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TASK FORCE ON LOW-VALUE CARE: "TOP FIVE" LOW-VALUE SERVICES FOR PURCHASER ACTION

Billions are spent every year on services that harm patients – or at best, offer no clinical benefit. The Task Force on Low-Value Care has identified a "Top Five" list of low-value clinical services that are unsafe, do not improve health, or both. The services were selected based on their association with direct and indirect harm, their cost, their prevalence, and the availability of levers for purchasers to help reduce their delivery.[1] The Task Force, comprising a range of leading purchasers, patient advocates, employer coalitions, and other healthcare stakeholders, suggests that purchasers prioritize these five recommendations in their efforts to identify, measure, and reduce low-value care.

- **Avoid unneeded diagnostic testing and imaging for low-risk patients before low-risk surgery.** Most patients undergoing low-risk surgery do not need laboratory tests such as complete blood counts, basic or comprehensive metabolic panels, or coagulation studies. Prior to non-cardiac surgery, low-risk patients also do not need baseline diagnostic cardiac testing, such as stress tests.[2] Other professional societies advise against needless pulmonary function testing[3] and routine chest x-rays – a source of unnecessary radiation – before surgery.[4] Incidental findings from unnecessary pre-surgical testing can lead to downstream risks, avoidable costs, and unnecessary delay.[5] If the patterns of one mid-sized US state are representative, an estimated 19.2 million unneeded pre-surgery tests and imaging services were performed in 2014. These services accounted for about $9.5 billion in avoidable spending.*

- **Avoid Vitamin D screening tests.** Up to 90 percent of Vitamin D tests may be clinically useless, as findings are not needed to guide clinical care.[6] Only patients with a handful of higher-risk clinical conditions should receive this service.[7,8] An estimated 6.3 million Vitamin D tests that were not clinically indicated were performed nationally in 2014, at an estimated cost of more than $800 million.*

- **Avoid prostate-specific antigen (PSA) screening in men 75 and older.** The US Preventive Services Task Force (USPSTF) issues a "D" recommendation (avoid) for PSA-based screening in men 70 years of age and older, given the potential for cascading downstream harm from unnecessary biopsies, surgeries, and radiation therapy. A range of professional clinical societies and expert panels have long agreed that screening for prostate cancer in asymptomatic older men with limited life expectancy should be avoided given that the vast share of men this age with prostate cancer will die with, not of, the disease.[9–11] Nevertheless, Medicare still covers the test, and more than one million Medicare fee-for-services beneficiaries age 75 and older received a PSA test in 2014.[12] PSA blood tests alone in this population cost Medicare at least $44 million.[12] These costs almost certainly pale in comparison with the harm and expense of unnecessary biopsy, surveillance, and treatment.

- **Avoid imaging for acute low-back pain for the first six weeks after onset, unless clinical warning signs ("red flags") are present.**
  At least nine professional societies have warned against overuse of x-rays, computed tomography (CT), and magnetic resonance imaging (MRI) for patients with acute low-back pain.[13–21] Imaging in the first six weeks of pain is especially problematic, unless specific clinical warning signs are present.[13,20,21] X-rays and CT expose patients to radiation, and all imaging increases the risk of incidental findings that can lead to unnecessary and potentially harmful surgeries. In 2014, Americans received 1.6 million avoidable imaging services for low-back pain, at an aggregate cost of about $500 million.*

- **Avoid use of more expensive branded drugs when generics with identical active ingredients are available.**
  The use of more expensive branded drugs when *chemically identical* generic options are available buys no extra health per dollar. Yet despite near-universal use of benefit designs to promote generic use, prescribing of more expensive branded medications persists even when less expensive identical alternatives are on the market. This situation is distinct from *therapeutic substitution*, when *chemically different* (i.e., non-equivalent) drugs in a pharmaceutical class are substituted for one another. According to data from QuintilesIMS, purchasers would have saved $14.7 billion in 2016 had 100% of prescriptions with generics available been dispensed as generics.

About the Task Force on Low-Value Care: this multi-stakeholder effort was established by VBIDHealth to catalyze health care purchaser action around the identification, measurement and elimination of low-value health care services. The Task Force is led by A. Mark Fendrick, MD, and Michael Chernew, PhD. Financial support is provided by Amgen, Johnson & Johnson, Pfizer, and Sanofi. Further information is available at http://www.vbidhealth.com/low-value-care-task-force.php.

* National estimates for the prevalence and cost of unneeded pre-surgery diagnostic testing and imaging, Vitamin D screening, and imaging for low-back pain were derived by extrapolating from a state-specific analysis conducted using an all-payer claims database and the Milliman MedInsight Health Waste Calculator.[1] Estimates are conservative, and do not include the downstream costs that may follow from unneeded testing and screening.

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