Building Systems for Appropriate Care

Transition from FFS to Population Health

Stephen Deutsch, MD, FACP
Chief Medical Officer
Cedars-Sinai Medical Care Foundation

Population Health

Population Health involves a systematic effort to assess the health needs of a defined population and proactively provide services to maintain and improve the health of that population

Bending the Cost Curve – Have we achieved that goal?

- approximately $3 trillion spent on health care last year
- a scant 0.8% increase in 2012 → less than GDP
- is this decrease in health care spending sustainable (population health) or secondary to the recession of 2008, and will it soon return to the historical pattern of 2.3% points > GDP?
- U.S. projected to spend $ 5 trillion on health services in 2022 (30% of projected Federal spending)
- 20% of Americans today with employer-sponsored coverage have high deductible plans, and that deductible exceeds a typical family's available savings

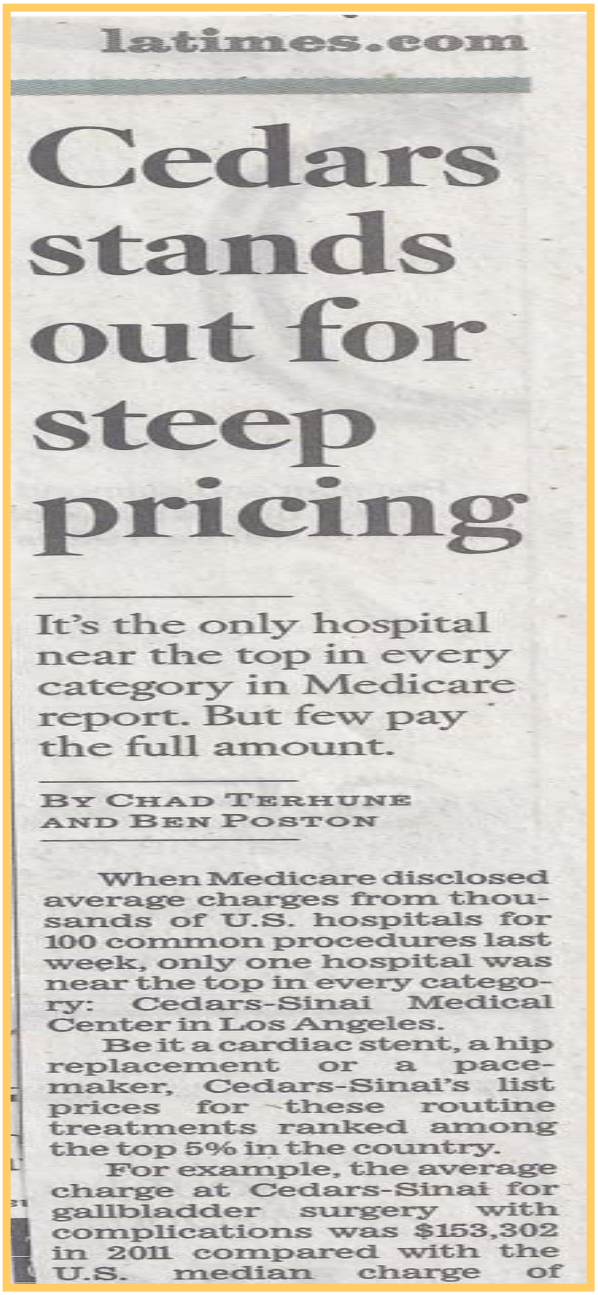
Bending the Cost Curve

….continued

- many of the bronze plans in the Exchange have deductibles in the $5K range
- wage increases for the middle-class are inversely related to the cost of healthcare benefits
- 10,000 baby boomers will turn 65 everyday for the next 18 years (70m in Medicare by 2022)
- we need to re-build America's health care system to be more efficient and to provide more appropriate care

Health Care Spending — A Giant Slain or Sleeping?
Blumenthal, et al.; NEJM 2013

Why is this so important to Cedars and other academic medical centers?



latimes.com

Cedars stands out for steep pricing

It's the only hospital near the top in every category in Medicare report. But few pay the full amount.

BY CHAD TERHUNE AND BEN POSTON

When Medicare disclosed average charges from thousands of U.S. hospitals for 100 common procedures last week, only one hospital was near the top in every category: Cedars-Sinai Medical Center in Los Angeles.

Be it a cardiac stent, a hip replacement or a pacemaker, Cedars-Sinai's list prices for these routine treatments ranked among the top 5% in the country.

For example, the average charge at Cedars-Sinai for gallbladder surgery with complications was $153,302 in 2011 compared with the U.S. median charge of

Los Angeles Times

Insurers limit doctors, hospitals

[Healthcare, from A1]

state agency implementing the federal healthcare law, said these trade-offs are necessary in many cases to keep premiums reasonable for California's families. Officials said they took steps to ensure that health plans offer an adequate number of quality medical providers and have measures in place for expanding their networks in the event that more people than expected sign up.

More than 5 million Californians are expected to be eligible for coverage in the exchange, and about half of them could qualify for federal premium subsidies.

Details on these insurance networks aren't known yet as insurers and providers wrap up their contracts and await regulators' review in the coming weeks. It's possible some medical groups and hospitals could be added.

Health Net Inc., another exchange option in Southern California, said it expects to seek state approval to use its existing network, which includes both UCLA and Cedars-Sinai, for one of its exchange plans.

Once all those decisions are finalized by early July, Covered California said it will help consumers find out online whether particular doctors and hospitals are in

Rates for Los Angeles County

Here are the proposed monthly premiums for a 40-year-old using the Silver plan and a 25-year-old buying the Bronze plan:

North Los Angeles County

Insurer	40-year-old Silver plan	25-year-old Bronze plan
Health Net HMO	$222	Not offered
Blue Shield PPO	252	$165
L.A. Care HMO	253	147
Anthem HMO	254	Not offered
Molina Healthcare PPO	259	160
Anthem EPO*	274	163
Health Net PPO	Not offered	195
Kaiser Permanente HMO	294	174

South Los Angeles County

Insurer	40-year-old Silver plan	25-year-old Bronze plan
Health Net HMO	$242	Not offered
Anthem HMO	259	Not offered
Molina Healthcare PPO	259	$160
L.A. Care HMO	265	154
Blue Shield PPO	287	188
Anthem EPO*	299	177
Kaiser Permanente HMO	325	192
Health Net PPO	Not offered	236

The Silver plan for all insurers carries a $2,000 deductible, a $45 co-pay for a primary care visit, a $250 co-pay for an emergency room visit and a maximum annual out-of-pocket expense of $6,350. It is expected to cover 70% of an individual's healthcare expenses.

The Bronze plan for all insurers has a $5,000 deductible, a $60 co-pay for three primary-care visits, $300 emergency room co-pay and a maximum annual out-of-pocket expense of $6,350. It is expected to cover 60% of an individual's healthcare expenses.

Source: Covered California

Los Angeles Times

cutive director of Covered California. "Consumers care about that information."

Meanwhile, some insurance agents said it's hard to judge these proposed prices in the state exchange without knowing what's on the menu in terms of available providers.

"Trying to determine whether these rates are low or high without knowing the provider networks is like trying to tell the value of a car when you can only see the tires — you don't know if you are looking at a Ferrari or a Yugo," said Bruce Jugan, an insurance agent in Monte-

ments in return for higher patient volume from these narrow networks.

Markovich said premiums for Blue Shield's existing individual policyholders will rise 13% next year on average for coverage under exchange plans.

That marked an improvement from earlier predictions of even bigger rate hikes. The state issued a report in March that estimated premiums for many consumers could go up 30%, on average.

Premiums are generally rising to reflect the federal law's requirements for richer benefits and guaranteed coverage regardless of people's medical history.

"The physicians and hospitals that signed up for our network have agreed to accept lower reimbursement specifically to make the exchange more affordable," Markovich said.

Blue Shield's exchange network in the Los Angeles area doesn't include UCLA or Cedars-Sinai. Instead, it features hospitals such as Keck Hospital of USC, Long Beach Memorial and St. John's Health Center. Blue Shield said its statewide network for exchange policies will include about 24,000 physicians, compared with 66,000 doctors in its full preferred provider organization roster.

In Los Angeles County, state officials expect 1.6 million people to be eligible for coverage in the exchange. Premiums will vary based on a person's age, location and level of coverage.

For instance, in the north Los Angeles County region, the rates for a 40-year-old purchasing a Silver plan range from $222 a month for Health Net to $294 a month for Kaiser Permanente. There will still be other individual policies for sale outside those offered through Covered California, but federal subsidies can be used only inside the exchange.

Health Net sees growing acceptance of these narrower networks. The Woodland Hills insurer said enrollment among employers in California, Arizona and Oregon in those smaller networks has grown 37% in the last year.

chad.terhune@latimes.com

Sunday
Los Angeles Times
latimes.com

CHRISTOPHER SERRA For The Times

NARROW NETWORKS

Insurers hold down premiums by making fewer doctors available, raising concerns about patients' access to care

BY CHAD TERHUNE

The doctor can't see you now.

