CONVERSATIONS ON LOW-VALUE CARE

Reducing Low-Value Care May Mean Tough Conversations With Stakeholders

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Reducing low-value care can free up money to be spent on high-value services, but it's a delicate conversation to have, according to panelists at the University of Michigan Center for Value-Based Insurance Design (V-BID)'s V-BID Summit, held March 13 in Ann Arbor, Michigan.

The concept of value is well known among health policy experts, the payer community, and policy makers, but patients do not necessarily have the same idea of what value means, explained Daniel Carey, MD, secretary of Health and Human Resources for the Commonwealth of Virginia.

For instance, when the concept of value is introduced into a conversation around achieving access to care, some stakeholders might get the wrong idea, he said.

"For some, I found out in the last 6 or 8 months, that sounds like we're trying to reduce access…trying to take something away," Carey explained.

The language being used in these discussions is crucial, said Gwen Darien, BA, executive vice president for patient advocacy and engagement at the National Patient Advocate Foundation. Her organization represents approximately 150,000 patients who are primarily low income and underresourced and have trouble accessing quality, affordable, and equitable care.

Patients don't think about the mathematical formulas that policy makers and other experts in the field are using to define value and remove services that are considered low value because they might cause harm or be unnecessary. Instead, patients are concerned with a notion ingrained in American culture that if something is being taken away from them, then they're being stinted.

The conversation has to make it clear that services are being taken away in order to keep patients safe from harm, she added.

"A lot of the ways that we've talked about reducing low-value services [have] had to do with waste and waste in the system," Darien said. "People do not want to hear that anything that their doctor is prescribing for them is wasteful."

That's why explaining the harm of unnecessary or low-value services is important and can help the patient understand that the concern is keeping them safe.

"Less can often be more, because more can lead to unintended consequences," she added.

When Cigna talks about reducing low-value services, many times people interpret that as taking away care, according to John Keats, MD, national medical director for affordability and specialty partnerships at Cigna. But the company tries to be very deliberate in using evidence generated by other organizations and the recommendations

of the United States Preventive Services Task Force (USPSTF) to make decisions on low-value care that can be removed. A D rating from the USPSTF means that a service is not recommended to be used in asymptomatic patients.

One service that the panelists gave as an example of a low-value service that is used often and can be mostly cut out of the system is vitamin D screening. Cigna defined a population for whom vitamin D screening was recommended and would not pay for the test for any patients who didn't meet those criteria. According to Keats, a year later, doctors have stopped ordering the test and it has saved $20 million.

"This whole idea of low-value care, I think, is great, but what I see time and again [is]…we have to be on the lookout for low-value physicians," Keats said. "At the end of the day, this is physician-driven."

Beth Bortz, president and chief executive officer of the Virginia Center for Health Innovation (VCHI), was in the audience and mentioned that some physicians don't even realize they're ordering the test as often as they are. She related the story of a member of USPSTF with whom VCHI was working in its quest to identify and measure uses of low-value care, who saw his data on vitamin D screening and thought that the data must have been wrong because he would never order that many vitamin D screenings. But when he dug into the data, he realized that a vitamin D screening was part of a bundled laboratory order, and he was ordering it far more often than he realized.

"I think that's a big piece of the secret sauce [to reducing use of low-value services]," Bortz said. "They have to sit with [the data], look at it, dig into it."

Carey admitted that there is pushback even from physicians when it comes to removing low-value care, and it's not because they think low-value care utilization isn't an issue. Most physicians agree with the concept of removing low-value care, but they worry that it will be overinterpreted and that the 5% or 10% who do need the service will miss out on it. The pushback, he clarified, has been on an "inflexible system" that doesn't allow leeway for someone to step off and provide services that might be of low value for the majority of people but fit for that specific patient.

All this work to remove low-value care can have real benefits for patients, as it saves money that might have been used on unnecessary services and frees those dollars up for high-quality services to be used. Darien used the example of lung cancer, where if money is freed up, all patients can get their tumors sequenced so they are given the right treatment that will have the best chance of working for them instead of being treated "scattershot."

"That's removing low-value care to add high-value care," she said.

In Virginia, VCHI just received $2.2 million to launch a 3-year statewide pilot to reduce the use of low-value care. The pilot will bring together 6 health systems and 3 clinically integrated networks to form a large-scale health system learning community and will also create an employer task force that includes employers, the Virginia Chamber of Commerce, and the Virginia Business Coalition. This is the next step after the work that Virginia has done to identify and measure low-value care utilization.

"Once we've moved the dial, then we'll explore the headroom," Carey said. "We need to turn waste into real dollars."