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Small Ideas for Saving Big Health Care Dollars

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There is broad consensus that the rapid increase in health care costs is America's most vexing and most critical domestic policy problem. Victor Fuchs, considered by many to be the father of health economics, has been quoted as saying, "If we solve our health care spending, practically all of our fiscal problems go away" (Kolata, 2012). Peter Orszag, former director of the Office of Management and Budget, has written that "Rising health-care costs are at the core of the United States' long-term fiscal imbalance" (Orszag, 2011). The Congressional Budget Office has identified growth in spending on mandatory health care programs, particularly the Medicare program, as the single greatest threat to the solvency of the U.S. government (Congressional Budget Office, 2010). And a recent RAND study revealed that a decade of health care spending growth wiped out the real income gains of average American families (Auerbach and Kellermann, 2011).

Many proposals for tackling the health care cost problem have been offered. But for decades, the health policy process has been in a state of perpetual gridlock. This is, in part, because many proposed policies—for example, tort reform, pay for performance, and changing Medicare and/or Medicaid eligibility requirements—are both sweeping and controversial, and they often threaten the economic interests of one or more key stakeholder groups. Passage of the Affordable Care Act is an exception to the gridlock, but cost-reduction proposals that require legislation will clearly be difficult to implement.

In this paper, we have reversed the policy perspective and tackled the cost problem by thinking small. That is, rather than focusing on large, controversial ideas for reducing health care expenditures, we explored relatively focused approaches that would, for any particular idea, generate modest cost savings. The annual health care spending in the United States is $2.8 trillion; we cannot afford to leave money on the table.

The ideas we consider are based on RAND studies. They represent a small sample of all possible cost-saving ideas and therefore may not necessarily be those that are the most promising or most feasible. However, because RAND's research portfolio spans the health policy spectrum, our list of small ideas may serve as proof of concept of the types of initiatives that are possible. The net could be widened—for example, by searching the literature, asking experts, looking at projects funded by the Center for Medicare and Medicaid Innovation, and looking at the lists created by specialty societies of evidence-based recommendations that should be discussed to help make wise decisions about the most appropriate care for an individual patient. Promising candidate ideas could be subject to the same cost and feasibility analysis we have conducted, potentially highlighting opportunities for modest cost savings.

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Why Thinking Small Could Save Big

The U.S. health care system has not lacked for suggestions about how to slow cost growth. What it has lacked is an ability to successfully implement them broadly. For example, RAND analysis has shown that the most promising options for curbing health care spending involve changing the way that doctors and hospitals are paid to provide care—for example, by bundling payments for hospital episodes and paying a fixed amount prospectively for each kind of bundle (Hussey et al., 2009).

Bundled payment provides a single payment for "bundles" of related services during an episode of care—for example, a heart operation or a hip replacement—rather than paying the hospital, physicians, and other medical providers for each unit of service provided. The expectation is that this approach gives providers incentives to work together; the goal is to provide care more efficiently and eliminate duplicative and ineffective treatment.

Bundled payment is an appealing concept, but it has proven challenging to implement. A RAND team reported results of the first evaluation of a bundled payment system, called Prometheus, which is being implemented in the private sector (Hussey et al., 2012; Hussey, Ridgely, and Rosenthal, 2011). Because of the complexity of the intervention and a variety of other reasons, none of the pilot projects using Prometheus had a bundled payment system in place after three years of implementation—nor had they executed contracts between payers and providers. It appears that the benefits of a bundled payment approach may take considerable time and effort to achieve (Hussey, Ridgely, and Rosenthal, 2011). Therefore, we did not include it in our analysis.

But not all suggestions for flattening the trajectory of health spending require systemwide changes. The potential savings to be derived from other ideas for reining in costs may be very small compared with estimated savings from bundled payment. However, the ideas may be relatively easy to implement.