Consumers may hear that a lot more often after getting health insurance under President Obama's Affordable Care Act.

To hold down premiums, major insurers in California have sharply limited the number of doctors and hospitals available to patients in the state's new health insurance market opening Oct. 1.

New data reveal the extent of those cuts in California, a crucial test bed for the federal healthcare law.

These diminished medical networks are fueling growing concerns that many patients will still struggle to get care despite the nation's biggest healthcare ex-

Doctors by plan

Insurers and their number of doctors in L.A. County for state health exchange:

Insurer	
Health Net	2,316
Molina	3,009
Anthem Blue Cross	3,855
L.A. Care	4,946
Kaiser	5,705
Blue Shield PPO	6,559
Anthem EPO	

because they cut off access for patients," said Dr. Richard Baker, executive director of the Urban Health Institute at Charles Drew University of Medicine and Science in Los Angeles. "We don't want this to become a roadblock."

To see the challenges awaiting some consumers, consider Woodland Hills-based insurer Health Net Inc.

Across Southern California the company has the lowest rates, with monthly premiums as much as $100 cheaper than the closest competitor in some cases. That will make it a popular choice among some of the 1.4 million Californians expected to purchase coverage in the state exchange next year.

But Health Net also has the fewest doctors, less than half what some other companies are offering in Southern California.

October 1, 2012 | VOLUME 19 | NUMBER 37

CALIFORNIA Healthfax

THE BUSINESS OF HEALTHCARE IN CALIFORNIA

TOP STORIES

Narrow Network Limits Choice for Los Angeles City Workers

UCLA and Cedars-Sinai physicians out of loop in 2013

Two major health systems in **Los Angeles** are being essentially excluded from a new health plan for Los Angeles city employees, with city officials citing cost-cutting measures as the reason.

Physicians associated with **Cedars-Sinai Medical Center** and the **UCLA Health System** will no longer be included in the **Anthem Select** health plan, which provides coverage for 27,000 city employees and their dependents. The change will go into effect on Jan.1, 2013, and will save the city an estimated $7.6 million each year by excluding physicians affiliated with hospitals where costs for care tend to be higher than other hospitals in the city. Approximately 2,200 employees and dependents are expected to lose access to their current physicians next year due to the change.

Anthem spokesperson **Leslie Porras** said the city of Los Angeles elected to choose a plan that will save the city and employees money. "The network the city of Los Angeles has selected is referred to as a "narrow network," which is a pro-

HealthLeaders Media

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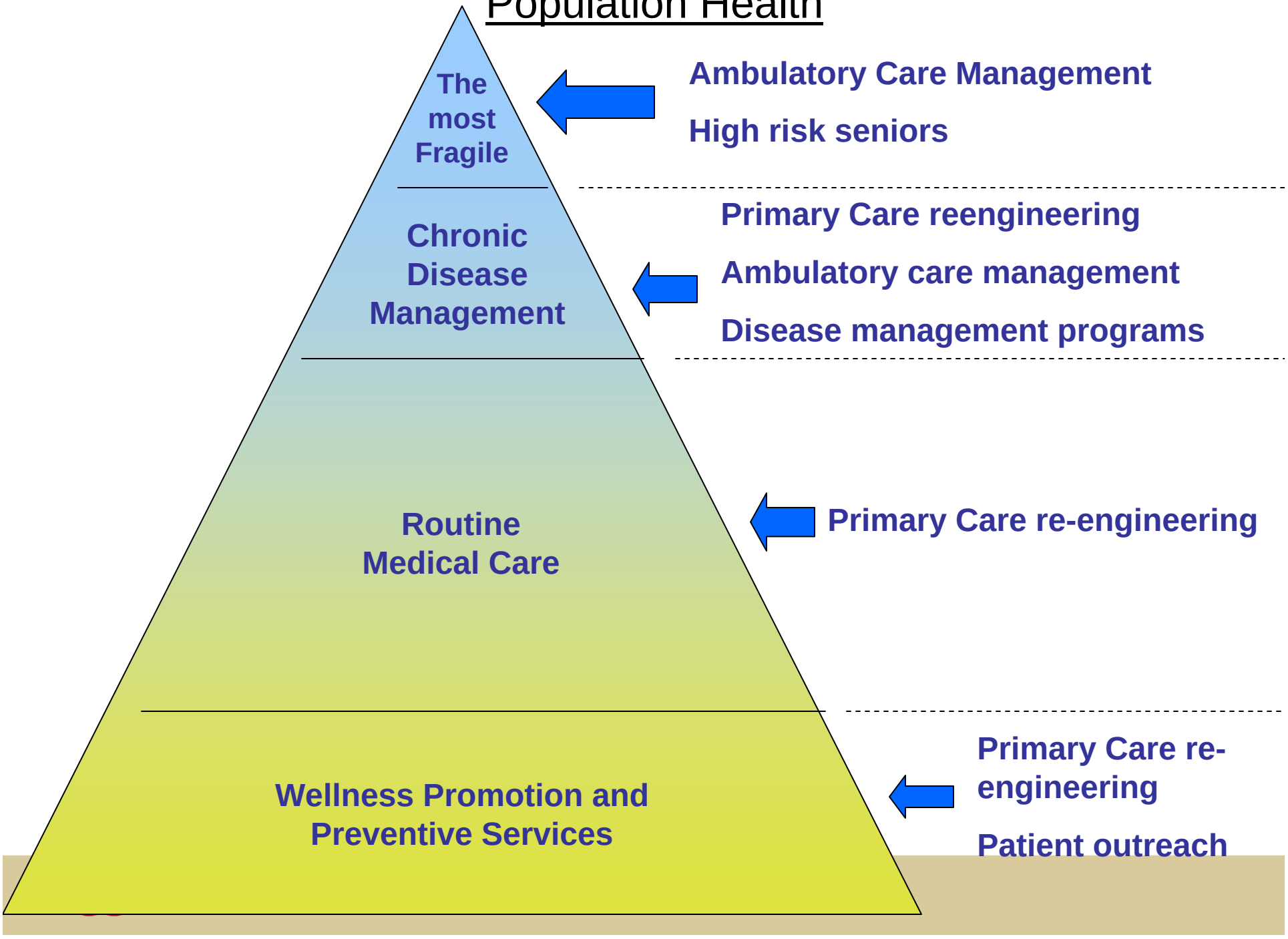
GOAL

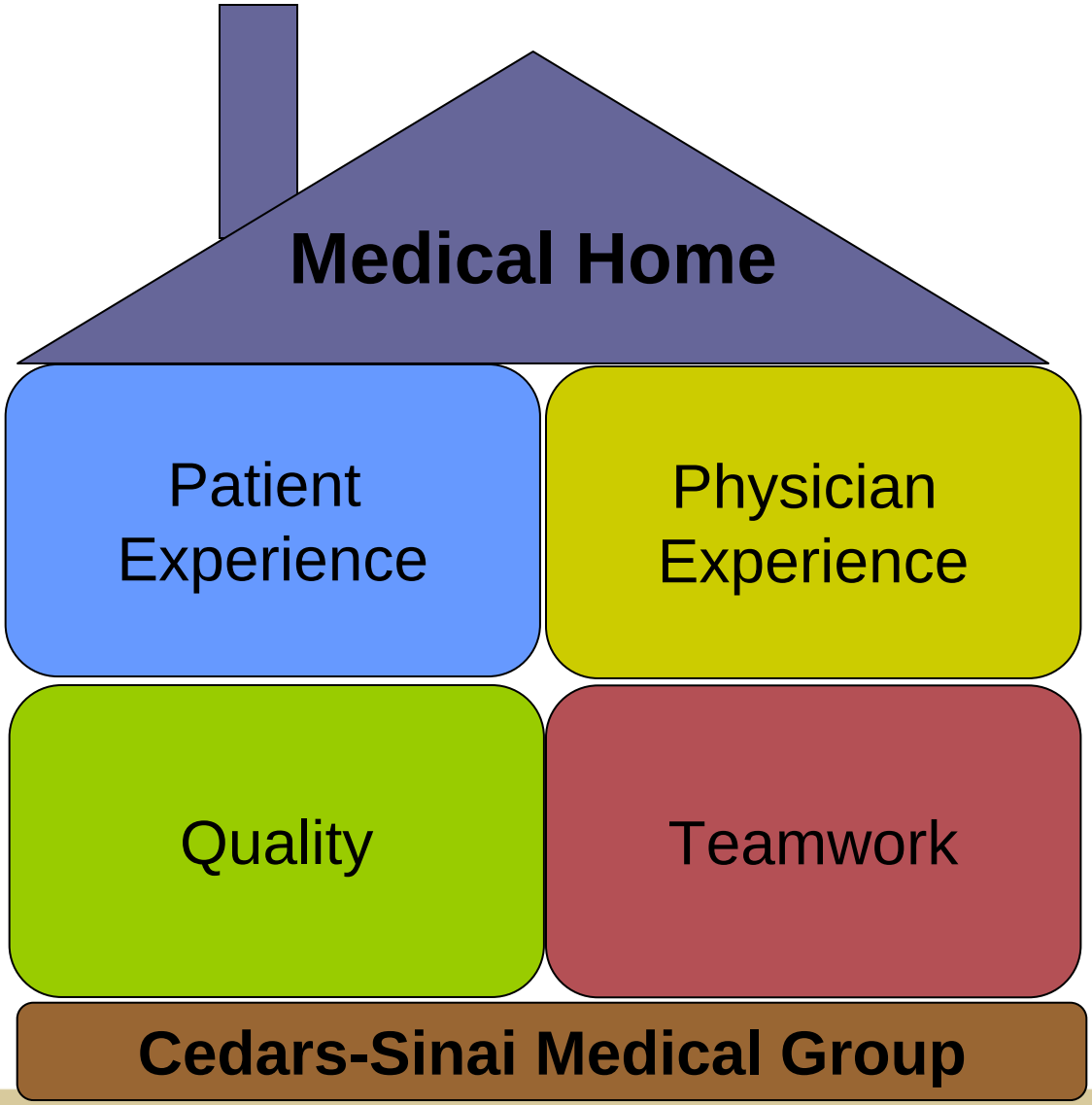
- Cedars-Sinai is high-cost, high-quality
- we must maintain our quality of care but at a much lower cost
- we are implementing and piloting multiple interventions
- goal → 12% improvement in clinical efficiency within 3 years

