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HEALTHCARE VALUE HUB

WELCOME TO:

A SPOTLIGHT ON THE VIRGINIA CENTER FOR HEALTH INNOVATION

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www.HealthcareValueHub.org
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Welcome and Introduction

Lynn Quincy
Director, Healthcare Value Hub

Housekeeping

- Thank you for joining us today!
- All lines are muted until Q&A
- Webinar is being recorded
- Technical problems? Call Tad Lee at 202-776-5126

Agenda

- **Welcome & Introduction**
  - **Lynn Quincy,** Altarum Healthcare Value Hub
- **A Conversation with Beth Bortz about oversight entities, value in healthcare and more!**
- **Q & A**

Why Make States Accountable?

- States are close to the unique, local market conditions that give rise to high healthcare prices, waste and “entrepreneurial spirit.”
- Inter-connectedness of the health system means a comprehensive view needed.
- The only stakeholder with the incentive to broadly consider the entire health system, from social determinants to provider workforce.
- When health system works well, helps all payers – relief for state budgets.
- Consumers, employers and even providers want states to play this role

KEY STATE STRATEGIES TO BETTER HEALTHCARE VALUE

States have responsibility for fair, efficient health systems. For details:

HEALTHCAREVALUEHUB.org/state-accountablility

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Why is a State Oversight Entity needed?

To manage the complexity and breadth of health care challenges, states need an entity that can:

- Assess spending in detail and *across the system*
- Address the broad set of factors influencing health
- Engage stakeholders
- Deploy an *integrated approach* to address the state's complex healthcare problems and opportunities

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Beth A. Bortz, MPP
President and CEO
Virginia Center for Health Innovation

ABOUT VCHI

Founded in 2012 as a 501(c)3 non-profit.

Mission: To accelerate the adoption of value-driven models of wellness and healthcare.

Governed by a diverse, multi-stakeholder board of directors.

Established as a Public-Private Partnership

- VCHI created in response to a recommendation of Governor Robert McDonnell's Virginia Health Reform Initiative with strong bipartisan support.
- It's the "Virginia Way" to not house this work within a state agency.
- Seven founding partners: Medical Society of Virginia, PhRMA, Virginia Association of Health Plans, Virginia Chamber of Commerce, Virginia Health Care Foundation, Virginia Hospital and Healthcare Association, and Virginians Improving Patient Care and Safety
- Founding chair was Virginia Secretary of Health and Human Services, Dr. William A. Hazel, Jr., MD; current Secretary Daniel Carey, MD serves on the Board of Directors
- Initially housed at the Virginia Chamber of Commerce
- Currently housed with Virginia's association for federally qualified community health centers

Funding

- Receive an annual appropriation from the Virginia General Assembly – has ranged from $1.6M to $100,000.
- Advisory Leadership Council Members each pay annual membership dues – amount is based on annual revenue and ranges from $500-$5,000.
- Actively compete for federal, corporate, and private philanthropy grants.
- Launching an individual giving program in 2019.
- More than 50 entities contributed to VCHI's funding in 2018.

VCHI Board and Leadership Council

AARP Virginia
Advocate Health
Aetna
Anthem
APC
Augusta Health
Aviant Health
Ballad Health
Biogen
Boehringer-Ingelheim
Bon Secours Virginia
Carilion
Centra Health
Cigna
Commonwealth of Va
Dominion Energy
GIST Healthcare
GlaxoSmithKline
HCA Virginia
Inova Health System
Johnson & Johnson
LabCorp
Maxim Healthcare Services
MSV Foundation
Merck
Novo Nordisk
Optima
PATH Foundation
Patient First
Pfizer
PhRMA
Privia Health
Riverside Health System
Sanofi
Sentara
UnitedHealthcare
UVA Health Care System
Va Academy of Family Physicians
Va Association of Health Plans
VCU Health
Virginia Health Care Foundation
Va Hospital and Healthcare Assn
Va Oral Health Coalition
Va Community Healthcare Association
Va Council of Nurse Practitioners
Virginia Nurses Association
Virginia Premier
Walgreens
Westrock

Health System Oversight: A Scan

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RESEARCH BRIEF NO. 20 | NOVEMBER 2017

Health System Oversight by States: An Environmental Scan

The high cost and uneven quality of healthcare have profound negative impacts on the health and financial security of American families. Unaffordable prices can lead consumers to delay or forgo needed medical care and cause painful budgetary tradeoffs, medical debt and bankruptcy.[1] Moreover, the quality of care that patients receive does not uniformly reflect our high healthcare spending.

