RESEARCH CONSORTIUM
for Health Care Value Assessment

CONCEPT PAPER NO. 2 | JUNE 2019

A Framework for Addressing Low-Value Care

We propose a framework for use in defining low-value care and prioritizing efforts to reduce the use of low-value clinical services. The framework consists of four guiding principles for selecting services to address first in efforts to reduce low-value care. Such services should be:

- Strongly backed by clinical evidence,
- Low in heterogeneity of value across patients and settings,
- Easy to measure using claims data, and
- Non-controversial.

The resultant emphasis on "low-hanging fruit" can help demonstrate the potential for subsequent larger, systematic efforts to reduce the delivery of low-value care.

IMPORTANCE OF A FRAMEWORK TO ADDRESS LOW-VALUE CARE

Low-value care is a significant source of inefficiency in the United States health care system. Existing estimates suggest that around 10 to 20% of health care spending (~$350 to $490 billion) is wasted each year on these services.[1,2,3] Initiatives to identify, measure, report, and reduce low-value care can help us better understand how to efficiently spend the significant, but not unlimited, resources dedicated to health care. Resources freed from avoiding low-value care spending could be redirected to underused, high-value care, for example.

The Research Consortium for Health Care Value Assessment (Value Consortium) released a concept paper in February 2019 addressing the benefits and fiscal implications of systematically addressing low-value care, especially for states. Reducing low-value care is a largely untapped opportunity to increase the value of health care spending while simultaneously reducing harm or overuse.

Stakeholders in the US have long been interested in *how much* we spend on health care, but now there is increasing interest in *how well* we spend it. Addressing both will ultimately help our understanding of whether we spend *too much* on health care and where more resources should be focused. Initiatives around low-value care, such as the Low-Value Care Task Force (Task Force) and the Value Consortium's Quick Strike project to develop high- and low-value indicators, will add substantially to this conversation.

The Value Consortium proposes a framework to define low-value care and guide prioritizing among identified low-value care services, as stakeholders begin to explore how they may go about capitalizing on the benefits of measuring and reducing low-value care. The framework is designed to recognize that, in the current state of US health spending, conversations at the *controversial margins* of value (i.e., modestly more cost-effective treatment X compared to Y) will be less productive than first addressing numerous examples of low value services that clearly provide little to no benefit and are considered especially "low-hanging fruit."

Establishing a clear framework could:

- address conceptual and practical barriers, reducing confusion among stakeholders
- align multiple efforts across stakeholders
- aid in promoting general momentum around low-value care initiatives

A Clear Framework Will Increase Success of Low-Value Care Initiatives

There are three important barriers to addressing low-value care. First, low-value care is a broad term that, when loosely defined, could be interpreted differently by different stakeholders. What is "valuable" to one patient or organization could be different for a different patient or organization. Second, the concept and measurement of clinical value is especially complicated by *clinical nuance*: no service is inherently high- or low-value for everyone in every circumstance. Even experts can find it difficult to achieve consensus on defining specific low value services. Robust efforts to identify low-value care, such as the Choosing Wisely initiative, have nonetheless identified hundreds of services that are low value in specific circumstances. Although such efforts constitute a critical step towards understanding the problem of overuse, hundreds of services with low value potential creates a very practical third barrier: where do we start?

We propose the following framework to define low-value care and guide organizational efforts to prioritize the order in which to address low-value care services. The framework is designed to recognize that we should first address "low-hanging fruit." Further, we propose a framework that focuses on services that are easily adjudicated using current tools and data (i.e., the value of a given service provision can be identified in claims data), which eases issues of measurement and implementation. Larger systematic efforts to reduce the delivery and use of low-value care will likely require the demonstrated value of targeted action built around low-hanging fruit.