As an example, consider a recent study identifying a target for cost savings in a clinical environment: unnecessary use of anesthesia providers to deliver sedation during routine gastroenterology (GI) procedures (Liu et al., 2012a; Liu et al., 2012b). Under current guidelines, the endoscopy fee includes mild intravenous sedation, often administered by the endoscopy team. But recently propofol has become more widely used. It must be delivered by an anesthesiologist or nurse anesthetist—for an additional fee. The service and its fee are medically justifiable for high-risk patients (e.g., those with serious chronic heart problems) who must be carefully monitored during any procedure, but are discretionary for low-risk patients.

In 2009, about $1.3 billion was spent on anesthesia providers during GI procedures, but only about $0.2 billion was spent on high-risk patients. The remaining $1.1 billion could be a source of substantial savings. How feasible and politically palatable would it be to change guidelines so that anesthesia providers need not be involved in routine GI procedures, given that both kinds of sedation are equally safe and acceptable (Poincloux et al., 2011) to patients? How much could be saved annually at the national level?

Another example focuses on co-payments for drugs. Researchers from Stanford, RAND, and the University of Southern California collaborated to look at how certain medications might potentially affect costs (Goldman, Joyce, and Karaca-Mandic, 2006a). Their analysis suggests that giving chronic disease patients a financial incentive to comply with recommended drug therapy could decrease preventable hospitalizations by 80,000 to 90,000 per year and reduce use of emergency departments by 30,000 to 35,000 visits per year. These reductions could generate annual savings of roughly $1 billion. Could such incentives be provided? What if incentives were also provided for other drugs known to be effective?

These approaches, and others that we have analyzed, may be quite feasible to implement and only moderately politically sensitive. This is not to say that system-level changes should not be pursued with energy. But we cannot afford to ignore less-sweeping ideas for controlling cost growth.

These approaches may be quite feasible to implement and only moderately politically sensitive. We cannot afford to ignore less-sweeping ideas for controlling cost growth.

Study Goals and Approach

Our study had two goals:

1. Identify ideas for relatively focused changes that would generate cost savings.
2. Estimate potential savings for each idea at the national level.

RAND has been conducting health services research for more than 45 years on topics that have evolved to keep pace with a changing policy environment. Given our project goals, we thought it prudent to begin with this body of work, about which we felt we were in a strong position to

make judgments about political and operational feasibility. Thus, the primary database from which this analysis draws comprises recent and current RAND Health work.

However, in order to provide the most robust analysis possible, we drew from multiple sources to generate new cost estimates. For example, if a RAND study showed that a particular approach reduced health care use and specified some measure of use—for example, visits to a primary care physician or emergency department—but did not provide cost information reflecting that measure, we combined the utilization data with price information from other sources to estimate potential cost savings. Finally, we provide the aggregate potential savings if all ideas were implemented.

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Selection Process and Criteria for Small Ideas

We used a three-stage process to select ideas and cast a wide net to identify candidates:

1. We solicited suggestions from a targeted list of senior RAND Health researchers.
2. We also drew on the project team's extensive experience stemming from work we had conducted on topics spanning RAND Health's research portfolio.
3. Finally, we searched a comprehensive database of RAND publications—both articles in the peer-reviewed literature and RAND documents—over the past ten years.

Our initial searches identified more than 100 potential ideas. We first screened these using general criteria: Was the idea really a "small" idea? (In general, we stayed away from ideas that required system-level changes.) Was the idea relevant to the study goals?

The first screening resulted in 56 candidate ideas. We further screened these, using the following more-specific selection criteria:

- To be useful for our purposes, an idea needed to **be well defined and affect the health care delivery system**. It also had to be one that was either expected to yield health benefits (for example, patient safety improvements) or at least be, in a sense, quality-neutral (for example, using lower-cost anesthesia services for routine colonoscopies). Moreover, we excluded public health interventions because direct health care costs are not easily assessed; savings may accrue many years after an intervention, or the benefits may be indirect savings outside of the health care system.
- Ideas needed to **be operationally and politically feasible**. In the case of operational feasibility, our selection reflected an estimate of whether it would be possible to scale up a promising cost-saving strategy to the national level if, for instance, it had been demonstrated to work in only a small geographic area or with respect to a relatively small subpopulation. In the case of political feasibility, the selection reflected our judgment about how many and which groups would be affected by implementing the idea. We selected the ideas based on our professional judgment of operational and political feasibility, drawing on our combined expertise and the experience of senior RAND colleagues. If an idea had already been implemented in some fashion, we drew specifically on the implementation results in determining our selection. Finally, in gauging both operational and political feasibility, we considered the economic incentive structure(s) faced by both consumers and providers. That is, our feasibility assessments considered the extent to which there may be a divergence of incentives between providers and consumers or between provider types (for example, physicians and hospitals).
- Because our goal was to estimate aggregate national savings, we included as a criterion the **expected feasibility of generating a credible cost estimate based on the study**. We assessed the feasibility of generating a cost estimate based on the expected availability of cost, utilization, and effectiveness data in the literature.

Examples of the kinds of ideas we excluded are adoption of health care information technology to improve efficiency of health care delivery, use of medical homes to reduce hospital spending, use of disease management, improving end-of-life care, and bundled payments.

After this second screening, we identified 14 ideas for analysis. Table 1 lists these ideas, along with a capsule summary and key references. We have grouped the ideas into two categories: those involving substitution of a lower-cost treatment for a higher-cost treatment and those drawn from the literature on patient safety. Moving forward, our plan is to add "small ideas" to this list as evidence from current and future RAND Health studies develops.

Table 1. Small Ideas for Saving Big Health Care Dollars

Cost-Saving Idea	Summary	Key References
Substituting Lower-Cost Treatments		
Reduce use of anesthesia providers in routine gastroenterology (GI) procedures for low-risk patients	The use of dedicated anesthesia providers for routine GI procedures is deemed medically justifiable only for high-risk patients. Eliminating these services for low-risk patients would reduce costs.	Liu et al., 2012a
Change payment policy for emergency transport	Changing Medicare's reimbursement policy would allow emergency medical service agencies to carefully manage selected patients in alternate ways. For example, transporting patients with non-emergent conditions to alternate care locations, such as a physician's office, or treating them on scene could generate savings for Medicare.	Alpert et al., 2013
Increase use of lower-cost antibiotics for treatment of acute otitis media (AOM)	Most antibiotics used to treat uncomplicated AOM (middle ear infection) in children at normal risk have similar rates of clinical success. Amoxicillin is a less costly and equally effective alternative to cefdinir.	Coker et al., 2010
Shift care from emergency departments to retail clinics when appropriate	For certain medical services, retail clinics offer lower-cost care of comparable quality. About 8 percent of all emergency department visits could take place at retail clinics. For analytic purposes, it was assumed that patients would select the appropriate place for care.	Weinick, Burns, and Mehrotra, 2010
Eliminate co-payments for higher-risk patients taking cholesterol-lowering drugs	Reducing co-payments can motivate patients to comply with drug therapy and manage treatment of chronic illness, thereby reducing hospitalizations and emergency department visits.	Goldman, Joyce, and Karaca-Mandic, 2006b
Increase use of $4 generic drugs	Only a small percentage of Medicare beneficiaries take advantage of existing $4 generic drug programs. Policies could encourage program use among beneficiaries who have not been using them or among those who could save the most; Medicare would also capture cost savings.	Zhang, Zhou, and Gellad, 2011
Reduce Medicare Part D use of brand-name prescription drugs by patients with diabetes	Medicare beneficiaries with diabetes use two to three times more brand-name drugs, at substantial costs, compared with a similar group within the Department of Veterans Affairs.	Gellad et al., 2013
Patient Safety		
Prevent three types of health care–associated infections:		
• Central line–associated bloodstream infections	The use of recommended practices for reducing central line–associated bloodstream infection—including hand hygiene, barrier precautions, chlorhexidine use, topical antibiotic use, education, checklists, and catheter kits—can avert infections, leading to reductions in treatment costs.	Shekelle et al., 2013a; Scott, 2009; Umscheid et al., 2011; Waters et al., 2011
• Ventilator-associated pneumonia	The use of prevention bundles—including head-of-bed elevation, sedation vacations, oral care with chlorhexidine, and subglottic suctioning endotracheal tubes—can avert pneumonia infections, leading to reductions in treatment costs.	Shekelle et al., 2013a; Scott, 2009; Umscheid et al., 2011; Waters et al., 2011
• Catheter-associated urinary tract infections	The use of strategies to encourage appropriate catheter use—including education, protocols on appropriate use, hospital/unit policy for appropriate catheter placement, computerized orders and removal reminders (for example, checklists, verbal/written reminders, stickers on charts or catheter bags, e-reminders) or stop orders—can avert infections, leading to reductions in treatment costs.	Shekelle et al., 2013a; Scott, 2009; Meddings et al., 2010; Clarke et al., 2013; Saint et al., 2005
Use preoperative and anesthesia checklists to prevent operative and postoperative events	The use of checklists, such as the World Health Organization Surgical Safety Checklist, has been shown to reduce surgical complications. The reduction of surgical complications is potentially cost-saving if the checklist intervention costs are less than the treatment costs for surgical complications.	Shekelle et al., 2013a; Semel et al., 2010