States are under financial pressure to prioritize and promote health system efficiency to manage their budgets, attract employers and to address the healthcare affordability concerns of their residents.[2] While all states have well-defined roles for certain segments of their health system—such as Medicaid, state employee coverage, healthcare delivered within the criminal justice system, and public health and safety-net coverage—relatively few states take a comprehensive, systematic approach to ensure that all consumers get value for the money they spend.

But there are exceptions: a few states such as Vermont, Colorado, Pennsylvania and others have oversight agencies focused on lowering spending, while increasing quality and access for their residents. This report compares state approaches to comprehensive health system oversight. Through this exercise, we hope to help states more effectively leverage this approach to reduce healthcare spending and improve quality.

SUMMARY

It's hard to imagine robust progress on healthcare value issues without an overarching entity whose role is to look at the big picture. And yet, to date, only a few states have a centralized oversight agency that focuses on reducing healthcare costs, improving quality, bringing spending in line with overall economic growth and implementing new innovations for better value.

This report is a comparison of broad healthcare oversight authorities in seven states. We found significant variation in the responsibilities and powers these entities hold. Common roles include recommending strategies to combat rising healthcare costs and monitoring aspects of healthcare quality. Less common roles include regulating health insurance rates, piloting new innovations and implementing global budgets.

By comparing these roles, we hope to help states more effectively leverage this approach to reduce healthcare spending and improve quality.

Why is an Oversight Authority Needed?

While there will always be a federal and private payer role, there are myriad reasons why much of the activity to successfully address poor healthcare value needs to occur at the state level.[3]

For one, our fragmented health system typically limits the ability of any one payer or stakeholder to incentivize the provider practice changes that will lead to lower costs.[4] States are well positioned to serve as a convener and support the multi-payer coordination that is critical for meaningful progress on healthcare value.

Further, broad access to coverage and getting to better healthcare value are inseparable, intertwined policy objectives. State efforts to ensure access to coverage will be eased if the costs of care are more reasonable. In addition, efforts to improve the value we get for our healthcare dollar—such as provider payment reform—are universally premised on a population having coverage.

Moreover, state governments are uniquely positioned to invest in "upstream" approaches that lead to healthier communities. Research shows that just 10-20 percent

State	Oversight Entity
Vermont	Green Mountain Care Board
Massachusetts	Health Policy Commission & Center for Health Information and Analysis
Oregon	Oregon Health Authority
Virginia	The Joint Commission on Healthcare
Pennsylvania	Pennsylvania Cost Containment Council
Colorado	Colorado Commission on Affordable Healthcare
Maryland	Health Services Cost Review Commission

HealthcareValueHub.org/state-accountability

What is a State Health System Oversight Entity?

An entity empowered to deploy an *integrated approach* to address a state's complex healthcare problems and evaluate opportunities.

Important roles can include:

- Leadership/legislative recommendations
- Data stewardship and infrastructure
- Convener
- Innovator
- Regulator

For more on state oversight entities, see the Hub's Dec 2017 webinar at healthcarevaluehub.org/events

Our Work

Convening and educating stakeholders interested in accelerating the adoption of value-driven models of wellness and healthcare in an effort to improve patient outcomes and advance Virginia's well-being and economic competitiveness.

Overseeing and facilitating demonstration research to test and evaluate models of value-driven wellness and health care.

Leveraging data and analytical resources that inform and enable health care providers, public health professionals, government representatives, community organizations, employers and consumers to make better decisions.

Helping prepare the health care delivery system and the public for a high quality, value-driven health care marketplace which features engaged and satisfied clinicians and patients.

Establishing a Virginia Health Value Dashboard

- The purpose of the Health Value Dashboard is to prompt action for improving the value of health care services.
- Our measurement approach is to identify and report on the delivery of **both** low value and high value clinical services across Virginia and its regions.
- Our action aims are to engage key stakeholders in systematically reducing low value services, increasing high value services, and improving the infrastructure for value-based care. We invite all organizations that provide, purchase, or fund health care to engage in this effort.