The Framework: Guiding principles for identifying and prioritizing low-value care

The framework consists of the following four guiding principles, as illustrated in Exhibit 1:

- Validation from the clinical community (i.e., using clinical community recommendations to define low-value care)
- No or low clinical heterogeneity in value by patient or setting
- Easily identifiable in claims data using currently available tools
- Non-controversial, politically sensitive

The Framework in Detail

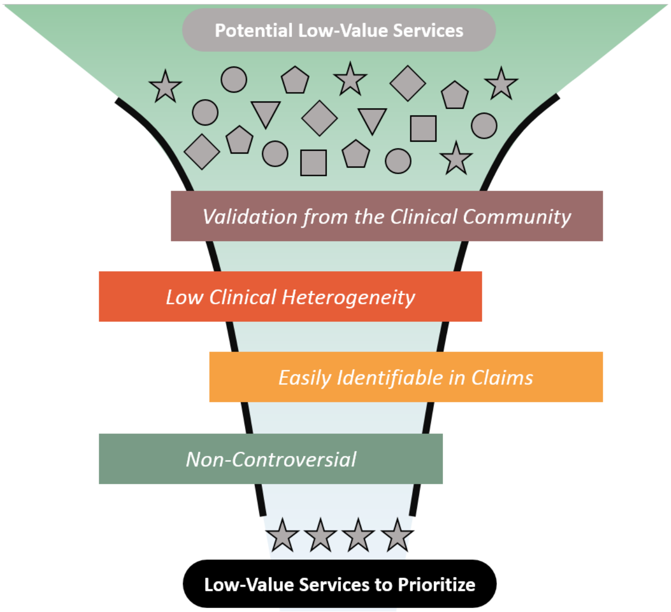
1. Validation from the clinical community

The first step to achieving consensus on low-value care is a clear and purposeful definition. Although there are numerous types of "waste" that impact the health care system, low-value care is a specific subset. We define low-value care as medical care where: there is zero benefit for the vast majority of patients (e.g., Vitamin D screenings for most people without specific conditions), the harms outweigh the benefits (e.g., PSA-screenings for men over 70), or an identical but cheaper treatment is available (e.g., the use of a branded drug when a chemically identical generic is available). Terms such as "overused" or "inappropriate" medical care are often used interchangeably with low-value care. This definition largely aligns with services determined to be low-value by a consensus of the clinical community, such as through published clinical guidelines or initiatives like Choosing Wisely.

The importance of provider buy-in cannot be overstated, hence the focus on a definition aligned with relevant clinical guidelines and recommendations. Clinical consensus reduces provider controversy and will facilitate the de-implementation (reduction) of supply-driven overuse. Choosing Wisely has been successful at generating consensus within the clinical community that some services being provided are not valuable for specific populations and situations. The initiative has spurred interventions centered on their recommendations, such as linking recommendations to electronic health record systems.[4] Buy-in from the provider community will improve shared decision-making. Public opinion on low-value care suggests that patients view personalized time discussing needs with the provider to be the most valuable component of low-value care initiatives.[5]

EXHIBIT 1.

FRAMEWORK FOR PRIORITIZING LOW-VALUE SERVICES



Even with a clear definition, *where to start* poses a significant barrier. The second, third, and fourth components of the framework can help guide organizations in prioritizing low-value care services to address. For many organizations, the list of Choosing Wisely recommendations or complex clinical guidelines can be daunting, and not all recommendations lend themselves to being measured easily. It is also unlikely that many organizations, especially purchasers without access to technology like electronic health records, would undergo reducing the use of all of these recommended services at once. Therefore, organizations need to prioritize, but how does an organization prioritize among the hundreds of services that could be low- or high-value in a number of different circumstances?

2. No or low "clinical heterogeneity" (i.e., a service is almost always low value for many people)

The Value Consortium recommends ensuring that the services addressed have low clinical nuance or low "clinical heterogeneity" (i.e., services are often low-value regardless of clinical context). No service is inherently high- or low-value for all people and contexts, but some services are more likely than others to be low-value regardless of external factors.