Population Health



Re-engineering Primary Care

Patient-Centered Medical Home



Re-engineering Primary Care

(Patient-Centered Medical Home)

- creating multi-disciplinary teams of nurse practitioners, physician assistants, medical assistants, pharmacists, case managers, social workers and lead by primary care physicians
- Goals
  a) improve quality of care
  b) improve access
  c) identify and employ appropriate resources to patients with chronic illness and to the most frail who account for a majority of health care costs

Quality of Care

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

The Quality of Health Care Delivered to Adults in the United States

Elizabeth A. McGlynn, Ph.D., Steven M. Asch, M.D., M.P.H., John Adams, Ph.D., Joan Keesey, B.A., Jennifer Hicks, M.P.H., Ph.D., Alison DeCristofaro, M.P.H., and Eve A. Kerr, M.D., M.P.H.

RESULTS

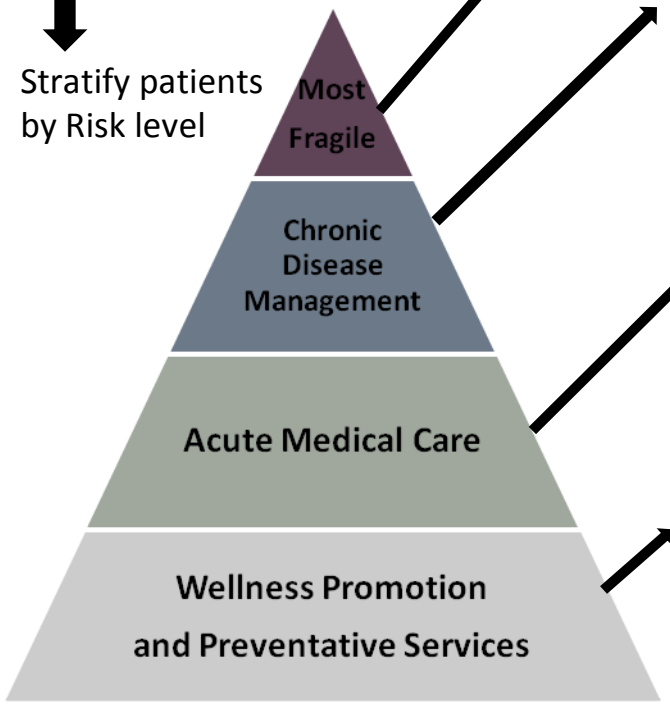
Participants received 54.9 percent (95 percent confidence interval, 54.3 to 55.5) of recommended care. We found little difference among the proportion of recommended preventive care provided (54.9 percent), the proportion of recommended acute care provided (53.5 percent), and the proportion of recommended care provided for chronic conditions (56.1 percent). Among different medical functions, adherence to the process-

Customizing the Patient Care Experience

Entry Point

- Physician referral
- Surgical Event
- IP/ED visit
- Data Query
- Health Risk Assessment

Stratify patients by Risk level



High Intensity Care Management Program

- Same as Chronic Disease Program
- SNF visits
- Home visits
- Biometric monitoring
- High-touch monitoring by a care manager
- Advanced care planning

Chronic Disease Program

- Education about condition, risk factors, preventative screening, appropriate site of care, health and wellness
- Pre-admission planning
- Discharge planning and follow-up
- Care setting appropriateness
- Chronic Disease management
- Drug Therapy Management and reconciliation
- Advanced care planning

Episodic Event Program

- Education about “event”, appropriate site of care, recovery, health and wellness
- Pre admission planning
- Discharge planning and follow-up
- Care coordination
- Drug Therapy Management and reconciliation
- Advanced care planning

Wellness Program

- Proactive education about preventative screening, risk factors, appropriate site of care, health and wellness
- Disease management programs such as– smoking cessation programs, weight loss/nutrition programs, back care, etc.
- Preventative Screenings
- Drug Therapy management and reconciliation
- Advanced care planning

Predictive Analytics in Health Care

- The sickest 5% of the population spends ***fifty times as much per person*** as the healthy majority

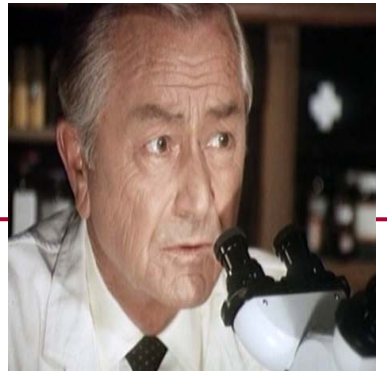
Source: AHRQ, August 2013: "Differentials in the Concentration in the Level of Health Expenditures across Population Subgroups in the U.S., 2010

- At CSHS we mine the data to find the patients who are at highest risk: catastrophic illness, chronic illness, prior utilization
- Innovations are designed to prevent escalation and support highest risk patients
- Back to basics:
  - House calls
  - Healing at Home
  - Care Management and Social Work
  - Advance care planning and Supportive Care Medicine
  - Pharmacists as part of the care team
- Enhancing the use of technology

$$$ PAID LAST YEAR ON PATIENTS WITH 2 OR MORE CHRONIC ILLNESSES

Cancer	**$8,244,973**	
Joint Degeneration	**$2,950,520**	
Behavioral Health	**$2,855,892**	
Inflammatory Bowel Disease	**$2,744,136**	
AIDS	**$1,067,660**	
Diabetes	**$940,381**	
Ischemic Heart Disease	**$927,599**	
Cerebral Vascular Disease	**$571,418**	
Hypertension	**$507,316**	
Chronic Renal Failure	**$491,938**	
Chronic Sinusitis	**$477,587**	
Obesity	**$427,284**	
Kidney Transplant	**$340,619**	
Adult Rheumatoid Arthritis	**$265,588**	
Immunodeficiencies	**$258,988**	
Hyperlipidemia	**$160,407**	
Osteoporosis	**$106,554**	
Other	**$4,348,239**	
TOTAL	**$27,687,099**	**N= 5,121**