Dashboard Aims

The Virginia Health Value Dashboard has three aims.

I. Reduce low value health care

II. Increase high value health care

III. Improve the infrastructure for advancing value-based health care, with a focus on data infrastructure, health information exchange, value-based payment models, and investment in population health initiatives.

Aim I: Reducing Low Value Care

A. Utilization and cost of avoidable emergency room visits

- Avoidable emergency department visits as a percentage of total emergency department visits
- Avoidable emergency department visits per member per year
- Avoidable emergency department visits per 1,000 member months

DATA SOURCE: APCD

B. Low-value care "Top Four" tests and procedures

- Avoid unneeded diagnostic testing and imaging for low-risk patients before low-risk surgery
- Avoid Vitamin D screening tests
- Avoid prostate-specific antigen (PSA) screening in men 75 and older
- Avoid imaging for acute low-back pain for the first six weeks after onset, unless clinical warning signs ("red flags") are present

**Virginia-specific wording*

DATA SOURCE: APCD

C. PQI discharges as a percentage of total hospital discharges: Avoidable Hospital Stays for Ambulatory Sensitive Conditions Per 100,000 Persons

- PQI discharges as a percentage of total inpatient discharges.
- Total PQI discharges per member per year.
- Total PQI discharges per 1,000 member months.

DATA SOURCE: VHI IP Discharge

Aim II: Increasing High-Value Care

A. Virginians who are current with appropriate vaccination schedules

- Child and Adolescent Immunization Status
- Percentage of patients 65 years of age and older who have completed the pneumoccocal vaccine series

DATA SOURCES: APCD; VIIS; Catalyst for Payment Reform

B. Screening and Treatment of Virginia's Diabetic and Pre-Diabetic Population

- Percentage of patients 18-75 years of age with diabetes who had HbA1c screening during the measurement year (HEDIS=1 year)
- Percentage of patients 18-75 years of age with diabetes who had a nephropathy screening

DATA SOURCES: APCD; Catalyst for Payment Reform

C. Clinically Appropriate Cancer Screening Rates

- Percentage of women 50-74 years of age who had a mammogram or DBT to screen for breast cancer
- Percentage of women 21-64 years of age who were screened for cervical cancer using cervical cytology
- Percentage of adults 50-75 yeras of age who had appropriate screening (FOE or colonoscopy) for colorectal cancer

DATA SOURCES: APCD

Aim III: Improving the Infrastructure for Value-based Care

A. Commercial in-Network Payments That Are Value Oriented

- Catalyst for Payment Reform Composite Score: Increasing the Percent of Commercial In-Network Payments that Are Value Oriented

DATA SOURCE: Catalyst for Payment Reform Scorecard 2.0

B. Claims in Virginia's All-Payer Claims Database

- Percent of Virginia Total Covered Lives with Claims Included in the Virginia All Payer Claims Database
- Percent of Virginia Commercially Insured Lives with Claims Included in the Virginia All Payer Claims Database

DATA SOURCE: APCD

C. Value-Oriented Payments that Place Doctors and Hospitals at Financial Risk for Their Performance

- Catalyst for Payment Reform Composite Score: Increase the Percent of Value-Oriented Payments that Place Doctors and Hospitals at Financial Risk for Their Performance

