Tackling Low-Value Clinical Care: Background

Task Force on Low-Value Care

September 2018

Outline

1. Background on Low-Value Care

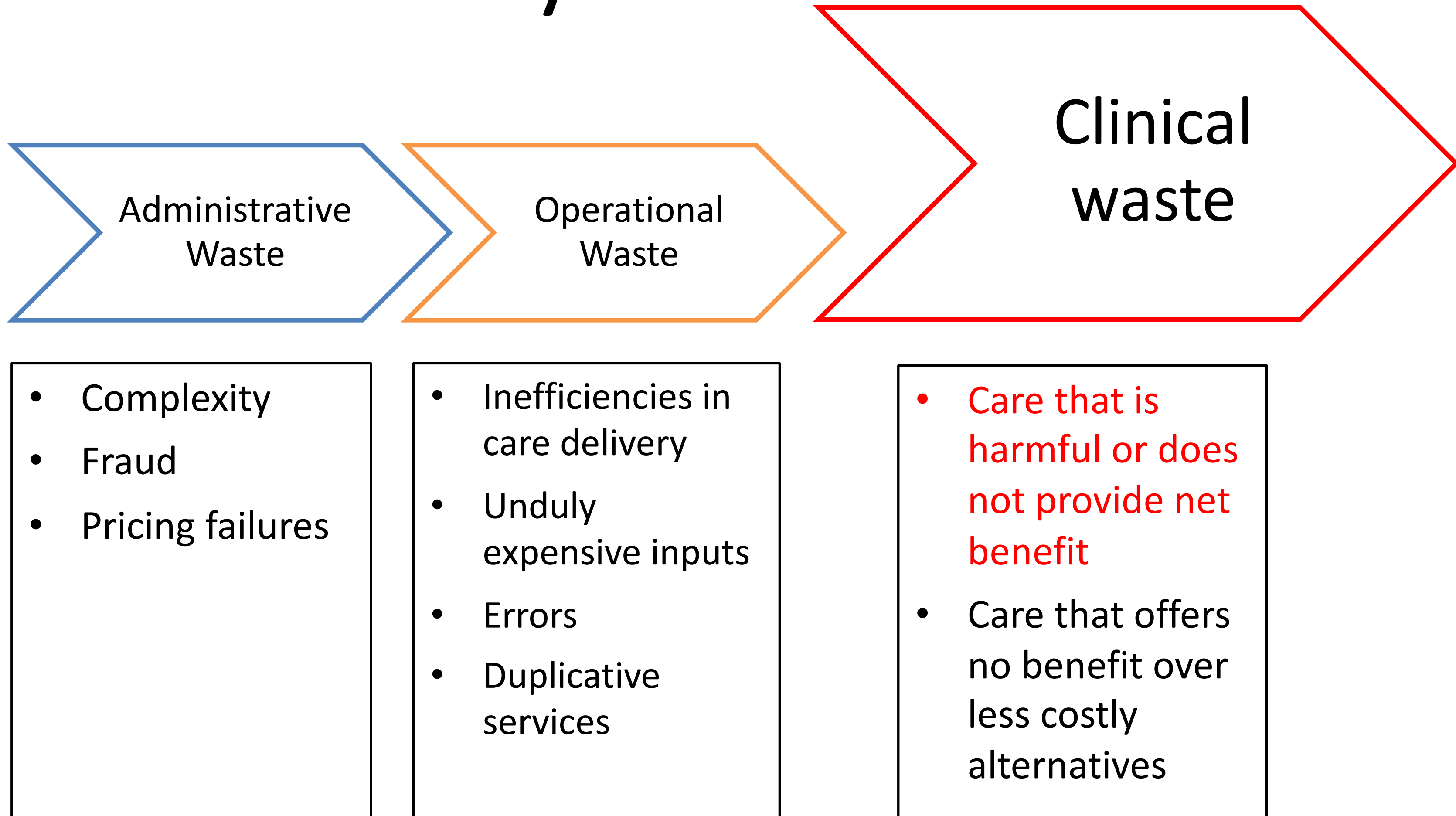
2. Why a Task Force

3. Top Five List and News

4. Levers

5. Resources

A Taxonomy of Waste



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 Clinical Waste?