Table 1—continued

Cost-Saving Idea	Summary	Key References
Patient Safety		
Prevent in-facility pressure ulcers	The use of interventions to reduce in-facility pressure ulcers—including components focused on organization (teams, policies, procedures, quality evaluation, staff education, and communications), prevention (risk and skin assessment, moisture management, nutrition and hydration optimization, and pressure management), and care coordination—can reduce the incidence of pressure ulcers and the associated treatment costs.	Shekelle et al., 2013a; Sullivan and Schoelles, 2013; Rosen et al., 2006
Use ultrasound guidance for central line placement	The use of real-time ultrasonography for central line placement reduces complications and associated treatment costs; effectiveness has been shown for patients in the emergency department, patients on ventilators, and critical care patients, among others.	Shekelle et al., 2013a; Calvert et al., 2004
Prevent recurrent falls	Medicare benefits for patients with a prior fall including physician payment for a fall risk assessment, reimbursement for rehabilitation therapy, and payment for a follow-up visit. Payment for these benefits is cost-effective and potentially cost-saving by preventing recurrent falls among high-risk elderly.	Wu et al., 2010; Shekelle et al., 2003

Estimated Cost Savings for Specific Ideas

Our cost savings estimates are either updates of existing estimates from RAND Health research or new estimates generated using information from multiple sources. Estimates stemming from RAND cost analyses include reducing use of anesthesia providers for GI procedures, changing payment policy for emergency transport, increasing use of lower-cost antibiotics for treatment of acute otitis media (AOM), eliminating co-payments for higher-risk patients taking cholesterol-lowering drugs, increasing the use of $4 generic drugs, reducing Medicare Part D use of brand-name prescription drugs for diabetes, and preventing recurrent falls. For ideas drawn from RAND analyses that lacked cost savings estimates, we generated estimates by combining information from RAND research with cost and utilization analyses from non-RAND work.

To generate cost savings estimates, we calculated the potential savings minus the costs of the necessary interventions or alternative actions. We assessed costs from the perspective of the health care system—that is, costs to hospitals, such payers as Medicare, or patients. We considered only direct costs to the health care system; we did not include lost patient wages and time and other indirect costs. We assumed that a change in payment policy would essentially be costless. We also calculated lower- and upper-bound estimates when ranges of parameter values were available; the bounds reflect uncertainty in the model inputs and assumptions.

