Tackling Low-Value Clinical Care

Task Force on Low-Value Care

March 2018

Outline


1
Background on Issue
2
Task Force
3
Top Five List
4
Accomplishments
5
Resources

A Taxonomy of Waste

Administrative Waste

- Complexity
- Fraud
- Pricing failures

Operational Waste

- Inefficiencies in care delivery
- Unduly expensive inputs
- Errors
- Duplicative services

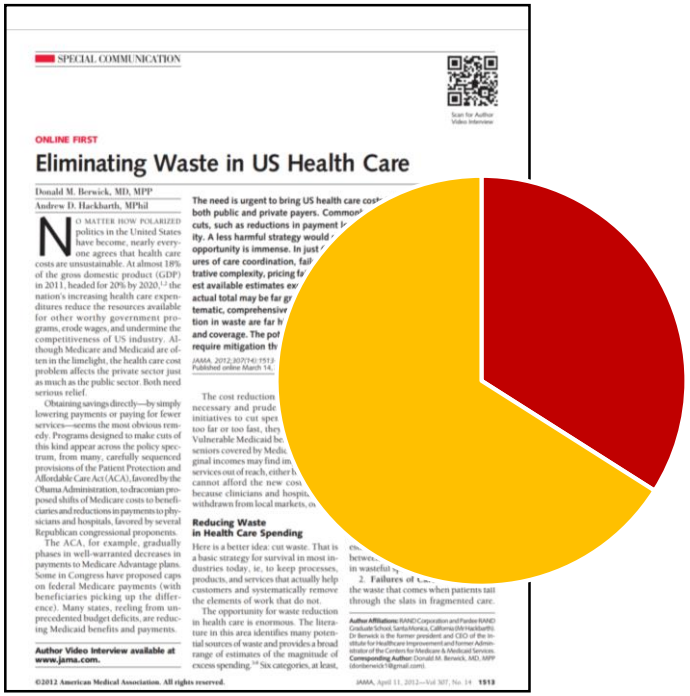
Clinical Waste

- Care that does not deliver net benefit (overtreatment)
- Care that offers no benefit over less costly alternatives
- Care that delivers benefit, but does not meet standards of cost-effectiveness

Bentley TGK, Effros RM, Palar K, Keeler EB. Waste in the U.S. Health Care System: A Conceptual Framework. *Milbank Q*. 2008;86(4):629-659.
OECD. *Tackling Wasteful Spending on Health*. Paris: OECD Publishing; 2017.

Why Waste?

2012 Analysis:
34% of
Spend Wasted



SPECIAL COMMUNICATION

ONLINE FIRST

Eliminating Waste in US Health Care

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NO MATTER HOW POLARIZED politics in the United States have become, nearly everyone agrees that health care costs are unsustainable. At almost 18% of the gross domestic product (GDP) in 2011, headed for 20% by 2020,[1,2] the nation's increasing health care expenditures reduce the resources available for other worthy government programs, erode wages, and undermine the competitiveness of US industry. Although Medicare and Medicaid are often in the limelight, the health care cost problem affects the private sector just as much as the public sector. Both need serious relief.

Obtaining savings directly—by simply lowering payments or paying for fewer services—seems the most obvious remedy. Programs designed to make cuts of this kind appear across the policy spectrum, from many, carefully sequenced provisions of the Patient Protection and Affordable Care Act (ACA), favored by the Obama Administration, to draconian proposed shifts of Medicare costs to beneficiaries and reductions in payments to physicians and hospitals, favored by several Republican congressional proponents.

The ACA, for example, gradually phases in well-warranted decreases in payments to Medicare Advantage plans. Some in Congress have proposed caps on federal Medicare payments (with beneficiaries picking up the difference). Many states, reeling from unprecedented budget deficits, are reducing Medicaid benefits and payments.

Author Video Interview available at www.jama.com.