2012 Analysis:
34% of
Spend Wasted

SPECIAL COMMUNICATION

ONLINE FIRST

Eliminating Waste in US Health Care

Donald M. Berwick, MD, MPP
Andrew D. Hackbarth, MPhil

2017 Physician Survey:
21% of
Care Unneeded

PLOS ONE

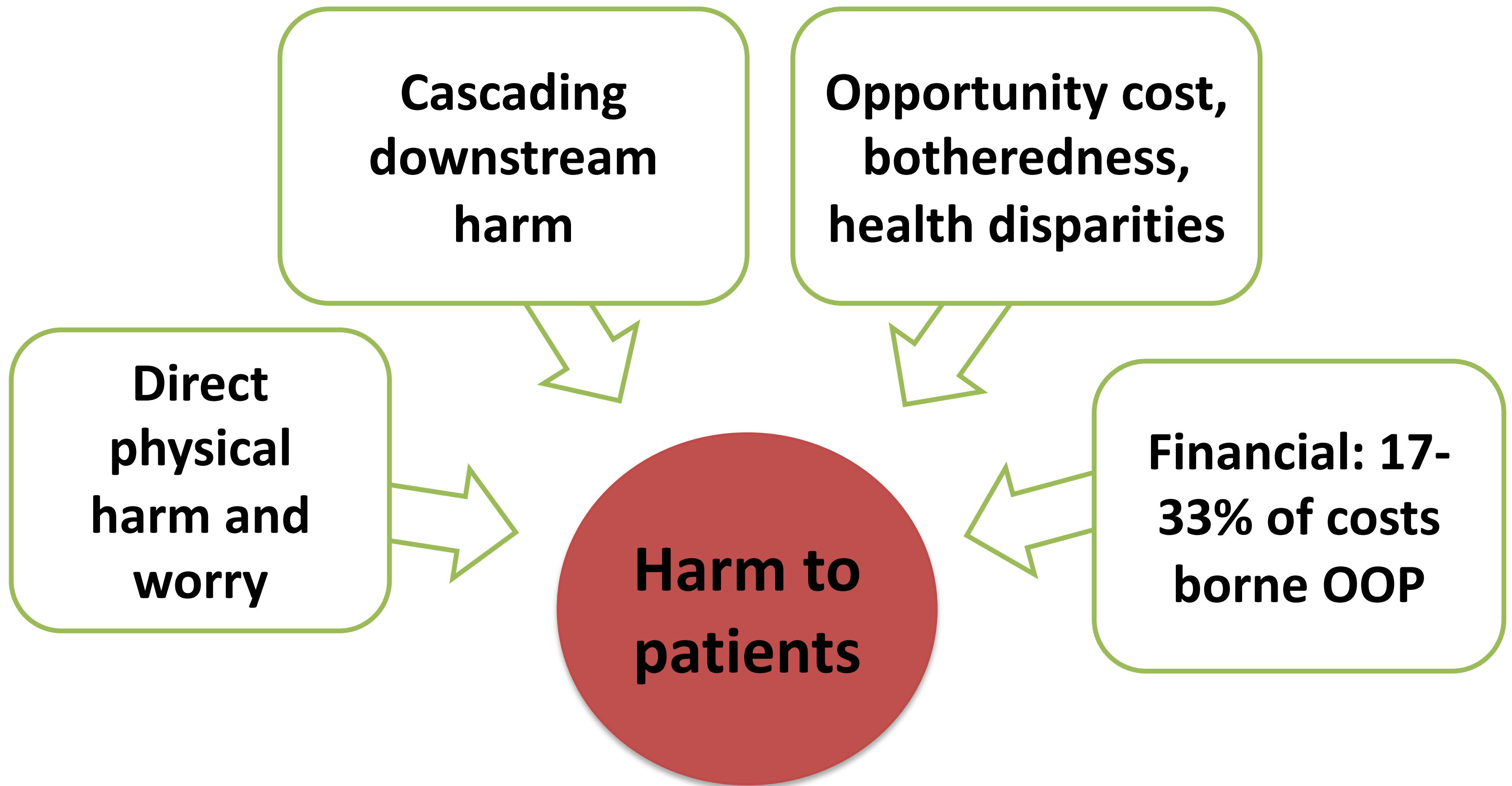
RESEARCH ARTICLE

Overtreatment in the United States

Why Clinical Waste?

