ROADMAP FOR ADDRESSING LOW-VALUE CARE
Going Below The Surface

The Going Below The Surface Forum is a multi-stakeholder partnership that is taking actionable steps to get at the root of what is driving health care spending in the United States and seek solutions. Its mission is to have a sustained, productive and informed dialogue with all stakeholders to address challenging questions about spending. The Going Below The Surface Forum’s goal is to provide clarity on how best to optimize health care spending so that patients receive the right care while simultaneously providing the right incentives to sustain next-generation innovation to improve patient well-being and health system efficiencies.

For more information, visit www.goingbelowthesurface.org and follow the hashtag #GoingBelowTheSurface on social media.
Navigating the Low-Value Care Roadmap

1. Set your goal to address low-value care
2. Identify opportunities to address low-value care
3. Prepare rationale for addressing low-value care
4. Determine whether or not initiative requires collaboration of organizations
5. Decide on the breadth of the initiative
6. Determine implementation approach (stakeholder-specific) and implement the initiative
7. Evaluate and share impact
8. Collaborate and disseminate

Roadmap for Addressing Low-Value Care

“Reducing the use of low-value services is not just doing less of what harms, it also creates opportunities to focus on doing more of what truly helps patients.”

– Parchman et al., Healthcare, December 2017–
EXECUTIVE SUMMARY

Background: What is low-value care, and why is it a problem?

Low-value care refers to treatments or services that don’t offer real value for patients, and in some cases may even cause harm.

Low-value care is a pervasive problem in the United States, with as much as $340 billion being spent on low-value or unnecessary care alone.\(^1\) With health care spending projected to reach nearly 20% of Gross Domestic Product in the next decade,\(^2\) eliminating low-value care and the associated costs to our health care system is becoming increasingly critical.

Low-value care exists across all sectors of the U.S. health care system. Examples of low-value treatments and services identified by the Task Force on Low-Value Care include:\(^3\)

- Diagnostic testing and imaging for low-risk patients prior to low-risk surgery
- Vitamin D screening tests
- Imaging for low back pain in the first six weeks after onset
- Prostate-specific antigen (PSA) screening in men who are 75 years of age or older
- Use of more expensive branded drugs when generics with identical active ingredients are available

Purpose and goals of the roadmap

The Going Below The Surface (GBTS) Forum comprises an expert group of stakeholders from key segments of health care, including payers, provider groups, patient advocacy groups and academic researchers, who have come together to look for areas of shared interest and agreement. GBTS Forum partners agree that reducing low-value care is of paramount
importance to optimizing health care spending and, building upon previous efforts aimed at reducing low-value care, have developed a roadmap to guide health care stakeholders as they consider and implement interventions that address low-value care. The roadmap is designed to serve as a reference guide to help organizations think about the questions, considerations and potential goals they need to achieve to implement an intervention or program aimed at addressing low-value care. To serve a broad constituency of stakeholders, the roadmap provides stakeholder-specific examples for potential interventions.

Approach

The GBTS Forum convened a low-value care subgroup tasked with identifying the key steps that an organization should consider when implementing an intervention focused on addressing low-value care. Relying on their real-world experience and academic expertise, the subgroup created a high-level, step-by-step roadmap and supplemented each step with illustrative examples derived from peer-reviewed and grey literature sources. The examples cited in this document are not intended to be comprehensive or exhaustive. Rather, the roadmap and the examples provided offer a menu of considerations and specific tactics that an organization can employ when creating a plan to address low-value care. A final draft of the roadmap was developed and approved by the Forum’s low-value care subgroup.

Organizational structure of the roadmap

The roadmap has eight high-level steps and each step has three underlying components. They are:

1) **Aspirational goal** – The ultimate goal for each step in the roadmap
2) **Motivating questions** – Questions organization(s) should consider during each step and some potential actions and/or opportunities to achieve the aspirational goal
3) **Case study example** – A real-world example of how each step has been (or could be) implemented
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I. SET YOUR GOAL TO ADDRESS LOW-VALUE CARE

**Aspirational goal** – A low-value care effort is identified and goals for the initiative are well-defined.

**Motivating questions**

What does this initiative intend to achieve?

**For example:**

1. Improve patient experience and/or outcomes?
2. Reduce costs?
3. Reallocate dollars for something new that an organization or stakeholder constituency wants to implement?

The overarching goal can then be instrumental in messaging both internally and externally (e.g., must answer the questions "why?" and "why now?" to mobilize your workforce) and in identifying potential collaborators.

