-five list » of tests, or treatments that are often prescribed, that are among the most expensive services provided, and that have been shown by the current available evidence not to provide any meaningful benefit for at least some major categories of patients for whom they are commonly ordered.
What came next: (1)

1. The American Board of Internal Medicine Foundation (ABIM) mandates and finances the National Physicians Alliance (NPA) [22’000 members, from all medical specialties and all states] to establish Top5 lists in:

- Family Medicine
- General Internal Medicine
- Pediatrics
The “Top 5” Lists in Primary Care

Meeting the Responsibility of Professionalism

The Good Stewardship Working Group

Top 5 List in Family Medicine

1. Don't do imaging for low back pain within the first 6 weeks unless red flags* are present
   - Imaging of the lumbar spine before 6 weeks does not improve outcomes but does increase costs
   - Low back pain is the fifth most common reason for all physician visits
   * Red flags include but are not limited to severe or progressive neurological deficits or when serious underlying conditions such as osteomyelitis are suspected
   Sources: AHCPR and Cochrane

2. Don't routinely prescribe antibiotics for acute mild to moderate sinusitis unless symptoms (which must include purulent nasal secretions AND maxillary pain or facial or dental tenderness to percussion) last for 7 or more days OR symptoms worsen after initial clinical improvement
   - Most maxillary sinusitis in the ambulatory setting is due to a viral infection that will resolve on its own
   - Despite consistent recommendations to the contrary, antibiotics are prescribed in over 80% of outpatient visits for acute sinusitis
   - Sinusitis accounts for 16 million office visits and $5.8 billion in annual healthcare costs
   Source: Cochrane and Ann IM

3. Don't order annual ECGs or any other cardiac screening for asymptomatic, low-risk patients
   - Little evidence that detection of coronary artery stenosis in asymptomatic patients at low risk for coronary heart disease improves health outcomes
   - False-positive tests are likely to lead to harm through unnecessary invasive procedures, over-treatment, and misdiagnosis
   - Potential harms of this routine annual screening exceed the potential benefit
   Source: USPSTF

4. Don't perform Pap tests on patients younger than 21 years or in women status post hysterectomy for benign disease
   - Most dysplasia in adolescents regresses spontaneously; therefore, screening Pap tests done in this age group can lead to unnecessary anxiety, morbidity, and cost
   - Pap tests have low yield in women after hysterectomy (for benign disease), and there is poor evidence for improved outcomes
   Sources: ACOG (for age), USPSTF (for hysterectomy)

5. Don't use DEXA screening for osteoporosis in women under age 65 years or men under 70 years with no risk factors*
   - Not cost-effective in younger, low-risk patients, but cost-effective in older patients
   * Risk factors include but are not limited to fractures after age 50 years, prolonged exposure to corticosteroids, diet deficient in calcium or vitamin D, cigarette smoking, alcoholism, thin and small build
   Sources: NOF, USPSTF, AACE, ACPM
Next steps:

1. Distribution of the Top5 lists to all physicians in their respective disciplines.

2. Distribution of videos to help physicians to gain their patients’ understanding and support, by learning the communication skills necessary to enlist patient partnership.

3. Close contacts between the NPA and the patient and consumer organizations.

4. Evaluation of the impact.
The Impact?

In the USA:

- 1/3 of health care costs could be avoided if physicians practicing in States with high medical costs would ordered tests and treatments along the same lines as physicians practising in States with low medical costs.

- Physicians who practice in States with low medical costs tend to order less non-evidence based tests or treatments.

« Physicians, not the government, could take the lead in identifying the waste to be eliminated. »

Can physicians take this lead?
Views of US Physicians About Controlling Health Care Costs

Jon C. Tilburt, MD, MPH; Matthew K. Wynia, MD, MPH; Robert D. Sheeler, MD; Bjorg Thorsteinsdottir, MD; Katherine M. James, MPH; Jason S. Egginton, MPH; Mark Liebow, MD, MPH; Samia Hurst, MD; Marion Danis, MD, MPH; Susan Dorr Goold, MD, MHSA, MA
**OBJECTIVE**  To assess physicians’ attitudes toward and perceived role in addressing health care costs.