For example, screening for Vitamin D deficiency is a commonly cited low-value care service. For the general public, Vitamin D screening is useless albeit not "harmful" to a patient (except perhaps financially for any out-of-pocket costs associated with extra screenings; inconvenience and time to get the screening; and the fact that the screening is done through a blood draw, which is not a universally benign process). The screening could, however, be useful for patients with certain diagnoses and symptoms, such as kidney disease. For the vast majority of people without a clear diagnosis that would indicate otherwise, supplements and lifestyle changes (e.g., more sun exposure) can address symptoms without the need for a screening. Thus, screenings have a high likelihood to be low-value – the service has low clinical heterogeneity compared to other services where other conditions and contexts may indicate that the service is indeed valuable.

3. Easily identifiable in claims data

For measurement purposes, it is easier to determine value for certain low-value care services than others through claims data. Analysis of services with low clinical nuance, for example, is more likely to capture cases where the service was indeed provided in a low value manner. Further, services with simple "exclusion" and "inclusion" criteria will make measurement simpler and more accurate. For example, a service that is high- or low-value depending on the *timing* of other services, or through indicators that would not be readily available through claims data (e.g., the patient's living situation or controlled A1c levels), or have complicated exclusion and inclusion criteria (e.g., a number of CW recommendations include "if this, then that" statements) could prove challenging to accurately measure. There may also be services for which the appropriate data may not be available at all. In practice, it is important to target interventions towards care that is clearly more wasteful than not, because efforts to reduce low-value care will inevitably capture some people for whom the service is necessary. Continuing the Vitamin D screening example above: the exclusion and inclusion criteria for Vitamin D screenings are relatively simple given that the screening should be attached to medical diagnosis that would be available in these data

4. Non-controversial or not sensitive to patient preferences

Prioritizing low-value care should consider who will be affected, whether it be patients, physicians, payers, or other stakeholders, depending on the lever used to address the overused service.[6] Any low-value care initiative risks conflicting with perceived value, especially from patients. Although this principle is more subjective than the other three, there are numerous examples of low-hanging fruit and accompanying change management strategies that are less likely to lead to stakeholder frustration (e.g., a surge in appeals if a service is no longer covered by a health plan). The perpetuation of low-value care despite clinical guidelines that indicate otherwise is driven by many factors and avoiding some of these situations could be one part of prioritizing where to start.

For example, reducing services that are commonly low-value but also large drivers of revenue for provider organizations will likely create challenges. Alternatively, services identified as low-value but frequently requested by patients because of commonly held preferences can create a different set of issues. Further, services connected to treatments that are politically controversial could risk jeopardizing the image of low-value care – for example, although Choosing Wisely recommends "minimizing" elected cesarean sections, these services are commonly preferred by patients for any number of legitimate, non-clinical reasons. An even more extreme example might be that certain cancer treatments have been shown not to be always high-value for all patients in all settings, but a program to measure and reduce the use of cancer treatments (in addition to the challenge of determining their value) may be more controversial than tackling other services first.

The less sensitive a service is to preferences and varying perceptions of value, the easier it will be to implement a program to reduce unnecessary use, but all services will face some pushback. For example, many people experience low back pain and would like their physician to help alleviate the pain. A low-value care program to reduce unnecessary imaging of the low back within the first six weeks of uncomplicated back pain (without serious "red flags" like trauma or cancer) could mitigate the risk of conflicting with patient preferences by emphasizing shared decision making strategies and provider communication with patients that other interventions, like physical therapy, will actually reduce the pain.

Framework Summary

While it can be tempting to start efforts to align spending with value on services with the highest spending or utilization, or even the services that create the most harm, the guiding principles above recommend focusing on services that are: the most consensus-driven, the least nuanced, the easiest to understand in terms of value , and the least controversial. For now, a productive conversation around low-value care would start with these lowest of low-hanging fruit, based on these principles, rather than complex discussions about value at slim margins, i.e., when one service is barely more valuable than the alternative.