Table 2 presents our savings estimates for each idea. Ranges indicate lower and upper bounds of our best estimate; ranges are not provided when only point estimates are available. The lower and upper bounds show the range of potential savings based on different scenarios and assumptions. All dollar values reported here are adjusted to 2012 U.S. dollars using the medical care Consumer Price Index for all urban consumers (U.S. Bureau of Labor Statistics, 2013). When the estimates given in the research were focused on a specific locale and national level data were not available, we assumed that the regional parameters were representative and scaled the estimates up to the national level. Additional details on the specific methodology and parameters used for each cost savings estimate are provided in the appendix.

Substituting Lower-Cost Treatments

The ideas we considered for substituting lower-cost for higher-cost treatment include reimbursement for anesthesia services, emergency transport, AOM antibiotics, retail clinic services, and medication payments. The estimated savings for these ideas do not include the cost of specific interventions. Although interventions to increase use of retail clinics, generic drug programs, or lower-cost antibiotics for AOM may be associated with some cost, we assume that these costs would be low. Our estimates may overstate the potential savings if substantial intervention costs would be necessary.

During **gastrointestinal endoscopies**, endoscopists may administer intravenous sedation with nurse support; the services of an anesthesiologist or nurse anesthetist are required for deep sedation or general anesthesia. Such services incur an additional payment that is potentially discretionary for low-risk patients. We estimate that restricting

Table 2. Savings Estimates for Small Ideas

Cost-Saving Idea	Estimated Annual Savings (2012 U.S. dollars in millions)
Substituting Lower-Cost Treatments	
Reduce use of anesthesia providers in routine gastroenterology procedures for low-risk patients	$1,200
Change Medicare payment policy for emergency transport	$290–$580*
Increase use of lower-cost antibiotics for treatment of uncomplicated acute otitis media	$36
Shift care from emergency departments to retail clinics where appropriate	$3,500 ($1,200–$4,400)
Eliminate co-payments for higher-risk patients taking cholesterol-lowering drugs	$1,300
Increase use of $4 generic drugs	$5,900 ($4,900–$6,800)
Reduce Medicare Part D use of brand-name prescription drugs by patients with diabetes	$1,500
Subtotal for substituting lower-cost treatments	$14,000 ($10,000–$16,000)
Patient Safety	
Prevent three types of health care–associated infections:	
• Central line–associated bloodstream infections	$18 (–$55–200)
• Ventilator-associated pneumonia	$47 (–$5–$110)
• Catheter-associated urinary tract infections	$100 (–$88–$170)
Use preoperative and anesthesia checklists to prevent operative and postoperative events	$170 (–$110–$950)
Prevent in-facility pressure ulcers	$2,400 ($1,600–$4,400)
Use ultrasound guidance for central line placement	$56
Prevent recurrent falls	$900
Subtotal for patient safety	$3,700 ($2,300–$6,800)
Grand total	**$18,000 ($13,000–$22,000)**

* The midpoint of the range was used as the best estimate in the totals.
NOTES: The savings estimates for each idea and the totals are rounded to two significant figures. A negative estimate indicates a net cost.

payments for anesthesia services for low-risk patients undergoing outpatient endoscopies and colonoscopies could save approximately $1.2 billion per year (Liu et al., 2012a).

The Centers for Medicare & Medicaid Services (CMS) currently reimburses **emergency medical services** providing transport only if the patient is transported to an emergency department. Although only a small portion of emergency situations could be appropriately managed at non–emergency department locations, an estimated $290–$580 million per year could potentially be saved by expanding Medicare reimbursement policy to cover emergency medical transport to non–emergency department locations (Alpert et al., 2013). The savings are due to a potential reduction in CMS spending by shifting emergency medical service transports of patients with non-emergent conditions from emergency departments to lower-cost care settings.

Antibiotic choice for treatment of AOM varies; however, comprehensive assessment of multiple studies identified no significant differences in the comparative effectiveness of different antibiotics. The use of lower-cost antibiotics for uncomplicated AOM would save money and result in similar clinical outcomes. For example, approximately $36 million could be saved annually if physicians prescribed amoxicillin instead of cefdinir for half of the children presenting with uncomplicated AOM each year (Coker et al., 2010). In this savings estimate, Coker et al. assumed that approximately half of uncomplicated AOM cases were appropriately prescribed cefdinir because of penicillin allergy.