DATA SOURCE: Catalyst for Payment Reform Scorecard 2.0

Measures for Future Consideration

A. Utilization of High Cost Service Siteswhen Lower Cost Sites are Available

B. Medication Adherence for Patients with Chronic Illnesses, Including Mental Health

C. Access to Primary Care for the Medically Underserved

D. Smokers in Smoking Cessation Counseling Programs

E. Utilization of Appropriate Hospice Care and Palliative Services for Patients with Advanced Illness

F. Adults with Serious Mental Illness Receiving Appropriate Treatment

G. Share of Total Dollars Paid to Primary Care Physicians vs. Specialists

H. Providers that Score Well on the Merit-based Incentive Payment System

I. Virginians with documented Advanced Directives

A Snapshot of the Dashboard Data on Low Value Care 2016

STATEWIDE 2016

REDUCING LOW VALUE CARE	Numerator	Denominator	Rate
Utilization and Cost of Avoidable Emergency Room Visits			
Potentially Avoidable ED Visits - As a Percentage of Total ED Visits	204,112	1,525,336	13%
Potentially Avoidable ED Visits - Per 1,000 Member Months	204,112	63,466	3.2
Potentially Avoidable ED Visits - Per Member Per Year	204,112	5,288,861	0.04
Low Value Services as Captured by the MedInsight Health Waste Calculator			
Don't obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery – specifically complete blood count, basic or comprehensive metabolic panel, coagulation studies when blood loss (or fluid shifts) is/are expected to be minimal	417,580	504,827	83%
Don't obtain EKG, chest X-rays or pulmonary function test in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery	32,518	426,836	8%
Don't perform population based screening for 25-OH-Vitamin D deficiency	123,950	487,412	25%
Don't perform PSA-based screening for prostate cancer in all men regardless of age	203,230	270,514	75%
Don't do imaging for low back pain within the first six weeks, unless red flags are present	31,670	41,304	77%
Inappropriate Preventable Hospital Stays			
Prevention Quality Indicator #90: Prevention Quality Overall Composite Rate (per 100,000 population)	79,463	3,678,939	2,160

STATE AND REGIONAL COMPARISON 2016

Legend
- = Better than statewide rate
- = Same as statewide rate
- = Worse than statewide rate

REDUCING LOW VALUE CARE	Statewide	Northwest	Northern	Southwest	Central	Eastern
Utilization and Cost of Avoidable Emergency Room Visits						
Potentially Avoidable ED Visits - As a Percentage of Total ED Visits	13%	●	●	●	●	●
Potentially Avoidable ED Visits - Per 1,000 Member Months	3.2	●	●	●	●	●
Potentially Avoidable ED Visits - Per Member Per Year	0.04	●	●	●	●	●
Low Value Services as Captured by the MedInsight Health Waste Calculator						
Don't obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery – specifically complete blood count, basic or comprehensive metabolic panel, coagulation studies when blood loss (or fluid shifts) is/are expected to be minimal	83%	●	●	●	●	●
Don't obtain EKG, chest X-rays or pulmonary function test in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery	8%	●	●	●	●	●
Don't perform population based screening for 25-OH-Vitamin D deficiency	25%	●	●	●	●	●
Don't perform PSA-based screening for prostate cancer in all men regardless of age	75%	●	●	●	●	●
Don't do imaging for low back pain within the first six weeks, unless red flags are present	77%	●	●	●	●	●
Inappropriate Preventable Hospital Stays						
Prevention Quality Indicator #90: Prevention Quality Overall Composite Rate (per 100,000 population)	2,160	●	●	●	●	●

VIRGINIA CENTER FOR HEALTH INNOVATION

A Deeper Dive into VCHI's Low Value Care Work: Analyzing Data to Identify Unnecessary Medical Tests and Procedures

- **Value Based Insurance Design & Choosing Wisely®** were key components of Virginia's State Innovation Model (SIM) design, as they were targeted by Virginia employers as a priority

- Key partners in this work include: Virginia Center for Health Innovation, Virginia Health Information, Milliman, and the University of Michigan's Center for Value-Based Insurance Design

- Main strategy is to utilize data from Virginia's **All Payer Claims Database** and the **Milliman MedInsight Health Waste Calculator** to identify priorities as to which medical tests and procedures are not generating value for patients and should be reduced.

Our Plan of Attack

1. Build consensus around the Choosing Wisely® principles and the need to measure low value care
2. Leverage data from Virginia's All Payer Claims Database and apply the Milliman MedInsight Health Waste Calculator with the aim of identifying priorities as to which medical tests and procedures should be reduced.
3. Share early data with partners to test validity and acceptance
4. Build consensus around initial focus and develop an action plan
5. Identify and test multiple improvement strategies

Step 1: Build Consensus Around Choosing Wisely® and the Importance Of MEASURING Unnecessary Care

Series of Conversations 2015-2016:

- Medical Society of Virginia
- Virginia Hospital and Healthcare Association
- Virginia Chamber of Commerce
- Virginia General Assembly Joint Commission on Health Care
- Virginia Association of Health Plans
- Virginia Consortium of Health Philanthropy
- Virginia Council of Nurse Practitioners
- Virginia Community Health Care Association
- Virginia Academy of Family Physicians
- Virginia Population Health Summit

Step 2: Leveraging APCD Data

Important Definitions

Choosing Wisely® – designed by the American Board of Internal Medicine and the National Physicians Alliance to help physicians, patients and other health care stakeholders think and talk about overuse of health care resources. Each medical specialty was asked to identify 5 medical tests and/or procedures that they know to be unnecessary and/or harmful.·

Low Value - Services that research has proven to add no value in particular clinical circumstances and in fact can lead to subsequent unnecessary patient harm and higher total cost of care.

