

Eliminating Low-Value Care: A New Model

BY KENNETH COHEN, MD, FACP



“To eliminate low-value care, providers and health systems must be willing to move to value-based care and quickly transition to risk-based arrangements.”

The U.S. healthcare system provides suboptimal outcomes at costs that are double the average of other wealthy nations. The four major drivers of these excess costs are administrative overhead, pharmaceutical pricing, pricing of medical and hospital procedures, and imaging costs.

The first two cost drivers may be beyond the control of physicians. However, we can have influence over the latter two by choosing the most efficient site of service and eliminating low-value care. These last two drivers account for 27 percent of the excess spend in our healthcare system. In fact, studies have suggested that low-value care represents about a third of all healthcare delivered.

The term “low-value care” actually

diminishes the significance of the problem. In reality, this care is at best wasted, and at worst, is often harmful. A recent study of Medicare, Medicaid, and commercial claims in Washington state placed the magnitude of low-value care at 44 percent of all care delivered.

The current reimbursement model creates perverse incentives that foster the delivery of such care. To eliminate low-value care, providers and health systems must be willing to move to value-based care and quickly transition to risk-based arrangements—where providers and health systems

are responsible for the total cost of care. A necessary element of this transition is an infrastructure that supports this new model.

One existing model is Choosing Wisely, a program from the ABIM Foundation. This is a well-intentioned program that attempts to reduce low-value care, but it only begins to address the magnitude of the problem. For example, this program fails to address many invasive, potentially harmful, and costly interventions that don't have supporting data of improved health outcomes or quality of life.

These include, but are not limited to: carotid endarterectomy in asymptomatic carotid artery stenosis, the aggressive treatment of low-risk Gleason 6 prostate cancer, the overuse of lumbar spinal fusion, and the overuse of arthroscopy for osteoarthritis of the knee—to name just a few.

To eliminate low-value care, a more robust model is required. The Optimal Care model (Figure 1) has been designed to meet this need.

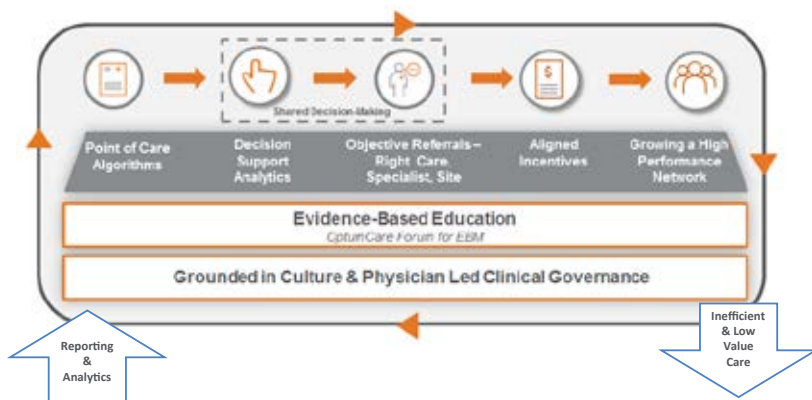
THE OPTIMAL CARE MODEL

OptumCare is the national, physician-led, ambulatory care delivery system of Optum. The Optimal Care model currently being scaled across OptumCare was conceived from the Bench to Bedside program of New West Physicians.

The fundamental tenet of this program is the rapid transition of high-quality, evidence-based medicine into daily practice. The Bench to Bedside program was previously detailed in the *Journal of America's Physician Groups*. Optimal Care takes this program to the next level, incorporating the following enhancements:

Introduction to Optimal Care

Figure 1: The goal is the rigorous elimination of wasted care



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1. Creating a cultural transformation at the provider, physician group, and national levels, driven by physician thought leaders across OptumCare.

2. Developing and promulgating an educational foundation for evidence-based medicine, focused on the elimination of low-value care. Here, CME-accredited lectures are created for each specialty area and supplemented by The OptumCare Forum for Evidence-Based Medicine:

- The Forum takes recent, high-quality studies—whose results should inform daily practice—and distills these into easily deployed recommendations in a CME-accredited periodical.
- Infographics embedded in electronic health records (EHRs) serve as point-of-care reminders on low-value care metrics.
- Short clinical briefs and patient-facing handouts support evidence-based conversations with patients.