The presence of **retail clinics** has increased across the United States. These medical offices are located in nontraditional care settings, such as pharmacies or grocery stores, and provide a range of preventive care services and treat-

ment for simple acute conditions. Treating about 8 percent of non–life-threatening conditions at retail clinics instead of emergency departments could save $3.5 billion dollars each year (Weinick, Burns, and Mehrotra, 2010). A limitation of this cost savings estimate is our assumption that for this 8 percent of conditions, patients will choose to visit retail clinics. We have not included any intervention costs for educating patients about retail care services or incentivizing patients to visit retail clinics for certain conditions.

Tailoring co-payments to risk group and disease has been explored as a way to improve medication compliance and disease management. Goldman, Joyce, and Karaca-Mandic (2006b) showed that **eliminating co-payments for higher-risk patients taking cholesterol-lowering drugs** could potentially save more than $1.3 billion per year because of improved drug compliance and reduced hospitalizations and emergency department visits.

Generic prescription drug programs offering $4 generics are available at such retail stores as Wal-Mart and Target. If 50 percent of individuals using brand-name drugs switched to $4 generics, annual savings are estimated at $5.9 billion; if 30 percent or 100 percent of users were to switch, the annual savings could be approximately $4.9 or $6.8 billion, respectively (Zhang, Zhou, and Gellad, 2011). These estimates are 2012 adjusted values of estimates calculated by Zhang, Zhou, and Gellad, using a nationally representative sample from the Medical Expenditure Panel Survey.

Brand-name drug spending for patients with diabetes in Medicare Part D is two to three times greater than spending in the Department of Veterans Affairs (VA) (Gellad et al., 2013). If Medicare Part D brand-name drug use matched VA use, the estimated annual savings would be approximately $1.5 billion. Gellad et al. attribute the difference in spending partly to structural differences between the two payers. For example, the VA pharmacy benefits are based on a single formulary, which permits more "therapeutic substitution"—that is, prescribers can more easily switch patients to other drugs in the same class. The VA provides a reasonable benchmark for use of generic drugs in Medicare, and policy levers for increasing appropriate use of generic medications in Part D are available.

Patient Safety

The patient safety ideas shown in Table 2 were among those assessed by staff from the Southern California Evidence-Based Practice Center (Shekelle et al., 2013a); these ideas were recommended for adoption because evidence for their effectiveness was strong (Shekelle et al., 2013b).

If 50 percent of individuals using brand-name drugs switched to $4 generics, annual savings could be approximately $5.9 billion.

We calculated savings estimates for the prevention of three common health care–associated infections (HAIs): **central line–associated bloodstream infection**, **ventilator-associated pneumonia**, and **catheter-associated urinary tract infection**. The bundled interventions would be cost-saving if the savings from averted infections and associated treatment costs outweigh the cost of the bundled interventions. We estimated that the savings resulting from preventing these infections were $18, $47, and $100 million per year, respectively. Although our best estimates are positive, indicating cost savings, the lower-bound estimates were negative, meaning that the interventions for each of these HAIs could potentially result in a net cost. The negative lower-bound savings estimates reflect the uncertainty in the cost parameters and intervention effectiveness. Nonetheless, these HAI interventions are evidence-based practices that are likely to be cost-effective (we did not include nonmonetary benefits, such as patient health improvements and reduced sick days).

Studies have demonstrated that **preoperative and anesthesia checklists** can help prevent wrong-site surgeries, such surgical complications as surgical site infections, and other operative events (Semel et al., 2010). Based on a cost-benefit analysis by Semel et al., we estimate that national use of surgical checklists, such as the World Health Organization's Surgical Safety Checklist, could potentially save $170 million per year in the prevention of surgical complications. Similarly to the HAI lower-bound estimates, the lower-bound estimate for surgical checklists indicates the possibility of a net cost because of uncertainty in the current utilization of checklists and the effectiveness of checklists nationwide.