All Payer Claims Database –includes paid claims from commercial health insurance companies and the Department of Medical Assistance Services. This voluntary program facilitates data-driven, evidence-based improvements in the access, quality, and cost of healthcare. For the purposes of this work, VHI and VCHI were also able to secure Medicare fee for service data to add to the Medicaid and commercial data.

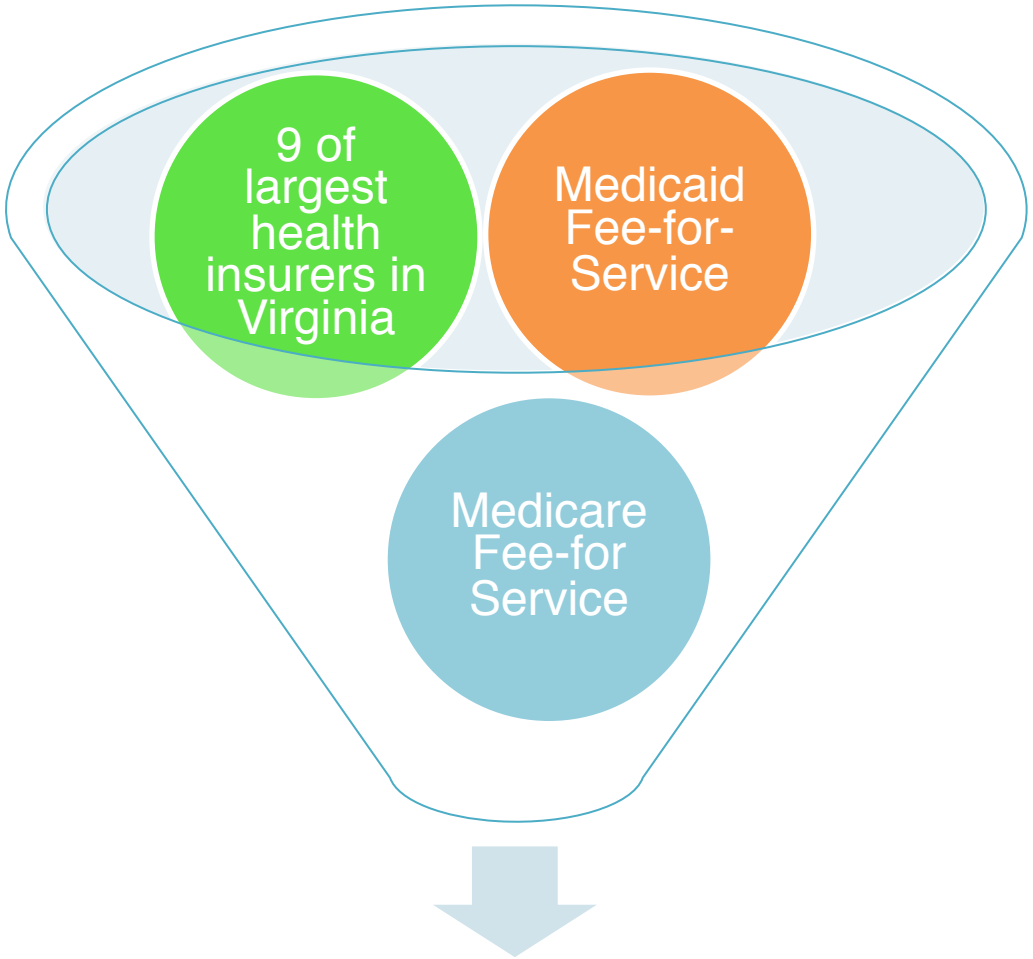
MedInsight Health Waste Calculator – an analytical software tool that provides actionable insight on the degree of necessity of healthcare services and determines optimal efficiency benchmarks.