- **Order of magnitude: $200 – 400 Billion annual spending on wasteful care**
- Both a financial imperative
  - Spending on low-value clinical care reduces headroom for high-value care
- And a moral imperative
  - Patient harm

Why Low-Value Care?



Why a Task Force?

As of September 2018, there are over 550 Choosing Wisely Recommendations…

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…But Minimal Progress from Information-Only…

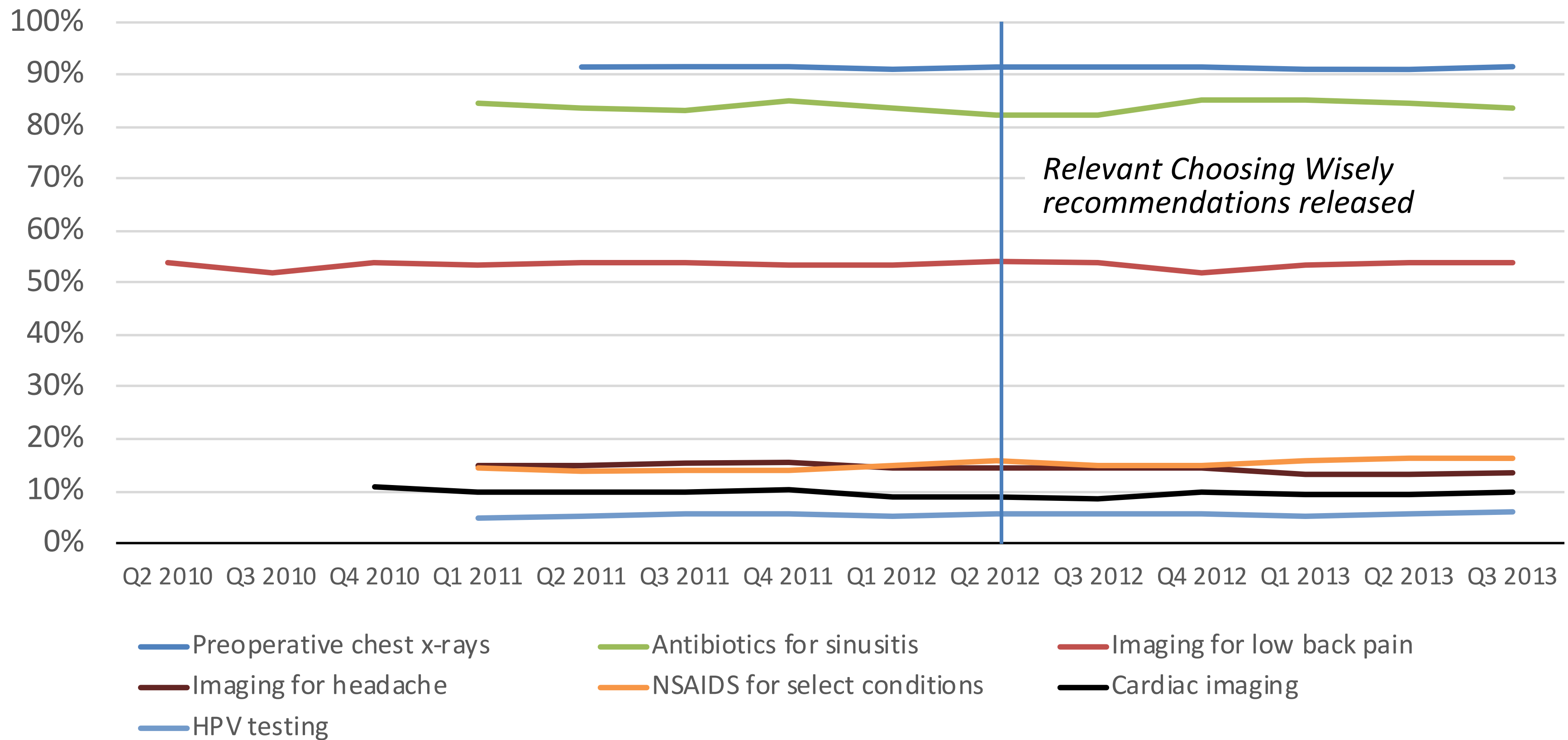
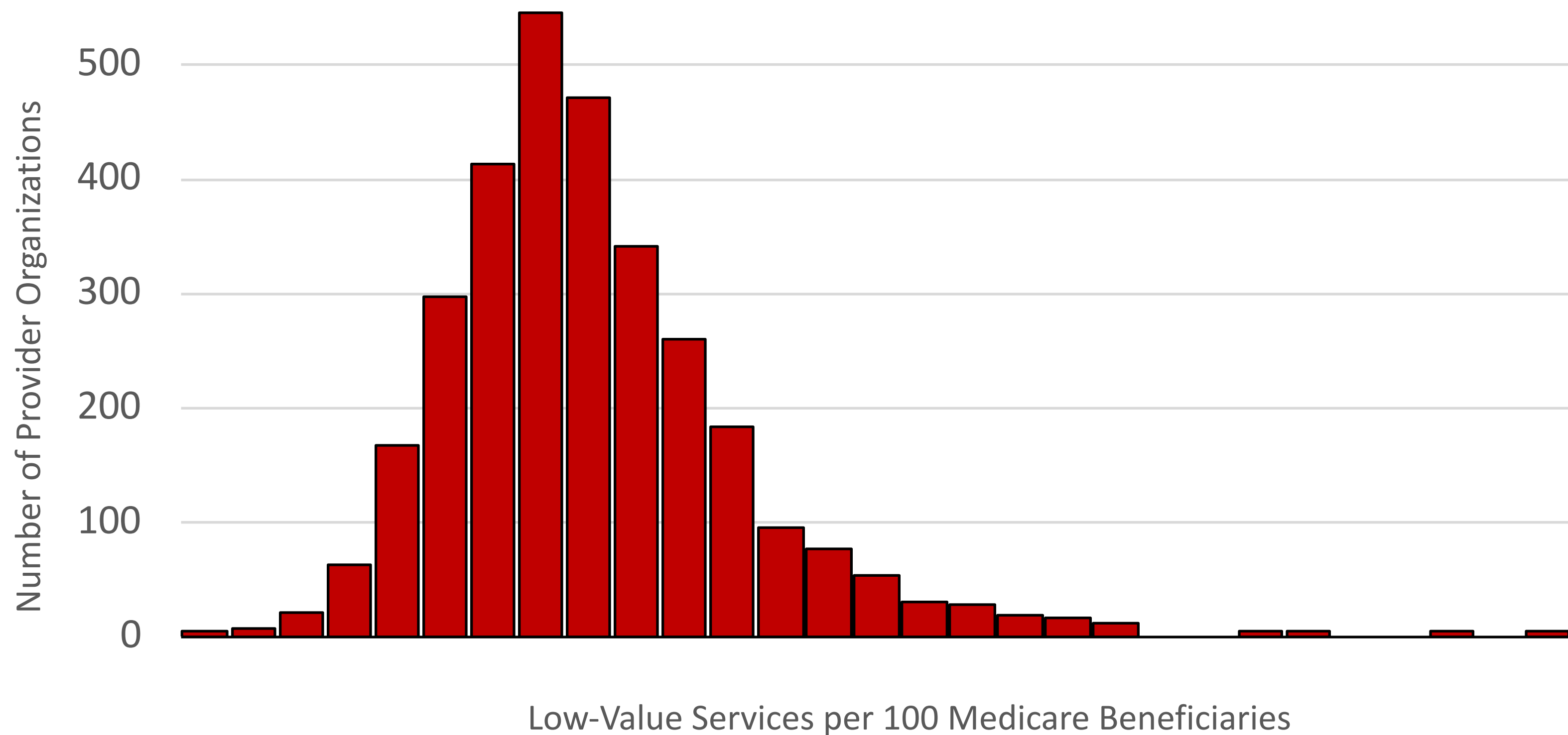


Figure derived from: Rosenberg A, Agiro A, Gottlieb M, et al. Early Trends Among Seven Recommendations from the Choosing Wisely Campaign. *JAMA Intern Med*. 2015;175(12):1913-1920.