Each year, more than 1 million patients develop pressure ulcers in U.S. acute and long-term care settings (Sullivan and Schoelles, 2013). Patients with pressure ulcers often have longer inpatient stays, and some late-stage pressure ulcers lead to life-threatening infections (Shekelle et al., 2013a). A combination of different education and evidence-based practices can **reduce the occurrence of in-facility pressure ulcers** by 82 percent (Sullivan and Schoelles, 2013). We estimate that these interventions can save approximately $2.4 billion annually in treatment costs.

The use of central venous catheters often saves lives, but the placement process is also risky. Using **portable ultra-**

sound devices that provide real-time imaging of central veins during the insertion process can potentially decrease these risks significantly (Shekelle et al., 2013a). We estimate that using this technology would reduce health care spending by $23 million each year.

Preventing recurrent falls requires multicomponent interventions. The proposed Falls Rehabilitation Program is a service to Medicare beneficiaries who have experienced a recent fall. It provides physician payment for fall risk assessment, reimbursement for rehabilitation therapy/exercise, and payment for a follow-up visit. A RAND cost analysis estimated that preventing recurrent falls in the Medicare population could save $900 million a year (Wu et al., 2010). Although the cost of prevention services would be borne by Medicare, the reduction in health care costs would benefit all payers.

Table 2 provides estimated subtotals of annual savings for each category of ideas. In the case of substituting lower-cost treatments for high-cost ones, the estimated total annual savings could be $14 billion, with a range of $10 to $16 billion. Small ideas in the area of patient safety could generate over $3.7 billion annually, with a range of $2.3 to $6.8 billion. Total annual savings for implementing all of the small ideas could be $18 billion, with estimates ranging from about $13 to $22 billion.

Our estimates reflect the difference in spending if we had implemented all of these ideas in the prior year. The savings are one-time in the sense that they would be a one-time change that moved us to a different cost trajectory. The cost savings we estimated are recurrent in the sense that these ideas could change the trajectory of health care spending by about $13 to $22 billion annually. That is, we could be spending about $13 to $22 billion more than we need to every year if we do not pursue these ideas.

The subtotal and total ranges reflect a straightforward addition of ranges for each specific idea. In cases in which an idea is associated with a single point savings estimate, we used that estimate in tallying both the upper- and the lower-bound totals. Our decision to report ranges stems from the inherent uncertainty associated with this exercise. But our goal is to suggest the magnitude of cost savings that could be generated by relatively small changes, should policymakers decide to focus on that level.

Rating Political and Operational Feasibility

Of course, achieving the estimated savings depends not only on bringing specific small ideas to the attention of those who could implement them, but also on an idea's political and operational feasibility.

Table 3. Feasibility of Small Ideas

Cost-Saving Idea	Political Feasibility	Operational Feasibility
Substituting Lower-Cost Treatments		
Reduce use of anesthesia providers in routine gastroenterology procedures for low-risk patients	Medium	High
Change Medicare payment policy for emergency transport	Low	High
Increase use of lower-cost antibiotics for treatment of uncomplicated acute otitis media	High	Medium
Shift care from emergency departments to retail clinics where appropriate	Medium	Medium
Eliminate co-payments for higher-risk patients taking cholesterol-lowering drugs	High	High
Increase use of $4 generic drugs	High	Medium
Reduce Medicare Part D use of brand-name prescription drugs by patients with diabetes	Medium	Medium
Patient Safety		
Prevent three types of health care–associated infections:		
• Central line–associated bloodstream infections	High	Medium
• Ventilator-associated pneumonia	High	Medium
• Catheter-associated urinary tract infections	High	Medium
Use preoperative and anesthesia checklists to prevent operative and postoperative events	High	Medium
Prevent in-facility pressure ulcers	High	Medium
Use ultrasound guidance for central line placement	High	Medium
Prevent recurrent falls	High	Medium

To provide some rough sense of these two dimensions, we assigned a ranking of low, medium, or high operational and political feasibility to each idea (Table 3). Our rankings reflect our review of the relevant literature and the professional judgment of two of the team members (Jeanne Ringel and Jeffrey Wasserman), based on their expertise and knowledge of the health care system. In general, there was little disagreement between these two team members. When disagreements arose, each laid out his or her case, and they then discussed and resolved their differences.

