

EDITORIALS

Focusing on Value: This Time Is Different

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Over the last 30 years, rounds of therapeutic treatments with cost consciousness and cost containment have been administered to the healthcare industry, with generally disappointing clinical response. The last treatment cycle came in the 1990s, with the combination therapy of prospective payment and managed care, treatments that produced a transient remission in cost inflation but that left the healthcare system spent and decidedly unenthusiastic about another round of intensive therapy. For the next 15 years or so, the underlying conditions remained untreated, and unsurprisingly, runaway healthcare inflation returned. To continue this metaphor only a bit further, in 2013 the healthcare system is again facing intensive treatments, but in this case the treatments seem more likely to produce a strong and durable clinical response.

Although some argue that current efforts shall also pass, we believe that the present day is clearly different. A major difference is the implementation of the Affordable Care Act, which creates new structures to facilitate and incentives to promote cost reductions. More importantly, there has been a sea change in how the public—not just payors or employers—view healthcare costs. The ideas that care is too expensive and that much of it adds no value to patients have gained wide acceptance across the political spectrum, among patients, and increasingly among physicians.

It was in this context that the American Board of Internal Medicine Foundation (ABIMF) launched its Choosing Wisely campaign in 2011.¹ The stated goal of the campaign was to promote “important conversations [between doctors and patients] necessary to ensure the right care is delivered at the right time.” Importantly, this careful framing successfully avoided the caricatures of “rationing” or “death panels,” reactions that doomed prior efforts to engage all stakeholders in a reasoned national dialogue about costs and value.

The ABIMF chose an approach of having physicians identify tests and procedures that may be unnecessary in certain situations. Working with Consumer Reports, the Foundation asked a wide range of medical specialty societies to develop their own list of tests and procedures that could potentially be avoided with no harm to patients. The vast majority, 25 as of July 2013, chose to participate.

In February 2013, the Society of Hospital Medicine (SHM) joined the initiative when it posted adult and pediatric versions of “Five Things Physicians and Patients Should Question.”² We are pleased to publish summaries of the recommendations and the processes by which the 2 working groups produced their lists in the *Journal of Hospital Medicine*.^{3,4}

In reading these articles, we are struck by the importance of the SHM’s work to reduce costs and improve value. However, it really is a first step: both articles must now catalyze a body of work to create and sustain meaningful change.

Although many of the 10 targets have strong face validity, it is not clear whether they are in fact the most common, costly, or low-value practices under the purview of hospitalists. Given the fact that the selection process involved both evidence-based reviews and consensus, it is possible that other, potentially more contentious, practices may provide even more bang for the buck, or in this case, nonbuck.

Nevertheless, these are quibbles. These lists are good starting points, and in fact many hospitalist groups, including our own, are using the SHM practices as a foundation for our waste-reduction efforts. The next challenge will be translating these recommendations into actionable measures and then clinical practice. For example, 1 of the adult recommendations is to avoid repeat blood counts and chemistries in patients who are clinically stable. Concepts of clinical stability are notoriously difficult to define within specific patient subgroups, much less across the diverse patient populations seen by hospitalists. One approach here would be to narrow the focus (eg, do not order repeated blood counts in patients with gastrointestinal bleeding whose labs have been stable for 48 hours), but this step would limit the cost savings. Other measures, such as those related to urinary catheters, are more clearly defined and seem closer to being widely adoptable.

For all these measures, the ultimate question remains: How much can actually be saved and how

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Received: July 2, 2013; Accepted: July 2, 2013
2013 Society of Hospital Medicine DOI 10.1002/jhm.2075
Published online in Wiley Online Library (Wileyonlinelibrary.com).

do we measure the savings? The marginal cost of a complete blood count is extraordinarily small in comparison to an entire hospital stay, but it is possible that eliminating redundant testing also reduces the costs related to follow-up of false positive findings. Reducing the use of urinary catheters can cut the costs of urinary tract infections and the complications of treatment, but these costs could be offset by the higher-level nursing care needed to mobilize patients earlier or assist patients in toileting, squeezing the proverbial balloon. For all these measures, it is unclear whether what might be relatively small variable cost reductions related to specific tests/procedures can lead to subsequent reduction in fixed costs related to facilities and equipment, where more than 70% of healthcare costs lie.⁵ In other words, reducing the number of lab technicians and the amount of laboratory equipment needed will lead to far greater cost reductions than reducing individual test utilization.

None of this is to say that the Choosing Wisely campaign is without merit. To the contrary, the campaign and the efforts of the SHM are early and critical steps in changing the behavior of a profession. Since the early days of hospital medicine, hospitalists have

embraced cost reduction and value improvement as a central focus. By successfully engaging consumers and the community of medical specialties, Choosing Wisely has created a language and a framework that will allow our field and others to tackle the crucial work of resource stewardship with new purpose, and we hope, unprecedented success.

Disclosures: Dr. Wachter is immediate past-chair of the American Board of Internal Medicine (ABIM) and serves on the ABIM Foundation's Board of Trustees. Dr. Auerbach receives honoraria from the American Board of Internal Medicine as a contributor to the Maintenance of Certification question pool.

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