(At least) we know we can do better.



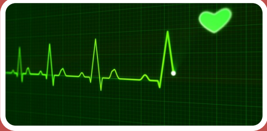
Schwartz AL, Zaslavsky AM, Landon BE, Chernew ME, McWilliams JM. Low-Value Service Use in Provider Organizations. *Health Serv Res*. November 2016.

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

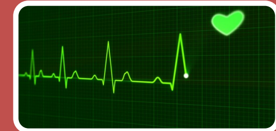
2. Vitamin D Screening

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
- Identify clinically insignificant abnormalities
- Delay needed care (opportunity cost too)

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

Top Five in the News

- **“The Man Who Sold America on Vitamin D – And Profited In the Process”**
  - Liz Szabo

The New York Times

2. Vitamin D Screening

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

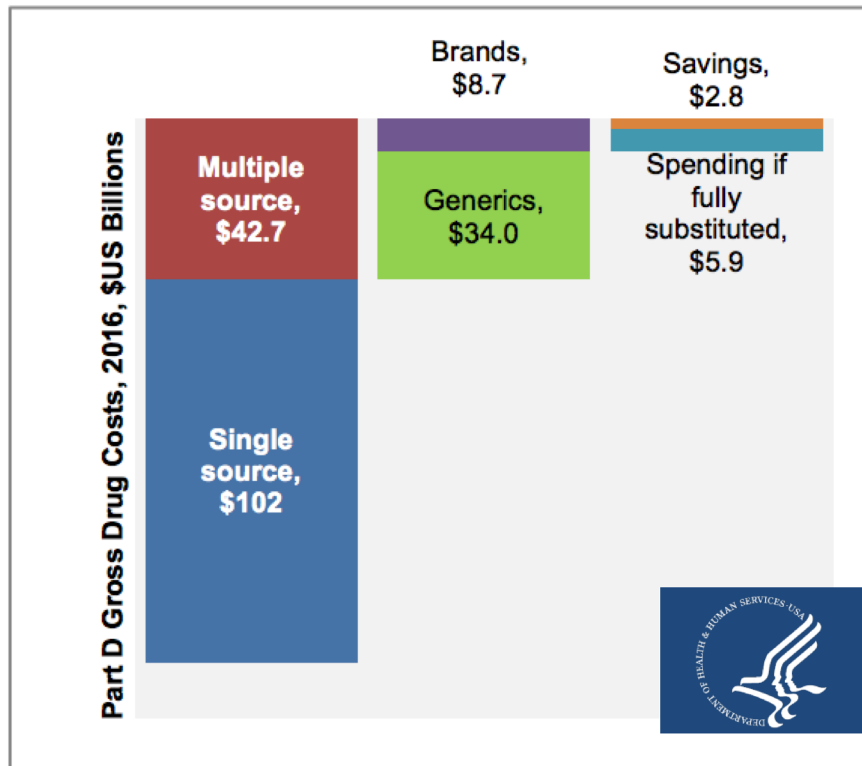
Prescribing of more expensive, chemically identical medications buys no extra health per dollar.

BURDEN

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

Top Five in the "News"

Figure 1: Effects of Moving to Full Generic Substitution in Part D.[12]



- Part D spent almost $9 billion in brand name drugs when equivalent generics were available, an opportunity to save $2.8 billion.

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

Top Five in the News

"The few. The effective. The cheapest. The waste-free formulary."

- PGBH is developing a "waste-free" formulary for purchasers to increase use of low-cost alternatives.

