Don't-Do Lists Aim to Improve Care, Cut Costs

BY ALICIA AULT

FROM ARCHIVES OF INTERNAL MEDICINE

Research among primary care physicians has outlined "Top 5" practices to avoid in order to deliver better quality, more cost-effective medical care.

For internists and family physicians, the top item on the not-to-do list: Don't do imaging for low-back pain within the first 6 weeks unless red flags are present. For pediatricians, the top quality-promoting, cost-reducing activity is: Don't prescribe antibiotics for pharyngitis unless the patient tests positive for streptococcus.

Working groups convened by the nonprofit National Physicians Alliance sought to find evidence-based activities that were common in primary care. To be included on the top 5 lists, the activities had to lead to significant health benefits, as well as reduce harms to patients and cut health care costs.

The top 5 practices that should be adopted by internists include:

▶ Don't do imaging for low-back pain within the first 6 weeks unless red flags are present.

▶ Don't obtain blood chemistry panels or urinalyses for screening in asymptomatic, healthy adults.

▶ Don't order annual electrocardiograms (ECG) or any other cardiac screening tests for asymptomatic, low-risk adults.

▶ Use only generic statins when initiating lipid-lowering drug therapy.

▶ Don't use dual-energy x-ray absorptiometry (DEXA) screening for osteoporosis in women under age 65 years or men under 70 years with no risk factors.

The top 5 not-to-do list for family physicians is similar, but not identical, and includes:

Endorsements from patient advocacy and patient safety groups could 'help dispel the misconception that these clinical recommendations represent rationing.'

▶ Don't do imaging for low-back pain within the first 6 weeks unless red flags are present.

▶ Don't routinely prescribe antibiotics for acute mild to moderate sinusitis unless symptoms last for 7 days or more or symptoms worsen after initial clinical improvement

▶ Don't order annual ECG or any other cardiac screening for asymptomatic, low-risk adults.

▶ Don't perform Pap tests on patients younger than 21 years or in women status post hysterectomy for benign disease.

▶ Don't use DEXA screening for osteoporosis in women under age 65 years or men under 70 years with no risk factors.

For pediatricians, the top 5 quality-improving activities include:

▶ Don't prescribe antibiotics for pharyngitis unless the patient tests positive for streptococcus.

▶ Don't obtain diagnostic images for minor head injuries without loss of consciousness or other risk factors.

▶ Don't refer otitis media with effusion early in its course.

▶ Advise patients not to use cough and cold medications.

▶ Use inhaled corticosteroids to control asthma appropriately.

Consensus lists were drawn up by working group members and tested initially with 83 NPA physicians who rated the activity based on how often they engaged in the activity in their practice, its impact on quality of care and cost, the strength of the evidence supporting the activity, and how easy or hard it was to eliminate from their practice.

Field testing then was expanded through an invitation to all NPA members. There were 172 testers in the second round, all of whom completed the same surveys as the initial testers.

Field testing showed support for the evidence that backed the recommendations, and the ease with which they could be implemented, according to the study's authors in the Good Stewardship Working Group. However, they pointed out, field testing physicians might not be representative of all internists, family physicians, and pediatricians.

The authors pointed out that although the groups worked independently, several activities to avoid appeared on more than one list. "This commonality across specialties reinforced the importance and relevance of addressing overuse of these activities," the authors said (Arch. Intern. Med. 2011[doi: 10.1001/archinternmed.2011.231]).

The NPA plans to distribute the top 5 lists to all its members who are internists, family physicians, and pediatricians. The organization also plans to create a virtual practice community to help members implement the recommendations. And it says it will create a training video that will teach physicians how to enlist their patients' support for the recommendations; another video will be created specifically to explain to patients the rationale behind the lists.

The NPA plans to seek endorsements from patient advocacy and patient safety groups to "help dispel the misconception that these clinical recommendations represent rationing and support the idea that often less is truly more."

The project was funded by a grant from the American Board of Internal Medicine Foundation. ■

Enrollment Lags for Pre-Existing Condition Insurance Plan

BY ALICIA AULT

A federal program to help people with pre-existing conditions obtain health insurance has lagged in terms of the government's projected enrollment, which may be partly because it has largely gone unnoticed as one of the benefits of the health reform law.