New Programs



ESRD Disease Management

High-risk Case Management

CHF Disease Management

Outpatient Antibiotic Therapy

Reduction in Avoidable Admissions and/or Total Cost of Care

Post Discharge Clinic

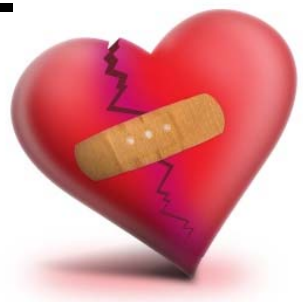
Population Health Flag

Outpatient Supportive Care Medicine

Dedicated OBS Unit

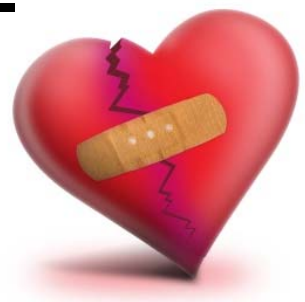
NP House Calls

Heart Failure Program



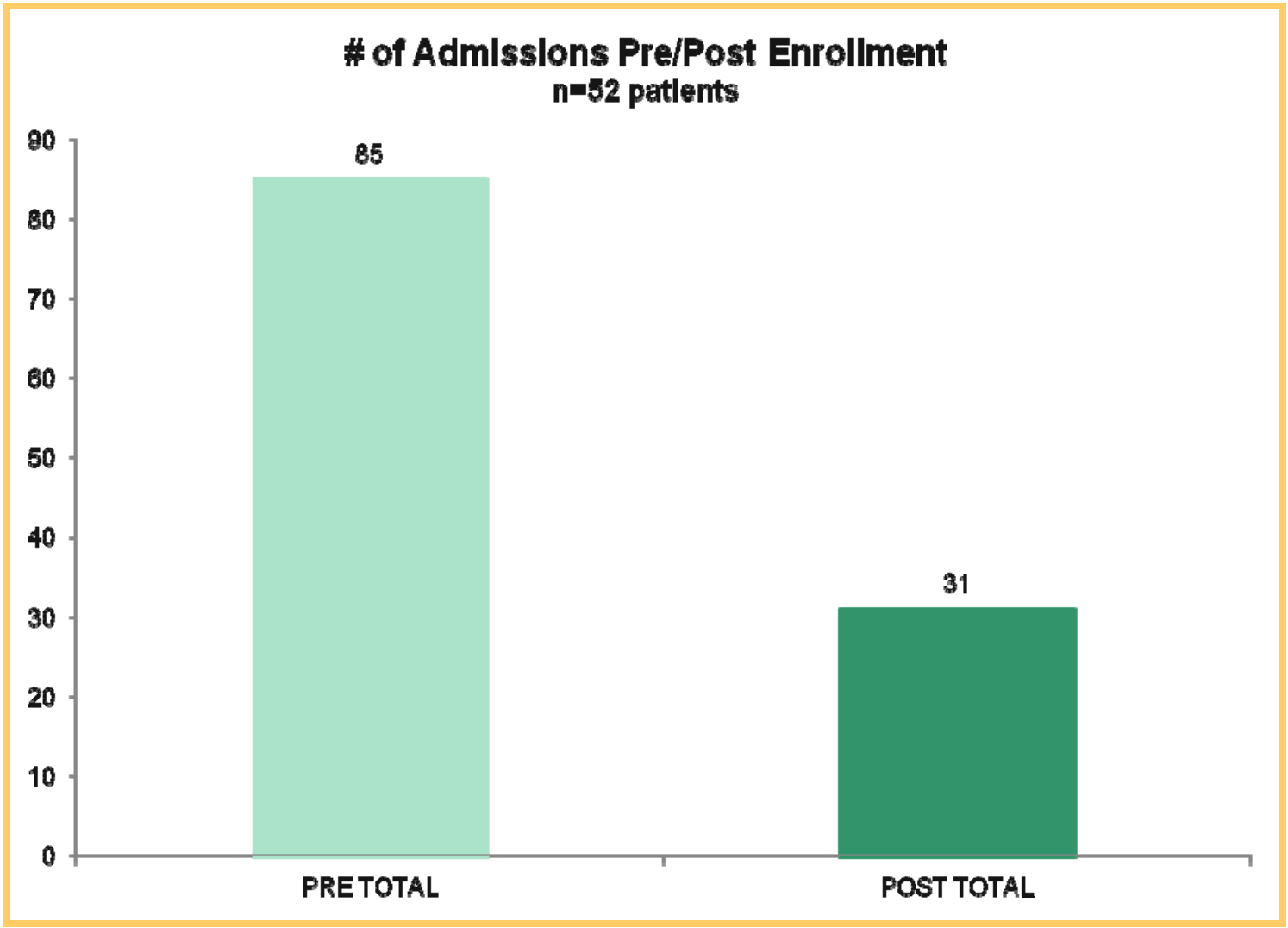
- Initiated pilot November 2012
- Interdisciplinary team:
  - 2 Cardiologists
  - 1 Pharmacist- part time
  - 2 Nursing staff
- Program Goals
  - decrease CHF hospital admissions and 30 day readmissions
  - decrease total cost of care
  - improve quality of care

Heart Failure Program

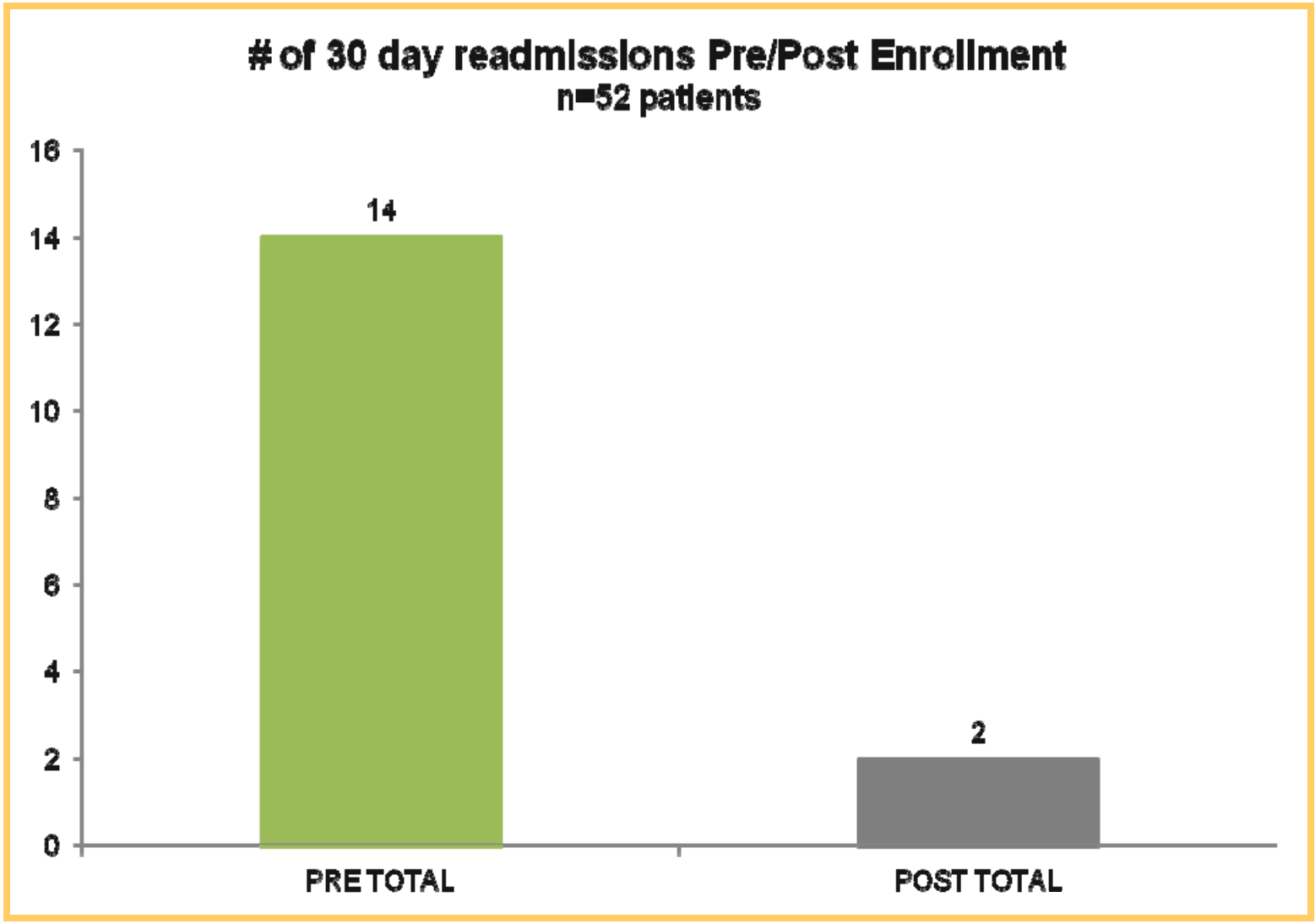


- Management
  - patient education and care coordination
  - medication optimization
  - medication adherence and safety monitoring
  - medication reconciliation
  - BNP and weighted guided therapy
  - bed-side ultrasound
  - cardiovascular co-morbidity management
  - nutrition consultation
  - nurse practitioner house call and home health
  - supportive care and advanced directive