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

Top Five Relevance

- June MedPAC report
- Our Top Five Featured:
  - Imaging for nonspecific low back pain
  - PSAscreening at age ≥75
  - Preoperative testing before low-risk surgery
  - Vitamin D testing in absence of hypercalcemia or decreased kidney function

http://medpac.gov/docs/default-source/reports/jun18_ch10_medpacreport_sec.pdf

Top Five Relevance

NHS wields the axe on 17 'unnecessary procedures'

Varicose vein surgery and tonsil removal feature on list of routine operations to be axed

- NHS cutting 17 services
- Included: injections for non-specific low back pain, only offered at patient request

Payer Levers

TABLE. Tools to Target Low-Value Care[12]

Provider Facing	Patient Facing
Coverage policies • Do not reimburse for services that are clearly inappropriate given data from claims and enrollment files. • Ensure medical policies do not require unneeded services in order for patients to receive coverage of medically unnecessary services.	Network design • Steer patients to providers and plans that minimize the use of inappropriate medical services, including through tools such as shared decision making, which has been shown to reduce unnecessary care.[16]
Payment rates and payment models • Adjust allowed amounts to reduce incentives to provide commonly overused/potentially harmful services. • Use a composite measure of low-value care in pay-for-performance programs, such as has been suggested for the Medicare Merit-based Incentive Payment System.[13] • Accelerate adoption of new payment models that reduce incentives for overuse, such as ACO programs with downside risk.[14]	Utilization management • Consider narrowly targeted PA programs.[17] • Minimize the administrative burden through tools such as electronic PA for a select number of services and with a seamless user-friendly interface.[18]
Provider profiling information • Distribute reports benchmarking the practice patterns of a clinician or practice against those of your peers.[15]	Value-based insurance designs • Align patients' out-of-pocket cost sharing with the value of the underlying service. For example, high-value chronic disease care, such as blood pressure medications, should be free. • For commonly overused services, selectively allow increases in cost sharing to serve as "speed bumps."[19]

ACO indicates accountable care organization; PA, prior authorization.

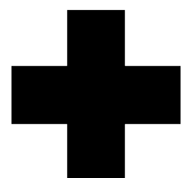
AJMC®

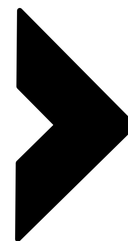
Editorial: "Levers to Reduce Use of Unnecessary Services: Creating Needed Headroom to Enhance Spending on Evidence-Based Care"

Levers work best in combination

- Multiple and "synergistic" interventions work better in concert than in isolation

For example…





Provider-facing information, eg CDS

Patient-facing incentives, eg VBID

Provider-facing information alone

Low-Value Care Prize Competition

Accelerating health system transformation from "how much" to "how well"

Motivation

- To bring more visibility to initial results of many efforts
- To spark conversations about low-value care and the Top Five
- To accelerate adoption and implementation of novel strategies
- To mobilize diverse thinkers (perhaps even those outside health care) and fresh ideas

Background

- A proposed partnership with Center for Technology and Medical Policy (CMTP)
- Process and concept modeled around Hearst Health Prize or AMGA Acclaim Prize
- Option to focus on Top Five or a broader look at low-value care and or clinical waste
  - Could do multiple categories

Potential timeline

Now – January 2019

- Develop project proposal and fill budget
- Recruit panel of judges
- **Establish judging criteria for submissions**

Spring 2019

- Announce the prize
- Publicize
- Open up for submissions

Summer 2019

- Announce finalists
- Judge panel deliberate finalists

Fall 2019

- Conference to showcase finalists
- Announce top prizes (can be multiple "winners")

Submission process

Task Force and CMTP accept submissions

Conduct initial screening

Send to panel of external judges with pre-determined criteria

Judges rank submissions, determine finalists

Finalists present at a conference

Judges determine final prizes

Finalists receive cash prize, implementation help

Working titles

- Low-Value Care Prize
- Health Waste Reduction Prize
- Waste in Health Innovation Prize
- Low-Value Care Task Force Prize
- The Prize for Low-Value Care Reduction
- The Health Care Waste Prize
- Waste Task Force prize

Suggestions welcome!

Reactions and discussion

We look forward to seeing you at the next LVC-TF meeting in March!

Save the date: March 14, 2019