Historically, the delay from the publication of high-quality research to practice implementation is five to 10 years. The Optimal Care model is designed to reduce this to 12 weeks.

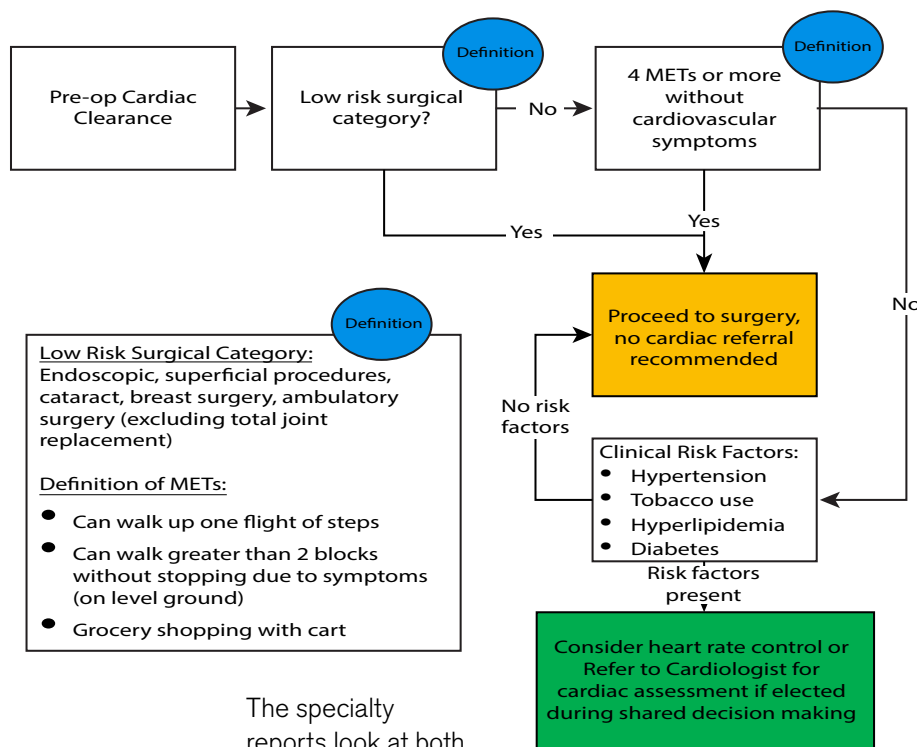
3. Embedding point-of-care technology in the EHR, so it is available to the patient and primary care provider at the time of the encounter. These tools include straightforward algorithms focused on the delivery of optimal care (Figure 2).

The tools also stratify specialist physicians by clinical outcomes and quality metrics, total cost of care per procedure or diagnosis, and proximity to the patient. They further identify the most efficient site of service for any test or procedure. Used in concert, these tools minimize low-value care and reduce total cost of care.

4. Transparently reporting quality and utilization metrics for both primary care and specialty providers. The primary care metric compares performance at a provider and medical group level (Figure 3). It looks at utilization of low-value tests and procedures, stratified against the performance of the provider's peers, other medical groups, and national OptumCare benchmarks.

Preoperative Cardiac Testing Algorithm

Figure 2: Stress testing is infrequently indicated



The specialty reports look at both individual specialist and practice-level metrics focused on quality, total cost of care, and optimal site of service—again, stratified against peer physicians and national benchmarks. The reports highlight specialists' utilization of low-value care measures. Regular meetings are conducted to share and analyze the data, focused on highlighting best practices to support both primary care providers and specialists in their efforts to reduce unnecessary care and improve patient outcomes.

OVERCOMING BARRIERS AND EDUCATING PATIENTS

The implementation of Optimal Care comes with several challenges:

- Cultural transformation is a difficult process and requires a history of trust and success at prior initiatives. It will not succeed if it is the "initiative of the month."
- Provider engagement around evidence-based medicine can face barriers. Evidence-based medicine will sometimes be in conflict with community standards and patient expectations, and will often be in conflict with revenue generation in a fee-for-service model. This is particularly true for

continued on next page

continued from page 53

those providers who are still largely practicing in a fee-for-service model and are just beginning to venture into value-based care.