Total Hospital Admissions for Patients Pre/Post Enrollment



Total 30 Day Readmissions for Patients Pre and Post Enrollment

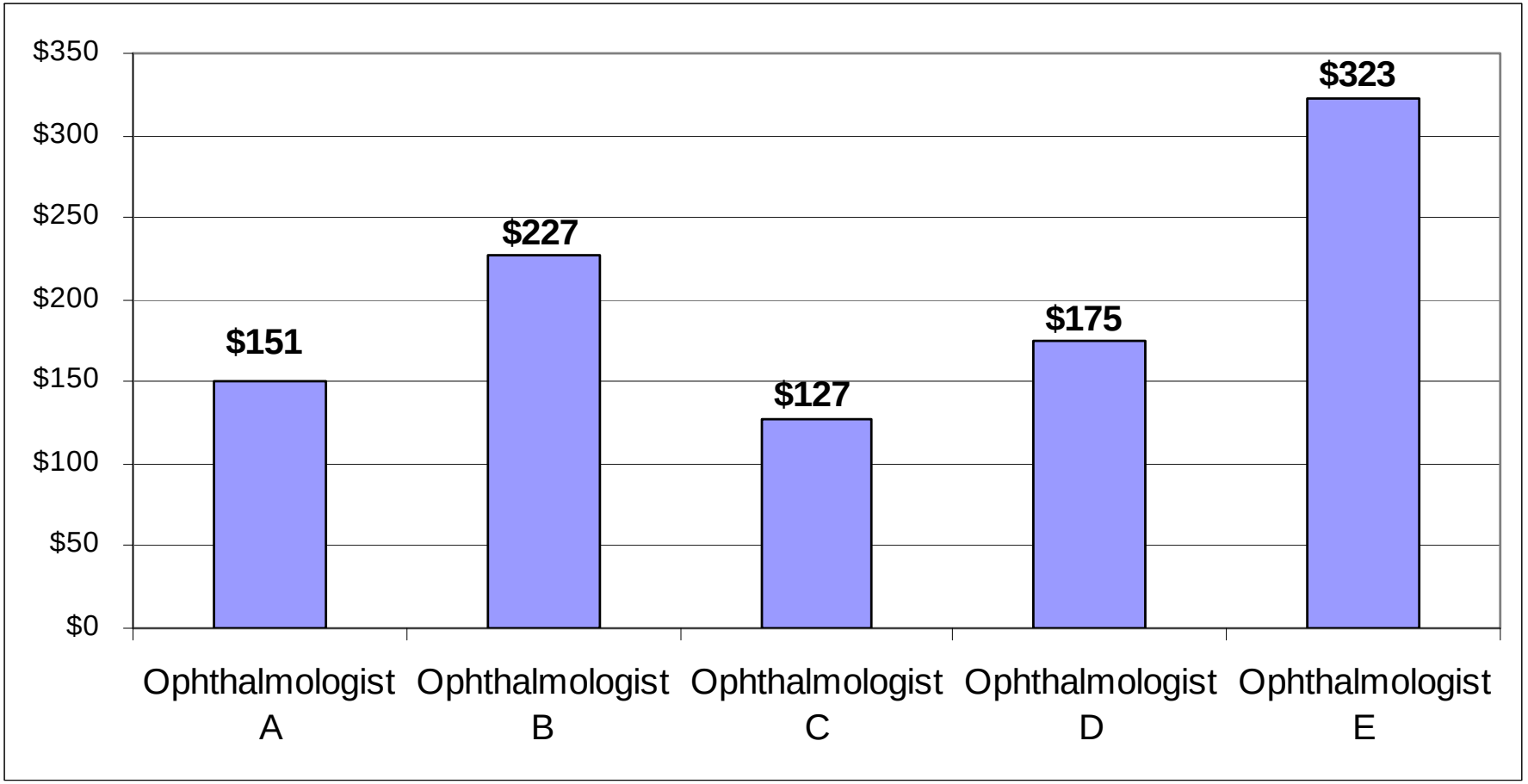


Variation in Care

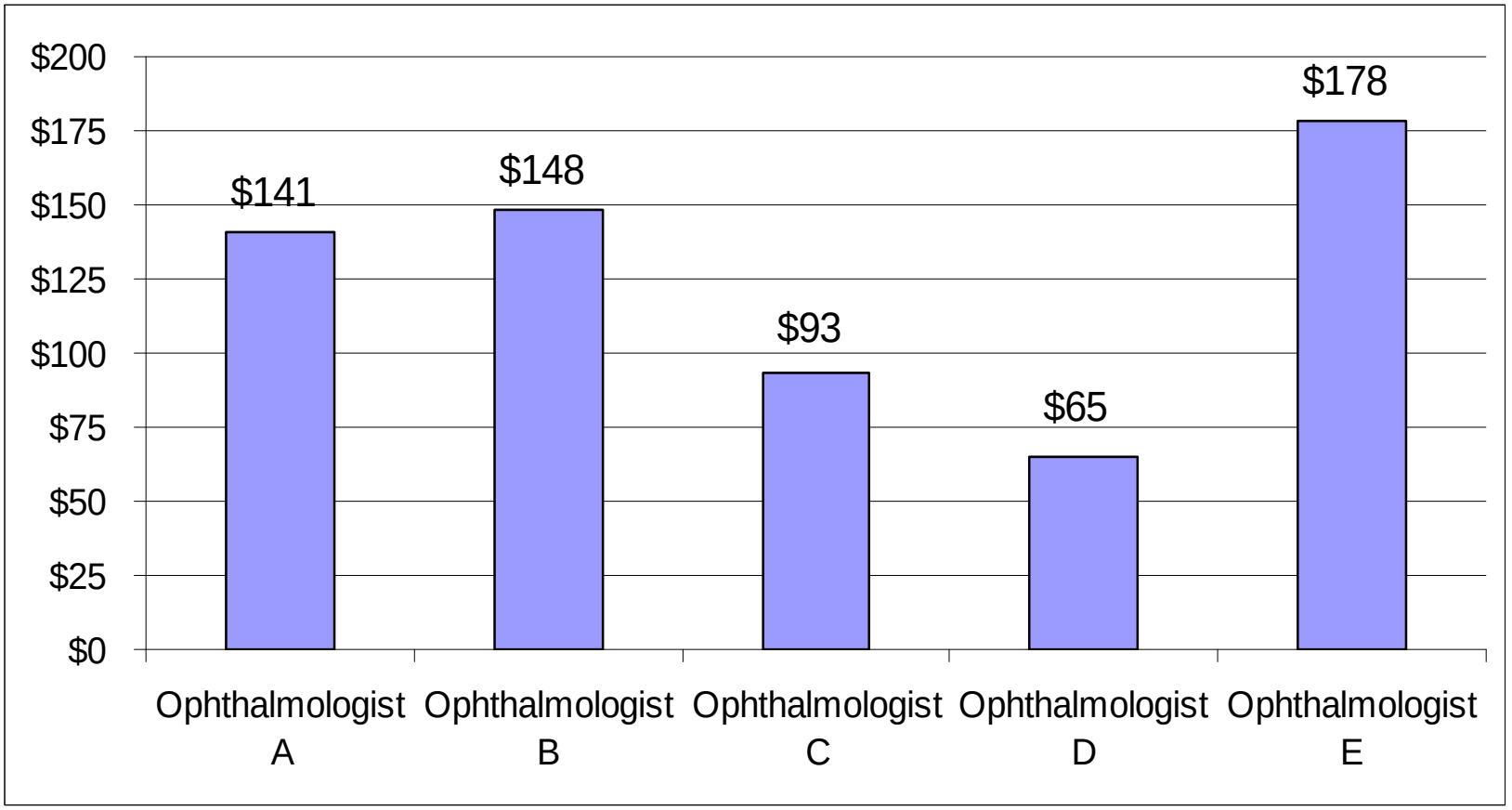
- Significant inter-physician variation in cost and quality

- 2,000 physicians on medical staff
- 134 physicians in CSMG
- 767 physicians in CSHA (includes faculty)
- 307 physicians on faculty

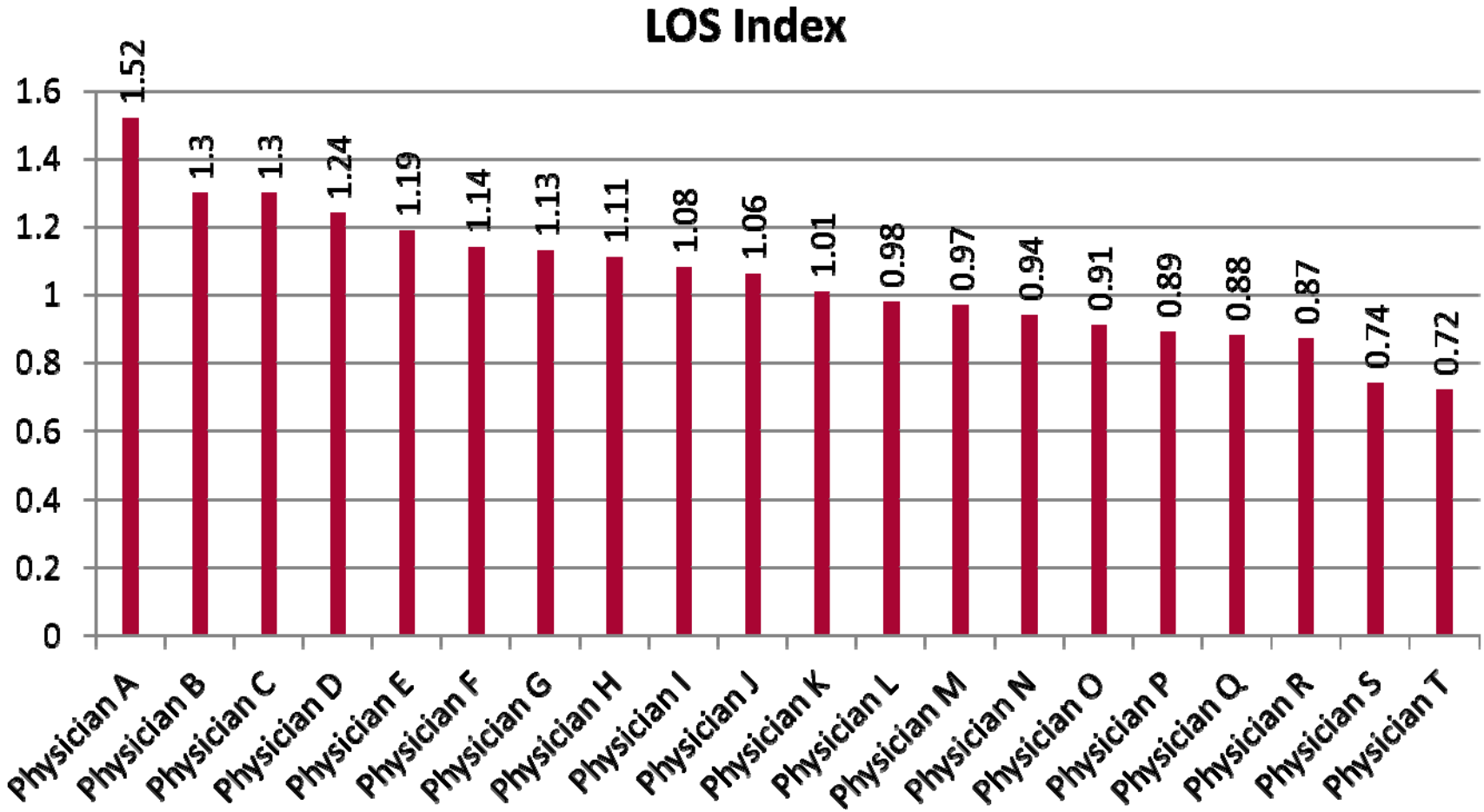
Average Cost of Treatment of Glaucoma without Complications – Year 2012