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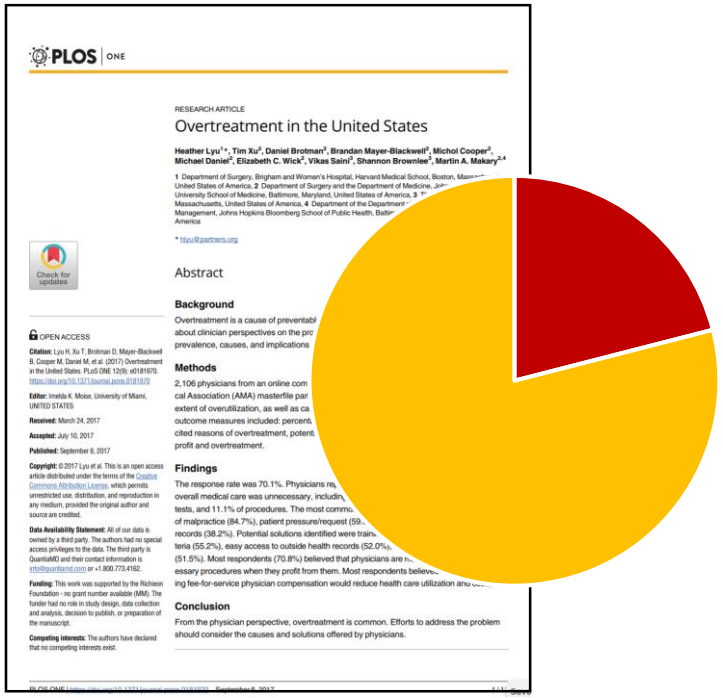
2017 Physician Survey:
21% of
Care Unneeded



PLOS ONE

RESEARCH ARTICLE

Overtreatment in the United States

Abstract

Background

Methods

Findings

Conclusion

From the physician perspective, overtreatment is common. Efforts to address the problem should consider the causes and solutions offered by physicians.

Why Low-Value Care?

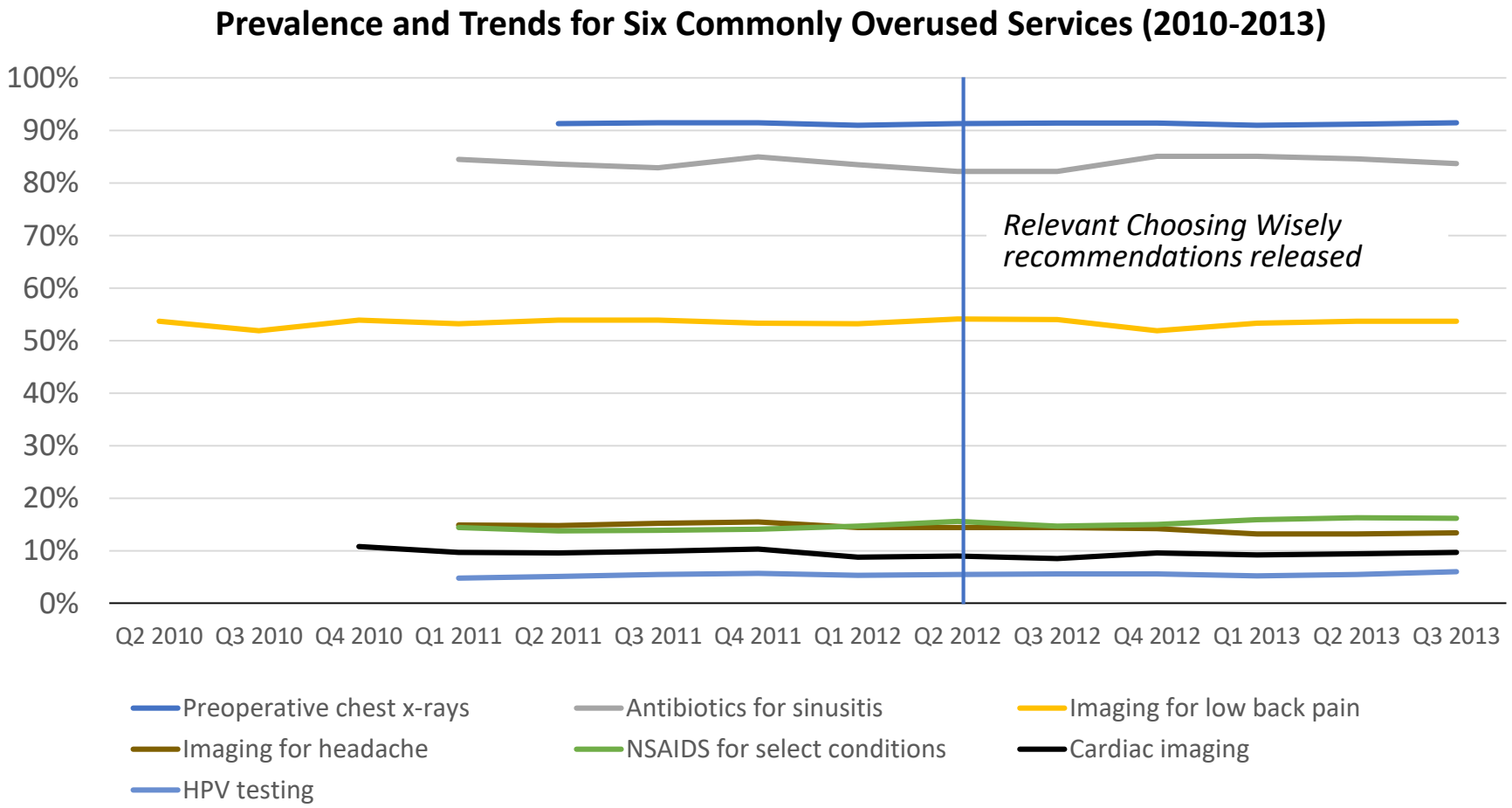
Harm to Patients	Direct physical harm and worry
	Cascading downstream harm
	Opportunity cost and time
	17-33% of costs borne OOP