In the case of political feasibility, the rankings reflect our judgment about the number and kinds of stakeholder groups who might oppose an idea. For operational feasibility, our rankings reflect an estimate of whether a promising cost-saving strategy could be scaled up. If an idea had already been implemented in some way, the implementation results figured prominently in our rankings. Operational feasibility rankings of most of the patient safety ideas are based on assessments of implementation issues in a patient safety evidence report (Shekelle, 2013a).

Ideas in the patient safety category are highly feasible politically and at least moderately feasible to operationalize. In contrast, we generally ranked ideas in the category of substituting lower-cost treatments for high-cost ones as only modestly feasible on both political and operational dimensions.

Summary

Our focused review of recent and current RAND Health research identified a handful of small ideas that if successfully implemented could, in the aggregate, save the U.S. health care system $13 to $22 billion per year. Small ideas have the virtue of not requiring systemic change; as a result, they may be both more feasible to operationalize and less likely to encounter stiff political and organizational resistance.

The ideas obviously differ in the amount of potential savings offered. However, they also differ substantially in terms of political and operational feasibility.

Patient safety ideas have high political feasibility, and it seems unlikely that stakeholders would oppose them in principle. Preventing infections, pressure ulcers, and falls is a sign of good care, and each of the patient safety ideas encapsulates a quality-of-care goal to be pursued in its own right. However, the need for behavioral and cultural change may make these ideas more challenging to implement. For example, implementation may require changing well-established habits and beliefs of nurses and physicians.

Total annual savings from implementing all of the small ideas could be $18 billion, with estimates ranging from about $13 to $22 billion.

The patient safety ideas offer only 28 percent of the savings that could result from implementing ideas in the category of substituting lower-cost treatment. But ideas in this latter category are likely to be more challenging to implement.

Consider, for example, the idea of reducing use of anesthesia providers for low-risk patients undergoing routine GI procedures. The estimated annual savings from implementing this idea are in the range of $1.2 billion. The idea is moderately feasible from a political perspective—one might anticipate pushback from some professional organizations or provider groups. However, the idea appears to be relatively straightforward to implement. Presumably, reimbursing GI anesthesia providers only for high-risk patients would provide a financial incentive for low-risk patients and providers to choose mild intravenous sedation, often administered by the endoscopy team. This was the standard procedure before the introduction of propofol in this clinical environment, and it is an option that many patients say they prefer.

On the other hand, in a generously insured fee-for-service environment, it has proven very difficult to control "treatment creep"—that is, the extension of treatments that are beneficial for some patients to other patients who are less severely ill or who have different diseases. In addition, it is hard to enforce such criteria as "high-risk patient" when it is the provider who assesses whether patients are high-risk and profits more if they are.

To take another example: Increasing use of lower-cost antibiotics for treatment of AOM offers modest savings of about $36 million annually. It is highly feasible politically, but it has lower operational feasibility because physician treatment practices may be difficult to change, given that antibiotic use interventions may be limited to guideline changes or educational materials.

Our analytic exercise highlights areas where modest savings could be generated without systemic changes. Going forward, a promising *tactical* approach to cost reduction, especially in a highly polarized political environment, may be to identify and implement small ideas, ultimately saving big health care dollars. We hope that this paper will serve as a catalyst to others. Our methodology could provide a model to suggest what cost savings might emerge from other studies.

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About This Report

A focused review of RAND Health research identified small ideas that could save the U.S. health care system $13 to $22 billion per year if successfully implemented. This research is likely to be of interest to policymakers and health care stakeholders in the United States.

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