Average Cost of Treatment for Cataract without Complications – Year 2012



CSMC Spine Surgeons
Spine Surgery – Severity-Adjusted LOS



Geographic Variation in Medicare Spending still a Mystery

- $15,357 in Miami Florida / $6,569 in Grand Junction, CO
- measuring the variation is easy; explaining is another matter

Possible Answers:

1) Medicare adjusts its payment to providers by region according to differences in overhead costs.
2) Variation in health status→ diabetes in Grand Junction was 15% compared to 44% in Harlingen, TX
3) Variation in use of services. Does higher spending in a particular region simply reflect the tendency of its hospitals, physicians and others to provider more services or more intense services, perhaps in response to patient preferences?

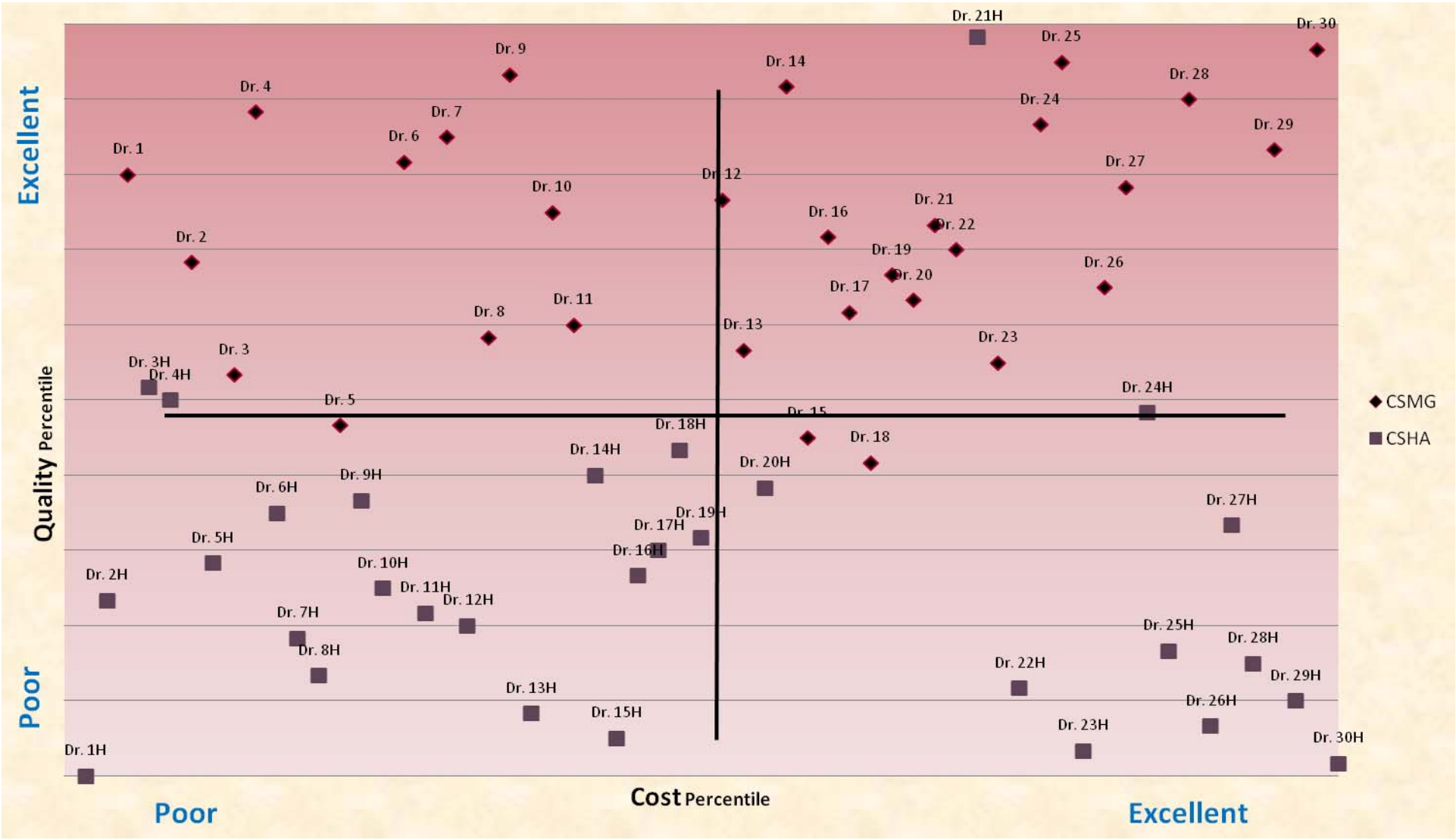
Geographic Variation in Medicare Spending still a Mystery

….continued

4) Does supply generate demand or do more physicians locate where patients are sicker? Even in areas where spending is higher, the volume and intensity of services vary from service to service.
5) The Institute of Medicine pointed out that in all areas, there are physicians who are low cost and high quality.

