Assessing When to Scale Back or Stop Unnecessary Routine Medical Services

Mandi L. Klamerus, Timothy P. Hofer, Adam A. Markovitz, Tanner J. Caverly, Jeremy B. Sussman, Sameer D. Saini, Lillian Min, Steven J. Bernstein, Roger Chou, Shannon E. Lohman, Whit Froehlich, David E. Goodrich, Sarah Skurla, Eve A. Kerr

VA CCMR — VA Center for Clinical Management Research

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION — UNIVERSITY OF MICHIGAN

Study Objective

To develop a systematic approach for identifying and validating recommendations for stopping or scaling back (de-intensifying) routine tests or treatments.

Background

- Providing appropriate health care means ensuring that patients get the care they need while avoiding care that is unnecessary or harmful
- Recommendations in current guidelines primarily focus on intensifying medical services
- Recommendations focusing on de-intensifying are needed to complement the many recommendations focusing on intensifying medical services

Methods

Step 1: Conduct an environmental scan of high-quality guidelines (from selected specialty societies and USPSTF) & Choosing Wisely recommendations to identify candidate de-intensification recommendations

Step 2: Redraft the recommendations for clarity

Step 3: Construct a high-level prevalence estimate of potential opportunities for de-intensification (or obtain an opportunity estimate from the published literature)

Step 4: Complete a rapid evidence synthesis for each recommendation that does not have a recent, published evidence review

Step 5: Using teleconference and an online collaboration tool, conduct two modified Delphi expert panels using the RAND/UCLA Appropriateness Method (RAM)
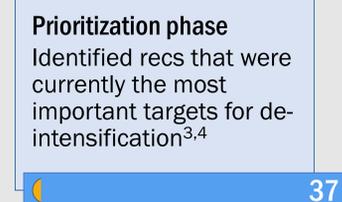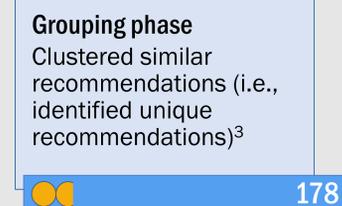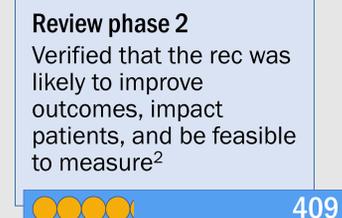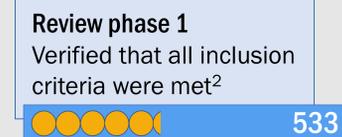
*Steps 2-4 were done concurrently

Step 1

Recommendation (rec) inclusion criteria:
1. Focused on routine, adult primary care
2. Represented de-intensification
3. Related to cardiovascular disease (CVD), diabetes, screening, or medication use

N of recs retained

Initial extraction[1] 947

Review phase 1
Verified that all inclusion criteria were met[2] 533

Review phase 2
Verified that the rec was likely to improve outcomes, impact patients, and be feasible to measure[2] 409

Grouping phase
Clustered similar recommendations (i.e., identified unique recommendations)[3] 178

Prioritization phase
Identified recs that were currently the most important targets for de-intensification[3,4] 37

Conducted by:
[1] Study Staff (non-physicians)
[2] Investigators (physicians)
[3] Principal Investigators (physicians)
[4] External Advisory Council

Step 2

De-intensification Recommendation from Step 1 (example)
Don't use dual-energy x-ray absorptiometry (DEXA) screening for osteoporosis in women younger than 65 or men younger than 70 with no risk factors

Redrafted De-intensification Recommendation (example)
Action (numerator): Screening using DEXA
Population (denominator): Women younger than 65 or men younger than 70
Exclusions [example risk factors]: osteopenia, kidney disease

Step 3 and Step 4

Opportunity Estimate (example)
"In 2015, 71,160 women younger than 65/men younger than 70, without known risk factors, received a DEXA scan."

Rapid Evidence Synthesis (RES)
A RES was completed to assess the benefits and harms of osteoporosis screening in the above age groups
A total of 18 RES summaries were completed

Products from Steps 2-4 were shared with expert panel members in Step 5

Results

Step 5

De-intensification Recommendations: No. rated highly by the expert panel

	CVD N=16	Diabetes N=5	Screening* N=13	Med Use* N=10	Total N=44
Validity (median ≥ 7) Based on high-quality evidence	10	4	13	10	37
Improvement Opportunity (median ≥ 7) Likely to affect a large no. of patients or have a significant impact on a smaller no. of patients	10	4	12	6	32
Feasibility of Implementation (median ≥ 7) De-intensification is under the control of the health professional or organization	12	4	13	7	36

*Excludes CVD and Diabetes related screenings or medications

25 panelists **13** women (52%)

specialties
17 internal medicine (68%)
5 geriatrics (20%)
3 endocrinology or cardiology (12%)

Recommendation Examples

CVD
Decrease aspirin dose in patients with DAPT and a daily aspirin dose >100mg

Diabetes
Reduce diabetes medications in patients at high-risk for hypoglycemia

Screening
Don't screen for breast cancer in women with limited life expectancy

Medication Use
Decrease benzodiazepines in older adults

Conclusions

- The Assessing When to Scale Back or Stop Unnecessary Routine Medical Service (ASSURES) study is the first study to systematically identify and validate recommendations involving de-intensification of routine primary care services
- We identified 44 high-priority recommendations and 37 were found to be valid through the RAM process