**DESIGN, SETTING, AND PARTICIPANTS**  A cross-sectional survey mailed in 2012 to 3897 US physicians randomly selected from the AMA Masterfile.

**MAIN OUTCOMES AND MEASURES**  Enthusiasm for 17 cost-containment strategies and agreement with an 11-measure cost-consciousness scale.
Table 3. Self-reported Responsibility and Enthusiasm for Various Means of Reducing Health Care Costs Among 2556 US Physician Survey Respondents

<table>
<thead>
<tr>
<th>Entities with potential responsibility to reduce cost of health care</th>
<th>No. (%)&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Major Responsibility</td>
</tr>
<tr>
<td>Trial lawyers (n = 2433)</td>
<td>1449 (60)</td>
</tr>
<tr>
<td>Health insurance companies (n = 2446)</td>
<td>1439 (59)</td>
</tr>
<tr>
<td>Pharmaceutical and device manufacturers (n = 2445)</td>
<td>1377 (56)</td>
</tr>
<tr>
<td>Hospitals and health systems (n = 2439)</td>
<td>1373 (56)</td>
</tr>
<tr>
<td>Patients (n = 2439)</td>
<td>1265 (52)</td>
</tr>
<tr>
<td>Government (n = 2440)</td>
<td>1073 (44)</td>
</tr>
<tr>
<td>Individual practicing physicians (n = 2438)</td>
<td>889 (36)</td>
</tr>
<tr>
<td>Physician professional societies (n = 2433)</td>
<td>667 (27)</td>
</tr>
<tr>
<td>Employers (n = 2429)</td>
<td>457 (19)</td>
</tr>
<tr>
<td>Statement</td>
<td>Strongly Agree</td>
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<td>--------------------------------------------------------------------------</td>
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<tr>
<td>I am aware of the costs of the tests/treatments I recommend (n = 2446)</td>
<td>556 (23)</td>
</tr>
<tr>
<td>I try not to think about the cost to the health care system when making</td>
<td>265 (11)</td>
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<tr>
<td>treatment decisions (n = 2449)</td>
<td></td>
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<tr>
<td>I should sometimes deny beneficial but costly services to certain</td>
<td>61 (3)</td>
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<td>patients because resources should go to other patients that need them</td>
<td></td>
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<tr>
<td>more (n = 2428)</td>
<td></td>
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<tr>
<td>Cost to society is important in my decisions to use or not to use an</td>
<td>268 (11)</td>
</tr>
<tr>
<td>intervention (n = 2439)</td>
<td></td>
</tr>
<tr>
<td>**Physicians should adhere to clinical guidelines that discourage the</td>
<td>807 (33)</td>
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<td>use of interventions that have a small proven advantage over standard</td>
<td></td>
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<td>interventions but cost much more (n = 2434)</td>
<td></td>
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<tr>
<td>The cost of a test or medication is only important if the patient has</td>
<td>81 (3)</td>
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<tr>
<td>to pay for it out of pocket (n = 2449)</td>
<td></td>
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<tr>
<td>Doctors are too busy to worry about costs of tests and procedures (n</td>
<td>138 (6)</td>
</tr>
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<td>= 2451)</td>
<td></td>
</tr>
<tr>
<td>Trying to contain costs is the responsibility of every physician (n =</td>
<td>900 (37)</td>
</tr>
<tr>
<td>2442)</td>
<td></td>
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<tr>
<td>There is currently too much emphasis on costs of tests and procedures</td>
<td>244 (10)</td>
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<td>(n = 2437)</td>
<td></td>
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<tr>
<td>Doctors need to take a more prominent role in limiting use of separate</td>
<td>1016 (42)</td>
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<td>tests (n = 2442)</td>
<td></td>
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<td>It is unfair to ask physicians to be cost-conscious and still keep the</td>
<td>339 (14)</td>
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<td>welfare of their patients foremost in their minds (n = 2439)</td>
<td></td>
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<tr>
<td>I should be solely devoted to my individual patients’ best interests,</td>
<td>927 (38)</td>
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<td>even if that is expensive (n = 2438)</td>
<td></td>
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<tr>
<td>Decision support tools that show costs would be helpful in my practice</td>
<td>483 (20)</td>
</tr>
<tr>
<td>(n = 2461)</td>
<td></td>
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<td>Barriers to and consequences of cost-conscious practice</td>
<td></td>
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<tr>
<td>I find the uncertainty involved in patient care disconcerting (n = 2449)</td>
<td>362 (15)</td>
</tr>
<tr>
<td>I generally order more tests when I don’t know the patient well (n =</td>
<td>185 (8)</td>
</tr>
<tr>
<td>2463)</td>
<td></td>
</tr>
</tbody>
</table>
CONCLUSION AND RELEVANCE  In this survey about health care cost containment, US physicians reported having some responsibility to address health care costs in their practice and expressed general agreement about several quality initiatives to reduce cost but reported less enthusiasm for cost containment involving changes in payment models.
Physicians agree that health care is overused