The Milliman MedInsight Health Waste Calculator

- Version 6 has 42 measures, representing 60 Choosing Wisely recommendations.
- Sources for measures can include:
  - Choosing Wisely (from the ABIM Foundation)
  - US Preventive Services Task Force Grade D Recommendations
  - The American Medical Association's Physician Consortium for Performance Improvement
  - The United Kingdom's National Institute for Health and Care Excellence (NICE) Recommendations on High Quality Care
  - Medical Specialty Society Guidelines
  - High-quality, evidence-based research papers
- 400+ measures in the pipelines – initial measures were prioritized by:
  - Amenability to claims data analysis;
  - High prevalence;
  - High cost impact; and
  - Potential to cover a variety of subspecialties and patient populations.

Data Source- Virginia's All Payer Claims Database

Administered by Virginia Health Information



Medical and Pharmacy
Claims for 5 million Virginians

Virginia Summary of Results

	January 2018
Reporting Period	2016
Number of Measures	42
CMS Data Included?	Yes
Dollars Spent on Unnecessary Services	$706 million per year
Unnecessary Services Identified	2.05 million per year

Virginia Overall Results – Summary

41% of members exposed to 1+ low service

37% of services measured were low value

$11.13 PMPM in claims were unnecessary

Potential Cost Savings of $706 Million Per Year

Top 5 Measures by Percent of Low Value Dollars for Virginia

MEASURE	RISK OF HARM	% of Low Value Dollars	Average Proxy Cost Per Service	Low Value Index
Don't obtain baseline laboratory studies in patients without significant systemic disease undergoing low-risk surgery.	L	28%	476.07	83%
Don't routinely order imaging tests for patients without symptoms or signs of significant eye disease.	L	24%	398.54	66%
Don't place peripherally inserted central catheters (PICC) in stage III-V CKD patients without consulting nephrology	H	8%	18,528.37	81%
Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.	M	7%	305.38	8%
Don't perform routine head CT scans for emergency room visits for severe dizziness	L	4%	1,732.25	68%

Step 3: Share data to test validity and acceptance

Early lessons learned

- Word Choice Matters- "Waste" will strike a nerve with certain audiences
- May want to focus on reducing harmful measures first – and not focus solely on potential cost savings
- May want to prioritize reducing those measures with a high waste index, even if the likely cost savings is lower. Easier to message and change behavior.
- Need to be prepared to address provider medical liability concerns
- Consumer education needs to be conducted concurrent with provider education

Statewide Data Starts to Create a National Stir

COSTS & SPENDING

By John N. Mafi, Kyle Russell, Beth A. Bortz, Marcos Dachary, William A. Hazel Jr., and A. Mark Fendrick

DOI: 10.1377/hlthaff.2017.0385
HEALTH AFFAIRS 36,
NO. 10 (2017): 1701–1704

DATAWATCH

Low-Cost, High-Volume Health Services Contribute The Most To Unnecessary Health Spending

An analysis of data for 2014 about forty-four low-value health services in the Virginia All Payer Claims Database revealed more than $586 million in unnecessary costs. Among these low-value services, those that were low and very low cost ($538 or less per service) were delivered far more frequently than services that were high and very high cost ($539 or more). The combined costs of the former group were nearly twice those of the latter (65 percent versus 35 percent).

Health Affairs article, ***"Low-Cost, High Volume Services Contribute The Most To Unnecessary Health Spending"***, was the 3rd most read Health Article in 2017.

Step 4: Build consensus and develop an action plan

Three Main Strategies

1. Work with the Emerging National Task Force on Low Value Care
2. Advance the Virginia Health Value Dashboard
3. Begin Pilot Projects with Interested Partners

Step 5: Begin Pilot Projects with Interested Partners

- State Employee Health Plan
- FQHCs
- Medicaid
- Health System Collaborative
- Employer Task Force

Questions for our Speaker?

- Use the chat box or to unmute, press *6

- Please do not put us on hold!