**Case study example**

In 2018, researchers from the Netherlands published “a typology that provides insight on the different reasons for care to be of low-value” to guide health care stakeholders “in designing a tailor-made strategy for reducing low-value care.”

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II. IDENTIFY OPPORTUNITIES TO ADDRESS LOW-VALUE CARE

Aspirational goal – The initiative is driven by data, evidence and the priorities of the group.

Motivating questions

Is there a substantial amount of low-value care that needs to be addressed? Can we document the baseline problem and then show how the initiative reduces it? How important is it to have high sensitivity (ability to capture potential low-value care services)? How important is it that the analysis has high “specificity” (e.g., identified services are truly low-value)?

Potential opportunities include:

1. Conduct an analysis of the strengths, weaknesses, opportunities and threats (SWOT) to identify: 1) what issues need to be addressed, 2) who needs to be engaged, and 3) what opportunity exists to engage other stakeholders

2. Determine the extent of low-value care by analyzing administrative data, electronic health records or chart review
   a. Prioritize the treatments and services to target based on feedback from patients and providers
   b. Publicly available algorithms and resources include:
      i. Schwartz et al. published an analysis of 26 low-value services identified in Medicare claims data. The data and ready-to-use

Case study example

A team of researchers used the Virginia All Payer Claims Database to analyze utilization of 44 low-value care services and found more than $586 million in unnecessary costs. Researchers also found that services considered both low-value and low-cost ($538 or less) were delivered much more frequently than those defined as high-cost.
algorithms underlying this analysis are publicly available through the Dataverse project.\textsuperscript{6}

ii. The U.S. Preventive Services Task Force rates preventive treatments from A to D, with D ratings reserved for treatments that are considered low-value or unnecessary. These treatments should not be utilized or reimbursed under Medicare.\textsuperscript{7}

iii. Choosing Wisely Canada published over 330 recommendations across a range of clinical specialties that identify tests and treatments that lack requisite evidence and could expose patients to harm.\textsuperscript{8}

iv. Colla et al. created claims-based algorithms to measure seven low-value services identified by Choosing Wisely in both commercial and Medicare populations.\textsuperscript{9}

v. The Virginia Center for Health Innovation developed the Virginia Health Value Dashboard to promote improved health value across the Commonwealth of Virginia. The Dashboard identifies nine value indicators across three goal areas.\textsuperscript{10}

vi. The Research Consortium for Health Care Value Assessment developed The Low Value Care Visualizer, a free, open-source tool that “takes the user’s processed claims data and creates easy to understand visualizations of complex data.”\textsuperscript{11}

c. Proprietary algorithms include:

i. Milliman’s Medinsight Waste Calculator software tool allows health care organizations to identify wasteful services within their own claims, billing or electronic medical record data.\textsuperscript{12}
III. PREPARE RATIONALE FOR ADDRESSING LOW-VALUE CARE

Aspirational goal – Broad understanding that doing more of what helps patients requires that we stop doing what does not help patients (and consumes vital resources).

Motivating questions

Why is this initiative important? What is needed to achieve its goals?

Potential actions and activities include:
1. Convene relevant stakeholders, including patients
2. Identify initiative “champions”
3. Delineate the rationale (e.g., reducing harm? Doing more of what helps patients? Limiting financial burden?)
4. Convey the need broadly within the organization(s) and to those affected

Case study example

One form of low-value care delivery is the overuse of unnecessary services or resources. The Taking Action on Overuse project developed an action-planning framework and change package to guide health care leaders and organizations as they embark on new initiatives aimed at addressing overuse. The framework includes an "Organization Assessment on Reducing Overuse" to help organizational staff and providers better understand their organization’s readiness to implement new programs aimed at overuse.
IV. DETERMINE WHETHER OR NOT THE INITIATIVE REQUIRES A COLLABORATION OF ORGANIZATIONS

Aspirational goal – Organizations within a region collaborate to achieve the most impact.

Motivating questions

Having multiple local or regional organizations working together may amplify the impact of an intervention. Is it practical or feasible to build a collaboration?

For example:
1. Collaboration among payers, providers, patient organizations, others
2. Collaboration of similar groups regionally (e.g., regional payers, regional providers)
3. Effort performed by the organization alone

Case study example

The Choosing Wisely campaign is working with several regional collaboratives to implement programs aimed at reducing unnecessary care. For example, the Washington State Choosing Wisely Task Force focuses on specific opportunities to reduce health care overuse and waste while ensuring safe, high-value care for patients. Twenty-two state-based organizations participate in the task force, including UW Medicine, Premera Blue Cross and the Washington State Department of Health.
V. DECIDE ON THE BREADTH OF THE INITIATIVE

Aspirational goal – Both the “symptoms” and the underlying “causes” are addressed, and multiple parties are involved in care decisions.