- Survey of primary care physicians
- 42% believe patients in their own practice are receiving too much care vs. 6% who say “too little”
- Perceived factors leading to overuse
  - Malpractice concerns: 76%
  - Clinical performance measures: 52%
  - Inadequate time to spend with patients: 40%

*Arch Intern Med.* 2011; 171:1582-1585
American College of Physicians
www.choosingwisely.org
How can physicians and patients have the important conversations necessary to ensure the right care is delivered at the right time? *Choosing Wisely®* aims to answer that question.

An initiative of the ABIM Foundation, *Choosing Wisely* is focused on encouraging physicians, patients and other health care stakeholders to think and talk about medical tests and procedures that may be unnecessary, and in some instances can cause harm.

To spark these conversations, nine specialty societies created lists of "Five Things Physicians and Patients Should Question" — evidence-based recommendations that should be discussed to help make wise decisions about the most appropriate care based on a patients’ individual situation.

Consumer Reports will be developing and disseminating materials to patients through large consumer groups to help patients engage their physicians in these conversations and ask questions about what tests and procedures are right for them.

Several more specialty societies have joined the campaign and will be unveiling their lists of "Five Things Physicians and Patients Should Question" in fall 2012.
Partners:

ABIM Foundation
Allergy Asthma & Immunology (AAAA-I)
American Academy of Family Physicians
American College of Cardiology (ACC)
American College of Physicians (ACP)
American College of Radiology (ACR)
American Society of Oncology (ASC)
American Gastroenterology Association (AGA)
American Society of Nephrology (ASN)
American Society of Nuclear Cardiology
ConsumerReportsHealth
National Physicians Alliance
American Society of Hospice and Palliative Medicine (AAHPM)
American Society of Neurology
American Society of Otolaryngology – Head and Neck Surgery
American Society of Obstetricians and Gynecologists
American College of Rheumatology
American Geriatrics Society (AGS)
American Society for Clinical Pathology
American Society of Echocardiography
American Urological Association
Society of Hospital Medicine (SHM)
Society of Nuclear Medicine and Molecular Imaging
For patients, Consumer Reports and the medical societies developed summaries of the lists including:

When do you need antibiotics for sinusitis? (American Academy of Asthma, Allergy and Immunology)
Bone-density tests: When you need them and when you don't (American Academy of Family Physicians)
When do you need a Pap test? (American Academy of Family Physicians)
When do you need imaging tests for lower back pain? (American Academy of Family Physicians)
When do you need antibiotics for sinusitis? (American Academy of Family Physicians)
When do you need an imaging test for a headache? (American College of Radiology)
How should you treat heartburn and GERD? (American Gastroenterological Association)
Can we do it in Switzerland?
Yes, we can!
En médecine, moins peut aussi être plus
Un bilan radiologique chez un patient avec des douleurs lombaires non-spécifiques depuis moins de 6 semaines.

Le dosage du PSA pour dépister le cancer de la prostate sans en discuter les risques et bénéfices avec le patient.