CASE STUDY IN PRIORITIZING—THE LOW-VALUE CARE TASK FORCE "TOP FIVE" AND THE VALUE CONSORTIUM "QUICK STRIKE" PROJECTS

The Low-Value Care Task Force is a VBID Health collaborative of stakeholders including national carriers, employer coalitions, Fortune 500 companies, life science companies, patient advocacy organizations, state and local governments, and health services researchers all dedicated to identifying, measuring, reporting, and reducing low-value care.[7] The Task Force used similar guiding principles to those discussed above to develop consensus around a "Top Five" list of low-value care services to generate momentum specifically among the purchaser community.[8]

The motivation for this Top Five list was simple: lists from initiatives like Choosing Wisely were overwhelming. A clearly defined short-list built through a consensus process would reduce barriers for interested, but leery organizations, especially purchasers like employers and states. The Task Force started the process by organizing Choosing Wisely recommendations into candidate services, ranked by several principles: harm, ease of implementation, high waste index (i.e., low clinical nuance), politically feasible, high unit costs, aggregate cost, and most common.

The stakeholder group established these principles and VBID Health narrowed the candidate services to about ten Choosing Wisely recommendations per principle, steering the group towards simple and straightforward recommendations. Stakeholders received background material and sample services ranked by each principle. Stakeholders then voted for the services they believed should represent the Top Five over the course of two convenings.

This collaborative process has informed the Consortium's framework, because the stakeholders largely agreed that principles like those in the framework were the most important. The final Task Force list of services, therefore, aligns well with the guiding principles of the Consortium's framework above. Vitamin D screening, for example, ranked highly on a number of key framework principles and was included on the list – relatively easy to implement, commonly low-value, and low political barriers. Although not the most harmful service (there is no evidence for direct physical harm) or the most expensive (a ballpark all-payer average of $125 per unit), Vitamin D screenings certainly represent relatively low-hanging fruit.

Following this process, the Task Force Top Five includes:

- Diagnostic testing prior to low-risk surgery for low-risk patients
- Population-based Vitamin D screenings
- PSA screenings for men over 75
- Imaging in the first 6 weeks of low back pain
- Branded drugs when a chemically identical generic is available

A number of other organizations recognize these Top Five as low-value services and are taking concrete action, both separately and in concert with the Task Force. Cigna and Aetna have announced policies to reduce coverage for unindicated Vitamin D screenings. In addition, the state of Washington (and others) started a significant campaign around diagnostic testing before low-risk surgery—“drop the pre-op”. The Task Force hopes to complement this Top Five list with Top Five lists for other populations such as a Medicaid- or Medicare-specific list.

Under its “Quick Strike” project, Altarum used the Top Five list to develop a research brief for the Value Consortium showing spending on these five low-value services as well as an additional five high-value services, which could serve as an “indicator” of how much the privately insured spend on high- vs. low-value care. Where we are spending our health care dollars is a critical question to understanding areas for fruitful policy changes, and alignment with our definitions of high-priority low-value care can aid in identifying such changes. The data suggest that even though there has been significant discussion on reducing low-value care services in the system, to-date, the reduction has been slight. The brief demonstrates that reducing low-value care, and even low-hanging fruit within that definition, is an untapped opportunity to improve health care quality and more efficiently allocate health care resources.

Conclusion

We believe that stakeholders, ranging from carriers to purchasers, can use this framework to discuss how to reduce the physical and financial burden of low-value care. Establishing a clear framework for identifying and prioritizing low-value care will align stakeholders around services that will prove the least challenging, hopefully building momentum. At minimum, establishing a clear framework will reduce confusion as to what we mean by low-value care in general. Identifying, measuring, reporting, and reducing low-value care has the potential to create headroom for shifting abundant resources to high-value care, which could improve population health and reduce out-of-pocket costs.

Notes

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ABOUT US

The Research Consortium for Health Care Value Assessment is a partnership between Altarum and VBID Health, with funding from the PhRMA Foundation as part of its Value Assessment Initiative, established to promote the pursuit of value in health care delivery in the U.S.

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Support provided by the PhRMA Foundation