Motivating questions

Will the initiative primarily address the “surface” issue, (e.g., identify and target lower use of unnecessary preoperative tests) or will it also address the underlying “drivers” or cultural factors (e.g., fear of malpractice, patient expectations, fee-for-service incentives)?

Which stakeholders will be the target of the initiative?

What is the effort trying to achieve? How will success be measured?

Potential considerations include:

1. Determine the targets for the interventions.
   Examples include:
   a. Physicians
   b. Patients
   c. Caregivers
   d. Hospitals
2. Determine which resources will be needed
3. Determine what leverage exists to engage other stakeholders

Case study example

In 2013, the ABIM Foundation and the Robert Wood Johnson Foundation awarded Choosing Wisely grants to 21 organizations, including medical societies, specialty societies and regional collaboratives. Although all grantees shared the same goal of educating health care stakeholders about Choosing Wisely recommendations, each had its own path and priorities for achieving this result.

For example, Better Health Greater Cleveland focused its effort on primary care practices in northeast Ohio and targeted five health care situations that can often be avoided, including cardiac testing, imaging for acute low back pain and imaging for headaches. The intervention implemented by another grantee, the American Academy of Ophthalmology, had a much narrower scope and offered an educational course on strengthening communication with patients for 299 ophthalmologists and ophthalmologists in-training. The Academy developed resources for patients related to preoperative testing, antibiotics for pink eye, antibiotics for eye injections and more. Despite sharing the
4. Determine which additional factors to address. Examples include:
   a. The culture of “more is better”
   b. Physicians’ desire to not miss anything (i.e., thoroughness)
   c. Financial structures that reward volume over value
   d. Concern about medical malpractice
   e. Patient perceptions/preferences
5. Determine goal(s) for the effort (preferably quantifiable)
VI. DETERMINE IMPLEMENTATION APPROACH (STAKEHOLDER-SPECIFIC) AND IMPLEMENT THE INITIATIVE

**Aspirational goal** – The initiative includes both multi-modality and multi-stakeholder interventions.

**Motivating questions**

Who is implementing the intervention? What “levers” can they operate? Can multiple interventions be used simultaneously to reinforce the messages? How should the effort be implemented?

**Potential implementation strategies by stakeholder:**

1. **Payers**
   a. Determine whether the approach will be payer-centric or will have active provider and/or patient involvement
   b. Specific payer interventions:
      i. Prior authorization of potentially low-value services (e.g., MRIs, back surgery)
      ii. Change in provider financial incentives (rather than fee-for-service reimbursement, change to bundled payment, pay-for-performance)
      iii. Patient incentives/disincentives (e.g., value-based insurance design)

**Case study example**

**Payer-centric approach with patient incentives**

The Oregon Public Employees Benefit Board implemented a value-based insurance design in 2010. Since then, “the plans available to Oregon’s public employees have included additional cost-sharing tiers intended to encourage public employees to ‘think twice’ before receiving certain commonly overused services.”

**Payer-led effort with provider involvement**

Blue Cross Blue Shield of Michigan sponsored an effort focused on decreasing inappropriate use of coronary computed tomography angiography. The initiative involved: 1) feedback to sites on rates of appropriate use, including the cultivation of site-specific clinical champions, 2) the provision of continuing medical education, and 3) warnings of further payer restrictions on coverage/loss of coverage if appropriate use criteria was not achieved. An analysis of the effort found that the “multi-component intervention was associated with a 60 percent decrease in the use of inappropriate scans.”
2. Providers
   a. Determine whether the approach will be provider-focused, patient-focused or a combination of the two
   b. Specific provider interventions:
      i. Alerts or pathways embedded in an Electronic Health Record (EHR) (point-of-service decision support)
      ii. Physician profiling and feedback on their own use relative to peers and benchmarks
      iii. General or individually targeted education or outreach
      iv. Communication with patients/families — encourage physicians to address the five shared decision-making questions

3. Patients/Consumers
   a. Determine how patients can lead efforts to address unnecessary or inappropriate care
   b. Potential steps for implementation include:
      i. Engage patients/families/patient groups in defining, identifying and communicating about low-value care
      ii. Communicate to those affected by the initiative using patient-friendly mechanisms (e.g., share initial data on