- Accurate comparative reporting requires sophisticated healthcare economic analytics, which need to be consistently applied across often-disparate practice models and markets.
- New tests and procedures need to be vetted with respect to improvements in health outcomes and cost effectiveness, using established benchmarks such as quality adjusted life years (QALY) and number needed to treat (NNT).

Despite these challenges, the above model has been demonstrated to improve healthcare outcomes while reducing total cost of care. To achieve even greater success around the elimination of low-value care, alignment needs to occur across multiple stakeholders—including, most importantly, our patients, so they are in lockstep with providers, health systems, and health plans.

Aligning patients around Optimal Care requires a patient-focused educational initiative supported by robust shared decision-making (SDM) tools, which can be deployed at the point of care. Although these tools exist, they are not yet fully developed to ideally serve this functionality. This important enhancement is in development.

In addition, most health plan benefit designs are not specifically oriented to align incentives around decreasing total cost of

care. For example, lower patient coinsurance (or rebates) for optimal care decisions would serve to better align patients and providers around the choice of high-performing specialists and the most efficient sites of service.

Lastly, health systems need to be willing to shift tests and procedures to the least expensive site of service, with equivalent outcomes and patient safety. More innovative benefit designs are beginning to move to reference-based pricing and service line capitation—both of which will force providers and health systems to focus on lowering total cost of care. The Optimal Care model supports providers on this journey.

The reality is that our government does not have a track record of successfully controlling rising healthcare costs. Our patients and employers cannot afford our current healthcare system, and they deserve a system that delivers better outcomes.

The tipping point is upon us. The solution relies to a large extent on the willingness of providers and health systems to eliminate low-value care. As this occurs, the magnitude of reduction in total cost of care will be large enough to reverse the trend of continually rising healthcare costs. ○

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PCP Optimal Care Performance Report

Figure 3: All Data Transparently Shared

Measure ID	Measure Description	Year-to-date-2018				Benchmarks		
		Total Cases	Total Cost	Cases per 1,000 (Annual)	Cost PBP/PM	Compared to... Last year 2017	2018 Percentile Lowest Utilization Amongst PCPs	Corporate Average 2018 YTD
A01	Lumber Fusion Surgery	18	\$400,288	0.7	\$1.74	2.6 ↓	1.0 ↓	1.3 ↓
A02	Hip Replacement Surgery	67	\$1,196,359	3.5	\$5.21	5.2 ↓	2.2 ↑	3.0 ↑
A03	Knee Replacement Surgery	98	\$1,510,531	5.1	\$6.58	7.0 ↓	5.2 ↓	5.8 ↓
A04	Cervical Spine Fusion Surgery	8	\$284,050	0.4	\$1.02	0.7 ↓	0.6 ↓	0.8 ↓
M01	Diagnostic Colonoscopies age over 74	209	\$926,837	10.9	\$1.42	13.0 ↓	7.8 ↑	7.8 ↑
M02	Knee Arthroscopies age over 50	41	\$90,419	2.1	\$0.40	4.2 ↓	0.8 ↑	1.5 ↑
M03	Echocardiograms	3,833	\$616,750	184.6	\$2.69	180.5 ↑	145.0 ↑	220.2 ↓
M04	Viscosupplementation Injections	117	\$154,849	6.1	\$0.67	7.8 ↓	5.3 ↑	24.6 ↓
M05	Carotid Doppler Duplex Scans	1,144	\$221,695	59.8	\$0.97	62.4 ↓	25.0 ↑	56.4 ↑
M06	Sleep Studies at facility/not at home	272	\$82,690	14.2	\$0.36	15.5 ↓	0.5 ↑	23.7 ↓
M07	Nuclear Stress Tests (non-angina cases)	436	\$253,140	22.8	\$1.10	24.9 ↓	11.0 ↑	30.6 ↓
M08	PSAs over age 69	4,831	\$160,545	252.4	\$0.70	231.8 ↑	29.0 ↑	153.9 ↑