The Pre-Existing Condition Insurance Plan (PCIP) was launched in July 2010 with $5 billion in funding from the Affordable Care Act. The goal is to provide an insurance option to people who may be barred from coverage or who have to pay huge surcharges because of a pre-existing condition such as hypercholesterolemia or cancer. The program will be in force until 2014, when the new insurance exchanges go into effect and insurers are prohibited from denying coverage to adults with pre-existing conditions.

Although the Department of Health and Human Services initially estimated that several hundred thousand people might benefit from the PCIP, as of early May only about 18,000 people had enrolled, according to the government's statistics.

In an interview, Richard Popper, director of insurance programs at the federal Center for Consumer Information and Insurance Oversight, would not comment on the number of enrollees. But he said that enrollment had been strongest in states with higher populations, such as Texas, California, Pennsylvania, and Illinois.

A "significant number" of patients with cancer, coronary artery disease, chronic obstructive pulmonary disease, and digestive system problems have accessed the program, he said. The average person who has enrolled has annual medical costs of $20,000 a year, he said.

To be eligible for the PCIP, an individual must have been without insurance for 6 months before enrollment. Mr. Popper said that because he was not working for DHHS at the time the Affordable Care Act was developed, he couldn't comment on the waiting period.

After that, the program varies according to whether it is administered by a state or the federal government, although there are minimum coverage criteria. Twenty-three states and the District of Columbia went with a federally run PCIP program, which is essentially the same as Blue Cross/Blue Shield's plan for federal employees. Twenty-seven states run their own programs.

Patients can apply at the federal government's website (www.pcip.gov). They must prove that they have been denied insurance and have a pre-existing condition. That can be accomplished through a letter of denial from an insurer, said Mr. Popper.

In all cases, the patient gets coverage immediately. There is no waiting period, and premiums will be the same as for a healthy person in the same age range.

At a meeting of the Association of Community Cancer Centers in March, Mr. Popper cited figures for the plan in Texas, which has a program that is operated by the federal government. For standard coverage, individuals could expect to pay from $174 to $557 monthly, depending on age, with a $2,000 deductible for medical care and a $500 deductible for medications. Higher benefit plans run $234-$749 for premiums, with $1,000 and $250 deductibles, respectively. There is also a health savings account option, with premiums of $181-$578 and a $2,500 deductible.

The out-of-pocket maximum that patients would pay under all plans is $5,950. There is no lifetime limit and no limit on physician visits or prescription drugs.

Relief in Rhode Island

At least one couple – Don and Renee Eddie of Rhode Island – has been thrilled to have stumbled upon the PCIP. The couple had been trying to stay insured over the last 6 years or so, through a patchwork of plans. They also have a son who is disabled.

Initially, they had family coverage through her teaching job, but after a series of back surgeries left her unable to work in 2004, she lost the coverage along with the job. Mr. Eddie had coverage through his workplace, Electric Boat, and when he retired in 2006, the Eddies elected a family plan through the company. But the premiums were $1,299 a month. "We did that for 18 months, and it was draining us," said Ms. Eddie in an interview.

They found a discount insurance program; the premiums were cheap at $300 a month, but the coverage was paltry. After being left with a $587 bill for a blood test, the family decided to drop the plan. And then, in April 2010, Mr. Eddie complained of chest pain and was taken to the emergency department. Shortly thereafter he had two stents inserted and spent 4 days in intensive care. The bill came to $92,000.

Ms. Eddie went back to trying to find an affordable insurance plan for Mr. Eddie. A few months later, she read about the PCIP in an article in the Providence Journal.

Ms. Eddie applied, and in October her husband got coverage for $519 a month through Blue Cross of Rhode Island. The state runs its own plan, which has a $1,000 deductible. Mr. Eddie's premiums have risen this year, as he just turned 60, but they are still a relatively affordable $567, said Ms. Eddie.

His prescriptions, which include Plavix, simvastatin, and Crestor, are relatively affordable also, she said. The best part of the plan, according to Ms. Eddie, is the monthly call from a Blue Cross nurse coordinator to offer tips and to monitor his care. "It's the first time we've had anything like that, so that's a very nice component," said Ms. Eddie. ■