Cassidy and Colleagues
Health Affairs, March 2014

MDN PCP Cost and Quality Scores

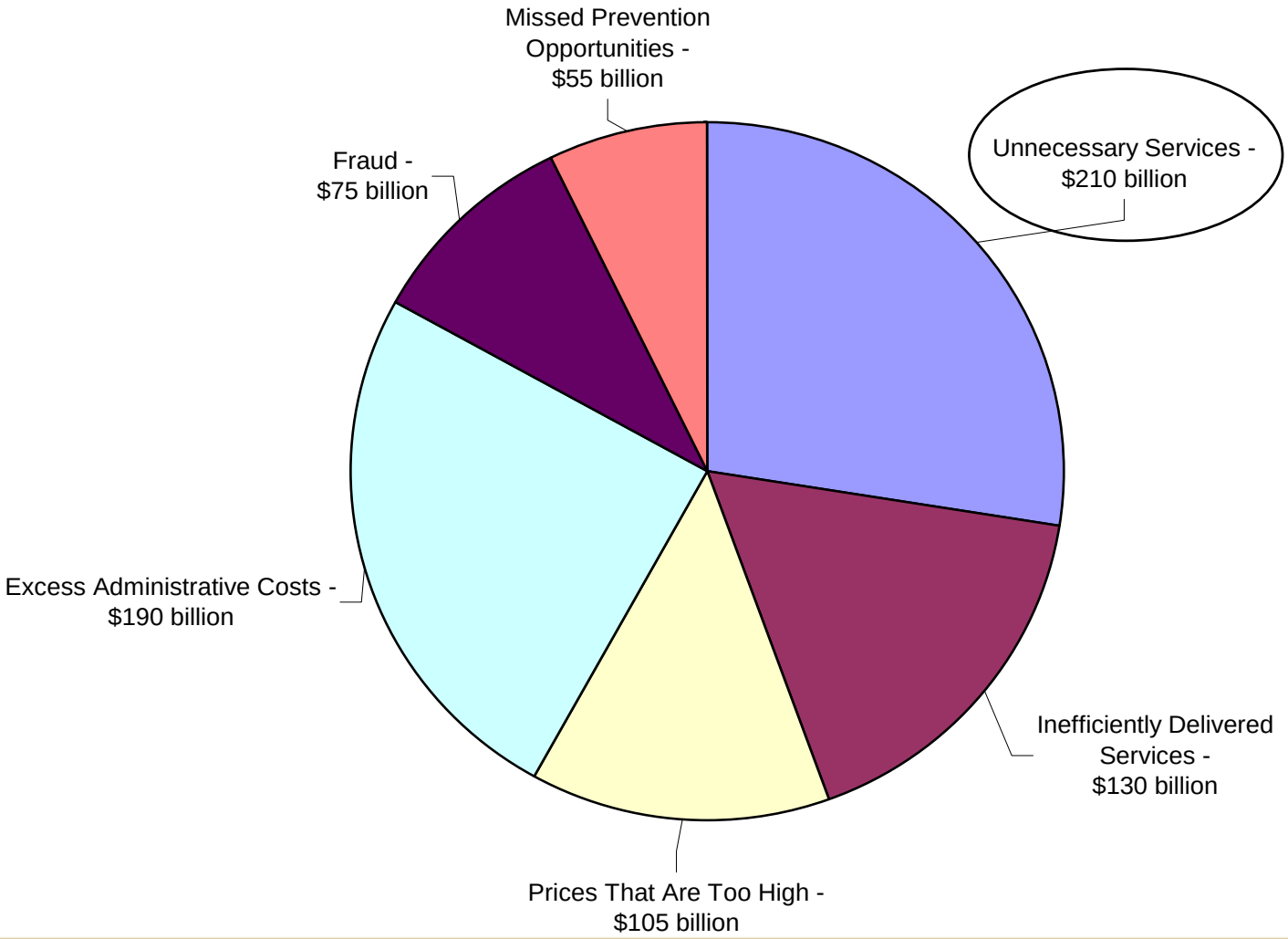


Eliminating Waste in US Health Care

- 20-30% of total health care expenditure
- 6 categories of waste
    a) overtreatment
    b) failure of care coordination
    c) failure in execution of care process
    d) administrative complexity
    e) pricing failures
    f) fraud or abuse

Berwick et al.
JAMA 2012.

Sources of $765B of Waste and Excess in Health Care



Unnecessary Services

Annals of Internal Medicine | IDEAS AND OPINIONS

Appropriate Use of Screening and Diagnostic Tests to Foster High-Value, Cost-Conscious Care

Amir Qaseem, MD, PhD, MHA; Patrick Alguire, MD; Paul Dallas, MD; Lawrence E. Feinberg, MD; Faith T. Fitzgerald, MD; Carrie Horwitch, MD, MPH; Linda Humphrey, MD, MPH; Richard LeBlond, MD; Darilyn Moyer, MD; Jeffrey G. Wiese, MD; and Steven Weinberger, MD

Unsustainable rising health care costs in the United States have made reducing costs while maintaining high-quality health care a national priority. The overuse of some screening and diagnostic tests is an important component of unnecessary health care costs. More judicious use of such tests will improve quality and reflect responsible awareness of costs. Efforts to control expenditures should focus not only on benefits, harms, and costs but on the value of diagnostic tests—meaning an assessment of whether a test provides health benefits that are worth its costs or harms. To begin to identify ways that practicing clinicians can contribute to the delivery of high-value, cost-conscious health care, the American College of Physicians convened a workgroup of physicians to identify, using a consensus-based process, common clinical situations in which screening and diagnostic tests are used in ways that do not reflect high-value care. The intent of this exercise is to promote thoughtful discussions about these tests and other health care interventions to promote high-value, cost-conscious care.

Ann Intern Med. 2012;156:147-149. www.annals.org
For author affiliations, see end of text.

What Is High-Value, Cost-Conscious Care?

The distinction between cost and value is essential (5). A high-cost intervention may provide good value if its net benefits (the extent to which benefit outweighs harms) is large enough to justify the costs. Examples of expensive but high-value interventions include antiretroviral therapy for HIV infection and implantable cardioverter-defibrillators in patients who meet the clinical criteria for the therapy and have a reasonable expectation of survival with good functional status for more than 1 year (5). Conversely, low-cost interventions may provide low value if they have little or no net benefit. Examples of a low-cost, low-value tests include annual Papanicolaou smears (compared with Papanicolaou smears every 3 years) for low-risk women and preoperative chest radiography in asymptomatic, healthy persons. Because high-cost interventions may provide good value and low-cost interventions may not, ef-

Methods for Identifying Tests That Clinicians Should Carefully Consider in Light of High-Value, Cost-Conscious Care

In light of increasing health care costs as well as overuse and misuse of tests and treatments, some have called for organized medicine to identify a list of "top 5" tests or treatments that are commonly overused (6). The American College of Physicians convened an ad hoc workgroup of experienced internal medicine physicians with the goal of identifying common screening and diagnostic tests relevant to internal medicine that they believe are commonly overused. Workgroup members represented a variety of internal medicine specialties, an array of practice environments, and diverse geographic locations in the United States. All members of the workgroup disclosed potential conflicts of

Choosing Wisely

- An initiative of the American Board of Internal Medicine (ABIM) to encourage physicians and patients to talk about tests and procedures that may be unnecessary, and in some cases cause harm.
- Consumer Reports is developing and disseminating this information for patients.

Choosing Wisely®

An initiative of the ABIM Foundation

Lists American Academy of Family Physicians

American Academy of Family Physicians

Fifteen Things Physicians and Patients Should Question

Download PDF

1 Don't do imaging for low back pain within the first six weeks, unless red flags are present.

Red flags include, but are not limited to, severe or progressive neurological deficits or when serious underlying conditions such as osteomyelitis are suspected. Imaging of the lower spine before six weeks does not improve outcomes, but does increase costs. Low back pain is the fifth most common reason for all physician visits.

2 Don't routinely prescribe antibiotics for acute mild-to-moderate sinusitis unless symptoms last for seven or more days, or symptoms worsen after initial clinical improvement.

Symptoms must include discolored nasal secretions and facial or dental tenderness when touched. Most 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 more than 80 percent of outpatient visits for acute sinusitis. Sinusitis accounts for 16 million office visits and $5.8 billion in annual health care costs.

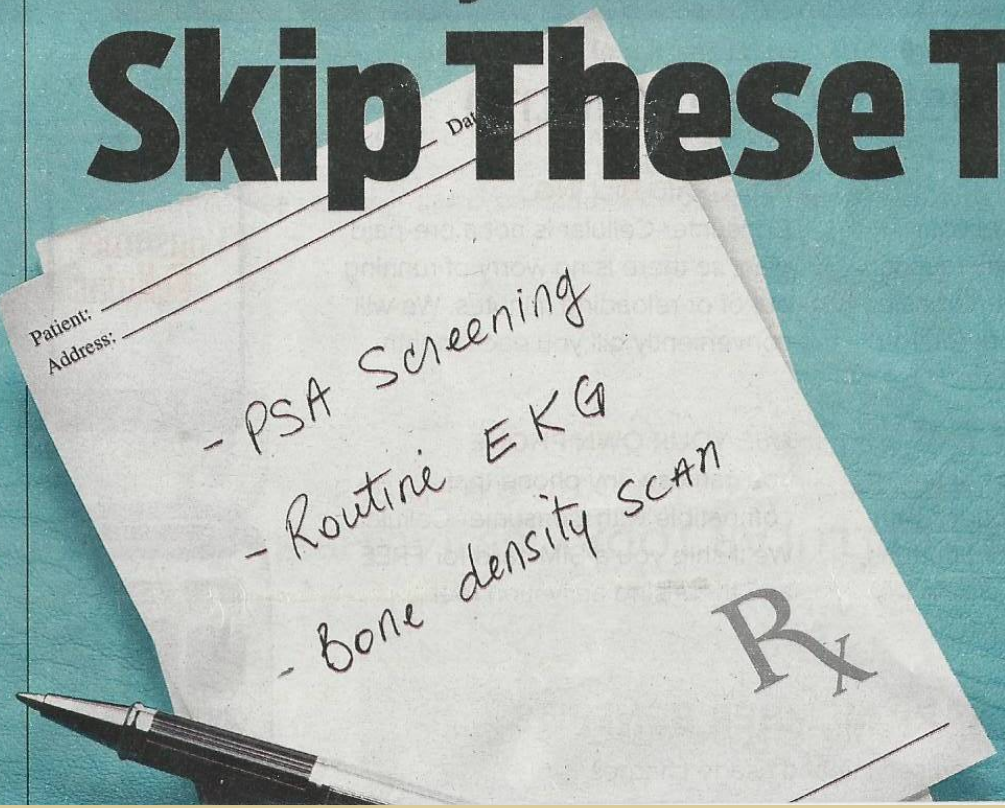
American Academy of Family Physicians | Choosing Wisely

13 **Don't routinely screen for prostate cancer using a prostate-specific antigen (PSA) test or digital rectal exam.**

There is convincing evidence that PSA-based screening leads to substantial over-diagnosis of prostate tumors. Many tumors will not harm patients, while the risks of treatment are significant. Physicians should not offer or order PSA screening unless they are prepared to engage in shared decision making that enables an informed choice by patients.

AARP Bulletin
Real Possibilities
aarp.org/bulletin MARCH 2014 Vol. 55 No. 2 $2.50

Doctors Say: Skip These Tests!