Why a Task Force?

As of March 2018, there are 546 Choosing Wisely Recommendations…

Why a Task Force?

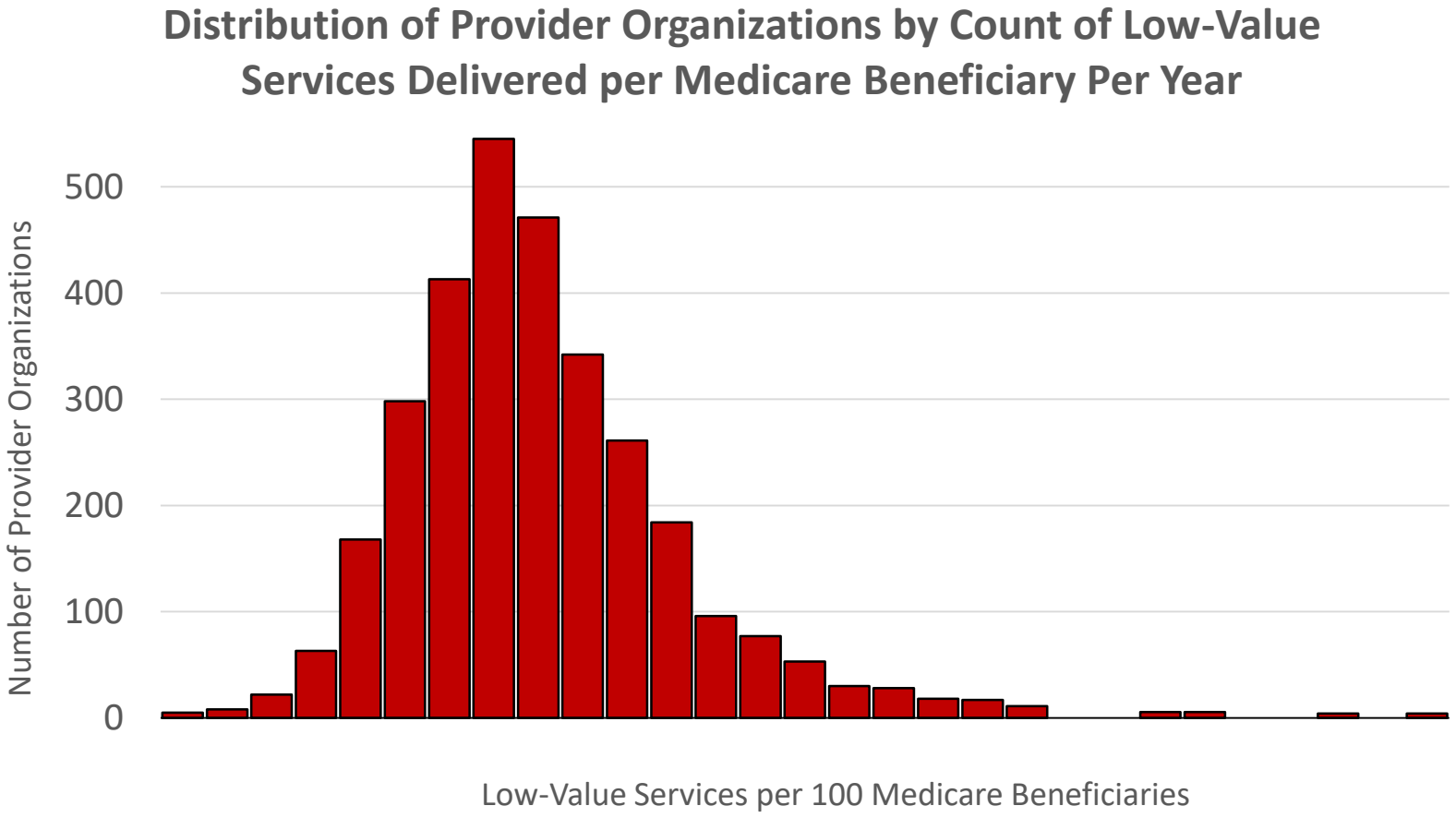
…But Minimal Progress from Information-Only…