Provider-focused efforts
Several researchers and organizations are pursuing efforts aimed at addressing low-value care by changing the way physicians are trained in medical school and focusing on “the human costs of overtreatment.”23 For example, the High Value Practice Academic Alliance created the Future Leaders Program (FLP), which is “designed to recognize high-potential physicians-in-training committed to high-value practice and advance their understanding of how to lead value-related quality improvement.”24

Provider-led effort with patient focus
The Wisconsin and Florida chapters of the American College of Cardiology led a pilot funded by the Center for Medicare & Medicaid Innovation (CMMI) focused on promoting appropriate treatment for patients with stable ischemic heart disease.25 The multi-faceted effort involved embedding evidence-based guidelines into EHR systems at 10 cardiology practices in Wisconsin and Florida and leveraging them to inform customized decision-making at the point of care. In some cases, patients were also shown an educational video explaining the risks and benefits of various cardiac procedures before meeting with a cardiologist. Patients also completed a questionnaire to assess their symptoms and severity. Cardiologists then drew on the survey data and videos to help patients understand their risks and options.
Patient- and consumer-led efforts

Choosing Wisely has developed several resources for patients and consumers who are focused on reducing inappropriate care. The “5 QUESTIONS to Ask Your Doctor Before You Get Any Test, Treatment, or Procedure” brochure includes five questions that patients can ask their providers to help make sure that patients receive the right care. The five questions include:

1. Do I really need this test, treatment or procedure?
2. What are the risks?
3. Are there simpler, safer options?
4. What happens if I don’t do anything?
5. What are the costs?

Existing resources for intervention implementation

Choosing Wisely also developed a toolkit for patient and public engagement. The toolkit provides several examples of how organizations can engage patients in the development of interventions that address low-value care. For example, the Canadian Rheumatology Association (CRA) partnered with patient collaborators to put together a list of recommendations. As described in the toolkit, “The patients who participated in the subcommittee were all individuals living with rheumatic diseases in three different provinces across the country. The patients were engaged in all components of list development, including the research process and review material. In addition to helping develop the recommendations, the patients advised Choosing Wisely Canada on the creation of two patient pamphlets related to the CRA list.”
VII. EVALUATE AND SHARE IMPACT

Aspirational goal – Rigorous methods for measuring and tracking low-value care are developed and implemented to improve health system efficiency and care delivery.

Motivating questions

Can we measure the impact of the implementation? What metrics would be most relevant (e.g., the number of low-value care services reduced, cost savings, clinical outcomes)? How much will it cost to implement the intervention? What is the timetable for the evaluation process? Who should receive the information?

Potential actions include:
1. Re-run the low-value care assessment
2. Develop relevant charts and reports
3. Determine the best approach to sharing the information
4. If the initiative starts with a modest goal, it can regroup and take on a more ambitious goal in a phase II iteration of the intervention

Case study example

In 2018, Miller et al. developed a framework for measuring low-value care that "combines multiple methods to comprehensively estimate and track the magnitude and principal sources of clinical waste." In addition, the authors also "identified a process and needed research" to implement the framework.28
VIII. COLLABORATE AND DISSEMINATE

Aspirational goal – Both positive and negative experiences are shared as broadly as possible to aid the advancement of other efforts.

Motivating questions

Will the experience be useful for other organizations?
How might this information be shared?

Potential activities include:

1. Share findings with other potential partners, collaborators and organizations
2. Prepare research article/poster/abstract submissions
3. Craft messages and mechanisms for the specific audience(s)
4. Develop a white paper or webinar to promote dissemination of key messages

Case study example

In 2016, Colla et al. published a systematic review of the literature on interventions aimed at addressing low-value care. In the analysis, the researchers identify several promising strategies that are supported by strong evidence, including approaches that incorporate clinical decision support and performance feedback. However, the authors note that there are several new types of interventions that require additional research and examination, including “research on effectiveness of pay-for performance, insurer restrictions, and risk-sharing contracts to reduce use of low-value care.” The authors also note that important gaps in the literature exist and additional experimentation, paired with evaluation and publication, is needed.
REFERENCES


7. U.S. Preventive Services Task Force. (2012). Grade Definitions. Available at: https://www.uspreventiveservicestaskforce.org/Page/Name/grade-definitions


10. Virginia Center for Health Innovation. Virginia Health Value Dashboard. Available at: https://www.vahealthinnovation.org/value-dashboard/
11 Research Consortium for Health Care Value Assessment. The Low Value Care Visualizer. Available at: https://www.hcvalueassessment.org/resource-tool.php


21 Ibid.