Doctors warn that some of the common medical tests routinely taken by Americans do more harm than good, waste billions of dollars and could endan-

Prostate Cancer

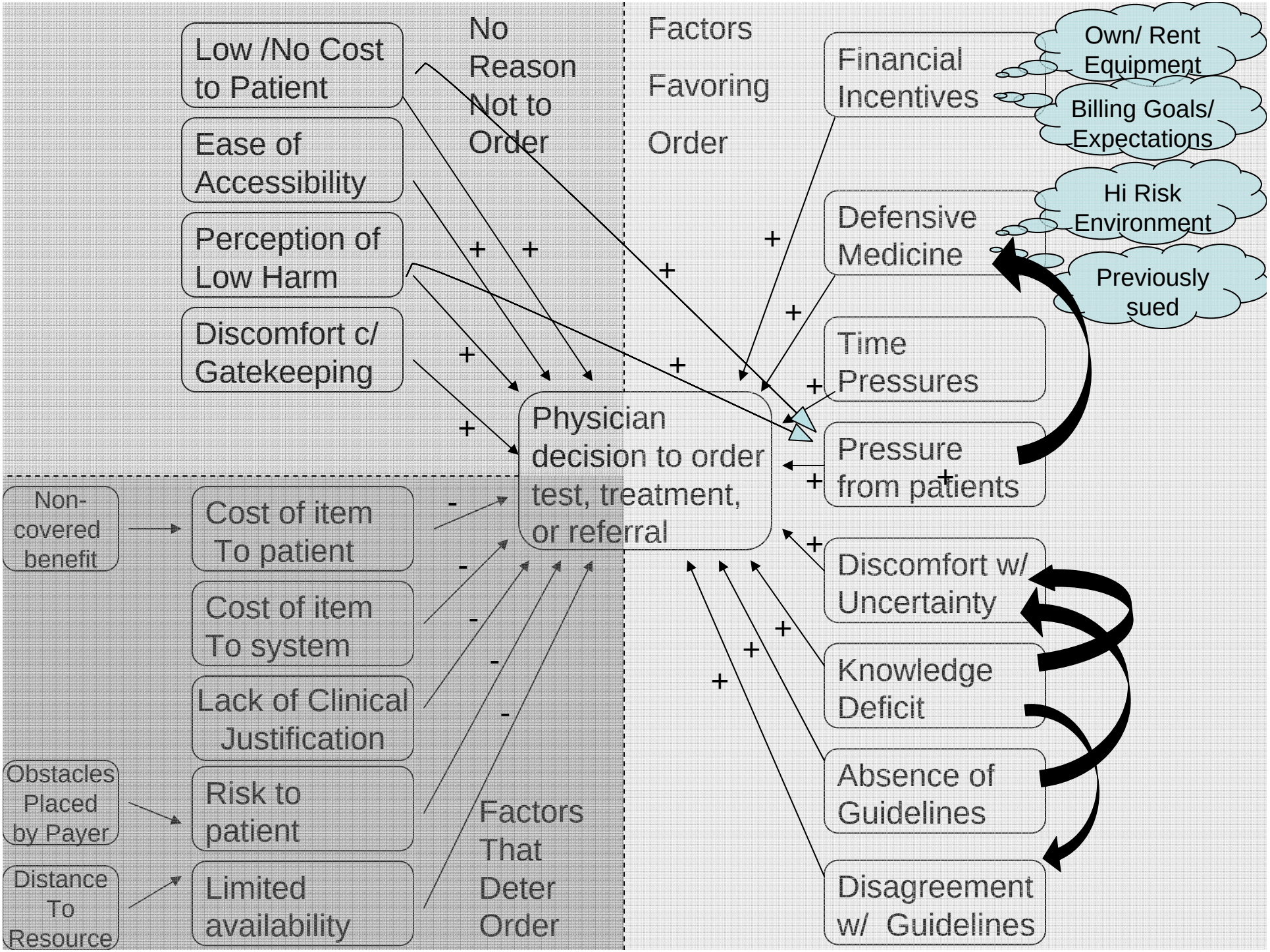
Facts

1) other than skin cancer, prostate cancer is the most common cancer in American men
2) second leading cause of cancer death in men (Lung #1)
3) 2014 → estimate 230,000 new cases/30,000 deaths
4) 1 in 7 men will be diagnosed with prostate Ca / 1 in 36 will die from prostate Ca
5) most men with prostate cancer will die with cancer, not from it

Prostate Cancer Screening

Potential Harms

1) approximately 10% false positive test → leads to unnecessary biopsies, potential bleeding or infection
2) overdiagnosis → still very difficult to distinguish an indolent tumor from an aggressive tumor
3) overtreatment — 90% of cancers found with a PSA test choose to receive treatment; can lead to erectile dysfunction, urinary incontinence, a small risk of death or serious complication from surgery


Low /No Cost to Patient
Ease of Accessibility
Perception of Low Harm
Discomfort c/ Gatekeeping
No Reason Not to Order
Factors Favoring Order
Financial Incentives
Own/ Rent Equipment
Billing Goals/ Expectations
Defensive Medicine
Hi Risk Environment
Previously sued
Time Pressures
Pressure from patients
Physician decision to order test, treatment, or referral
Discomfort w/ Uncertainty
Knowledge Deficit
Absence of Guidelines
Disagreement w/ Guidelines
Non-covered benefit
Cost of item To patient
Cost of item To system
Lack of Clinical Justification
Obstacles Placed by Payer
Risk to patient
Distance To Resource
Limited availability
Factors That Deter Order

Non-Malignant Neoplasm of Prostate

2008-2012 Data

Urologist	Total Amount Allowed (Actual)	Number of Episodes	$ Amount Allowed per Episode
A	$138,983	289	$481
B	$90,581	180	$503
C	$143,519	306	$469
D	$138,830	225	$617

Efficiency Index by Physician

Urologist	# of Episodes	Case Mix	Efficiency Index
A	131	1.05	0.89
B	176	0.9	1.30
C	184	1.05	0.77
D	82	0.97	1.11

Time Period: 09/30/2009 – 09/30/2011

Non-malignant neoplasm of prostate

Urologist	Service Category	Number of Services	Services per Episode	Network Services per Episode	Total Cost	Cost per Service	Network Cost per Service
A	Cystoscopy	0	N/A	N/A	N/A	N/A	N/A
B	Cystoscopy	25	0.14	0.08	$4,932	$197	$204
C	Cystoscopy	18	0.10	0.08	$3,662	$203	$204
D	Cystoscopy	0	N/A	N/A	N/A	N/A	N/A
A	Prostate Biopsy	2	0.02	0.05	$282	$141	$151
B	Prostate Biopsy	12	0.07	0.05	$1,856	$155	$151
C	Prostate Biopsy	17	0.09	0.05	$2,329	$137	$151
D	Prostate Biopsy	1	0.01	0.05	$143	$143	$151
A	TURP	3	0.02	0.02	$2,525	$842	$763
B	TURP	5	0.03	0.02	$3,745	$749	$763
C	TURP	5	0.03	0.02	$4,160	$832	$763
D	TURP	1	0.01	0.02	$863	$863	$763

Non-malignant neoplasm of prostate

Urologist	Service Category	Number of Services	Services per Episode	Network Services per Episode	Total Cost	Cost / Service	Network Cost per Service
A	Urodynamics	48	0.37	1.07	$1,046	$22	$37
B	Urodynamics	252	1.43	1.07	$6,596	$26	$37
C	Urodynamics	74	0.40	1.07	$1,640	$22	$37
D	Urodynamics	209	2.55	1.07	$10,469	$50	$37
A	Ultrasound - Abdominal or Pelvic	77	0.59	0.16	$6,443	$84	$83
B	Ultrasound - Abdominal or Pelvic	1	0.01	0.16	$96	$96	$83
C	Ultrasound - Abdominal or Pelvic	6	0.03	0.16	$276	$46	$83
D	Ultrasound - Abdominal or Pelvic	4	0.05	0.16	$407	$102	$83

Time Period: 09/30/2009 – 09/30/2011

MDN-Related Urologist Utilization Fingerprints

Urologist	Service Category	Number of Services	Services per Episode	Network Services per Episode	Total Cost	Cost per Service	Network Cost per Service
A	Ultrasound - Abdominal or Pelvic	77	0.59	0.16	$6,443	$84	$83
B	Ultrasound - Abdominal or Pelvic	1	0.01	0.16	$96	$96	$83
C	Ultrasound - Abdominal or Pelvic	6	0.03	0.16	$276	$46	$83
D	Ultrasound - Abdominal or Pelvic	4	0.05	0.16	$407	$102	$83

3

Don't order creatinine or upper-tract imaging for patients with benign prostatic hyperplasia (BPH).

When an initial evaluation shows only the presence of lower urinary tract symptoms (LUTS), if the symptoms are not significantly bothersome to the patient or if the patient doesn't desire treatment, no further evaluation is recommended. Such patients are unlikely to experience significant health problems in the future due to their condition and can be seen again if necessary. [While the patient can often tell the provider if the symptoms are bothersome enough that he desires additional therapy, another possible option is to use a validated questionnaire to assess symptoms. For example, if the patient completes the International Prostate Symptom Scale (IPSS) and has a symptom score of 8 or greater, this is considered to be "clinically" bothersome.]

End