La prescription d'antibiotiques en cas d'infection des voies aériennes supérieures sans signe de gravité.

Une radiographie du thorax dans le bilan préopératoire en l'absence de suspicion de pathologie thoracique.

La poursuite à long terme d'un traitement d'inhibiteurs de la pompe à proton pour des symptômes gastro-intestinaux sans utiliser la plus faible dose efficace.
Nest steps of “Smarter medicine”

Information to Swiss physicians through Swiss professional journals

Residents training

Public campaign
Top-5 Recommendations

"SMARTER MEDICINE IN THE HOSPITAL"

Annual Congress SGAIM
Basel, May 25th 2016
Smarter Medicine in the Hospital
Objectives

- Generate a list of 5 low-value interventions which, according to the available evidence, may not provide any meaningful benefit and may carry the risk of generating harms.

- Publish & distribute this list to discourage the use of these interventions.

- Implement “Smarter Medicine in the Hospital” in medical education and practice to contribute to the efforts of fostering better patient quality of care.
Top-5-list

The Swiss Society of General Internal Medicine recommends this Top-5 interventions to be avoided in hospital care:

1. Don’t order blood tests at regular intervals (such as every day) or routine extensive lab panels including X-rays without specific clinical questions.

2. Don’t place, or leave in place, urinary catheters for incontinence, convenience or monitoring of output for non-critically ill patients.

3. Don’t transfuse more than the minimum number of red blood (RBC) units necessary to relieve symptoms of anemia or to return a patient to a safe haemoglobin range.

4. Don’t let older adults lie in bed during their hospital stay. In addition, individual therapeutic goals should be established considering the patients’ values and preferences.

5. Don’t use benzodiazepines or other sedative-hypnotics in older adults as first choice for insomnia, agitation or delirium and avoid prescription at discharge.
Smarter medicine et vous
Recommandations « Top 5 » de la Société Suisse de Médecine Interne Générale

Kevin Selby; Jacques Cormiz; Christine Cohidon; Nicolas Seem; Jean-Michel Gaspoz
143 général internists chosen at random in 2015-16 (SPAM):

• 58% knew about « Smarter Medicine ». (USA: 38%)
• Agreement with the list : 8,8 – 9,1 /10
• % of physician following the list:
  – 75 % for AB in IVRS; chest X ray
  – 70 % for spine imaging
  – 50% for PSA
  – 37 % for proton pump inhibitors
Is it enough ?
NICE:

1. Since 1999, the National Institute for Health and Clinical Excellence (NICE) supports the NHS by identifying « low values activities » that can be stopped », b/c of:

- Not clinically effective
- Poor risk-benefit profile
- Not supported by adequate evidence.
2. Mandatory aspect: local NHS bodies must fund technologies that NICE has approved within 3 months.

3. 2005. Chief medical officer and 2006 Health Minister: NICE should be asked to issue guidance to the NHS on desinvestment.
5. Controversies. NICE concluded that a designated technology appraisal programme was not warranted: few identifiable candidates for total desinvestment; lack of national usage data.

6. « Not to do » recommendations and clinical guidelines: best way to identify candidates for desinvestment.
Lessons from NICE:

• Too much political, technocratic or administrative pressure may endanger strategies aimed at reducing unnecessary medical tests or procedures;

• Too strict rules or regulations systematically trigger important controversies and oppositions.
• It unlikely that they would be accepted and significantly reduce health care costs.

• By contrast, opinion leaders, whether physicians, academic leaders, or ethicists, may make a difference. Nobody will ever forget the editorials of Howard Brody in the New England Journal of Medicine.
Conclusions:

Only intense networking integrating all stakeholders (patients, physicians, politicians, insurers and the media) will be able to disseminate the message that medical tests or treatments that do not provide any meaningful benefit to patients and that may carry the risk of generating harms and unnecessary costs should be abandoned.
Agenda:

• That patients receive « the right care, at the right time, in the right way ».

• This is the main objective of continuing the « Smarter Medicine » campaign in Switzeland, together with the Swiss Academy of Medical Sciences.