Rosenberg A, et al. Early Trends Among Seven Recommendations from the Choosing Wisely Campaign. *JAMA Intern Med*. 2015;175(12):1913-1920.

Why a Task Force?

We know we can do better.



Schwartz AL, et al. Low-Value Service Use in Provider Organizations. *Health Serv Res*. November 2016.

Payer Levers

Provider-Facing
Coverage Policies
Payment Policies
Alternative Payment Models (APMs)
APM Performance Measures
Prior Authorization
Learning Collaboratives
Provision of Profiling Data
Incentives for Use of Clinical Decision Support

Patient-Facing
Value-Based Insurance Design
Network Design
Support for Shared Decision-Making

Building a Top Five List

Key Criteria

Unit Price	Volume	Aggregate Cost
Harm	Political Sensitivity	High Waste Index

5 Commonly Overused Services Ready for Purchaser Action

1. Diagnostic Testing and Imaging Prior to Surgery

2. Vitamin D Screening

3. PSA Screening in Men 75+

4. Imaging in First 6 Weeks of Low Back Pain

5. Branded Drugs When Identical Generics Are Available

1. Unindicated Diagnostic Testing and Imaging in Low-Risk Patients Prior to Low-Risk Surgery

WHAT

Low-risk patients undergoing low-risk surgery do not need many commonly provided blood tests, imaging services, and more.

WHY

Unneeded tests and imaging services:

- Rarely change patient management
- Delay needed care
- Identify clinically insignificant abnormalities

BURDEN

Nationwide in 2014:

- About **19 million** unneeded pre-surgery tests/images performed
- About **$9.5 billion** in spending resulted

2. Vitamin D Screening

WHAT

Population-based screening for 25-OH-Vitamin D deficiency should be avoided.

WHY

Vitamin D deficiency is rare. If deficiency suspected, patients should simply be advised to take an over-the-counter supplement and increase sun exposure.

BURDEN

Nationwide in 2014:

- About **6.3 million** unneeded screening tests performed
- About **$800 million** in spending resulted

3. Prostate-specific antigen (PSA) screening in men 75 and older

WHAT

In men 75 and older, screening for prostate cancer through the PSA blood test should almost never be performed.

WHY

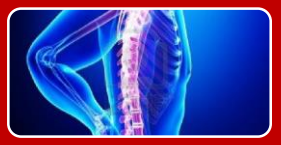
- Over-diagnosis associated with serious harm
- Harms of screening in men 75+ unambiguously outweigh benefit

BURDEN

Nationwide in 2014:

- At least **1 million** unneeded screenings in men 75+ performed
- Tests alone resulted in at least **$44 million** in spending

4. Imaging for acute low-back pain for first six weeks after onset, unless clinical warning signs are present



WHAT

X-rays, computed tomography (CT), and magnetic resonance imaging (MRI) should be avoided during first six weeks of low-back pain, unless a specific clinical warning sign is present.

WHY

- Rarely changes patient management
- X-rays and CT expose patients to unneeded radiation
- Detects clinically insignificant abnormalities

BURDEN

Nationwide in 2014:

- About **1.6 million** avoidable imaging services performed
- About **$500 million** in spending resulted

5. Use of more expensive branded drugs when generics with identical active ingredients are available

WHAT

Branded medications should not be prescribed when less expensive, chemically identical generics are available. (This is distinct from therapeutic substitution, when non-equivalent medications are substituted for one another.)

WHY

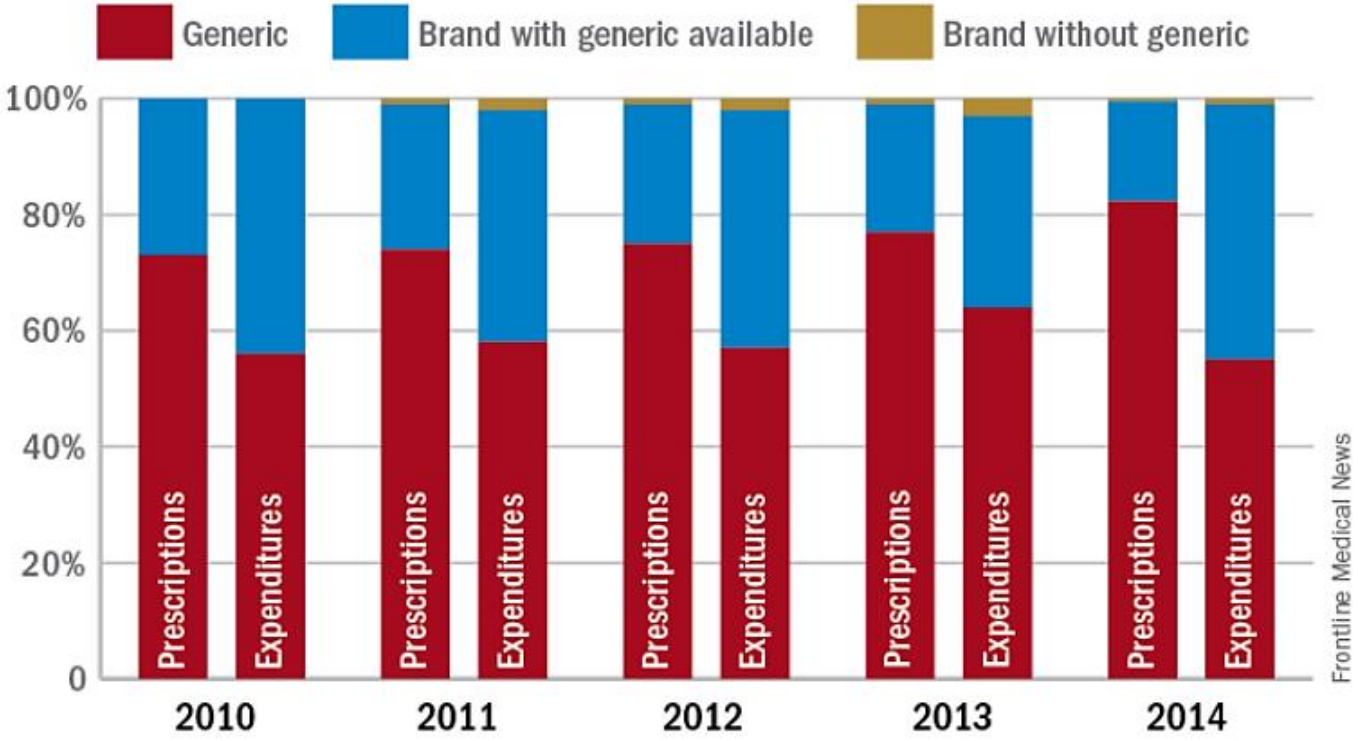
Prescribing of more expensive, chemically identical medications buys no extra health per dollar.

BURDEN

Purchasers would have saved $14.7 billion in 2016 had 100% of prescriptions with generics available been dispensed as generics

5. Use of more expensive branded drugs when generics with identical active ingredients are available

Distribution of Oral Contraceptive Prescriptions and Expenditures



Note: Based on data for 19,944 prescribing events from the Medical Expenditure Panel Survey.

Source: JAMA Intern Med. 2018 Jan 16. doi: 10.1001/jamainternmed.2017.7849

Outreach

Media

- Press Release
- Modern Healthcare References
- American Journal of Managed Care
- New York Times Reference
- Twitter
- More

Presentations

- AcademyHealth National Health Policy Conference
- Health Affairs briefing
- AcademyHealth Webinar
- Mid-America Coalition on Health Care
- American College of Preventive Medicine (Upcoming)

Materials

Resources

- Materials for distribution
- Specifications for claims-based analyses
- Sample RFI language for purchaser use with health plans
- Health Affairs Blog post – outline of levers

Materials

Google “Task Force on Low-Value Care”