One-Third of Healthcare Spending is Wasted

Average Healthcare Spending per Person (2016)

$11,193

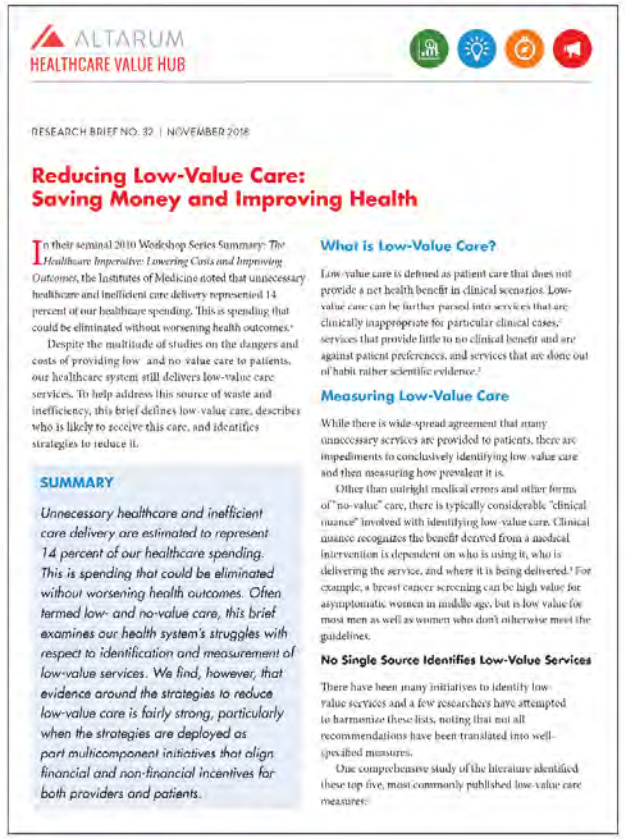
Wasted Spending

$3,431

Necessary Spending

Low-Value Care	**14%** of spending	**Unnecessary Services** *Examples: Duplicate Tests, Choosing Wisely Services* **Inefficient Care Delivery** *Example: Test Results Not Shared*
Administrative Waste	**8%** of spending	*Example: Billing Errors*
Pricing Failures	**4%** of spending	*Example: Excessive Profits*
Fraud	**3%** of spending	*Example: False Claims*
Prevention Failures	**2%** of spending	*Example: Missed Flu Shot*

Hub Resources to Address Waste



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RESEARCH BRIEF NO. 32 | NOVEMBER 2018

Reducing Low-Value Care: Saving Money and Improving Health

In their seminal 2010 Workshop Series Summary: *The Healthcare Imperative: Lowering Costs and Improving Outcomes*, the Institutes of Medicine noted that unnecessary healthcare and inefficient care delivery represented 14 percent of our healthcare spending. This is spending that could be eliminated without worsening health outcomes.[1]

Despite the multitude of studies on the dangers and costs of providing low- and no-value care to patients, our healthcare system still delivers low-value care services. To help address this source of waste and inefficiency, this brief defines low-value care, describes who is likely to receive this care, and identifies strategies to reduce it.

SUMMARY

Unnecessary healthcare and inefficient care delivery are estimated to represent 14 percent of our healthcare spending. This is spending that could be eliminated without worsening health outcomes. Often termed low- and no-value care, this brief examines our health system's struggles with respect to identification and measurement of low-value services. We find, however, that evidence around the strategies to reduce low-value care is fairly strong, particularly when the strategies are deployed as part multicomponent initiatives that align financial and non-financial incentives for both providers and patients.

What is Low-Value Care?

Low-value care is defined as patient care that does not provide a net health benefit in clinical scenarios. Low-value care can be further parsed into services that are clinically inappropriate for particular clinical cases,[2] services that provide little to no clinical benefit and are against patient preferences, and services that are done out of habit rather scientific evidence.[3]

Measuring Low-Value Care

While there is wide-spread agreement that many unnecessary services are provided to patients, there are impediments to conclusively identifying low-value care and then measuring how prevalent it is.

Other than outright medical errors and other forms of "no-value" care, there is typically considerable "clinical nuance" involved with identifying low-value care. Clinical nuance recognizes the benefit derived from a medical intervention is dependent on who is using it, who is delivering the service, and where it is being delivered.[4] For example, a breast cancer screening can be high value for asymptomatic women in middle age, but is low value for most men as well as women who don't otherwise meet the guidelines.

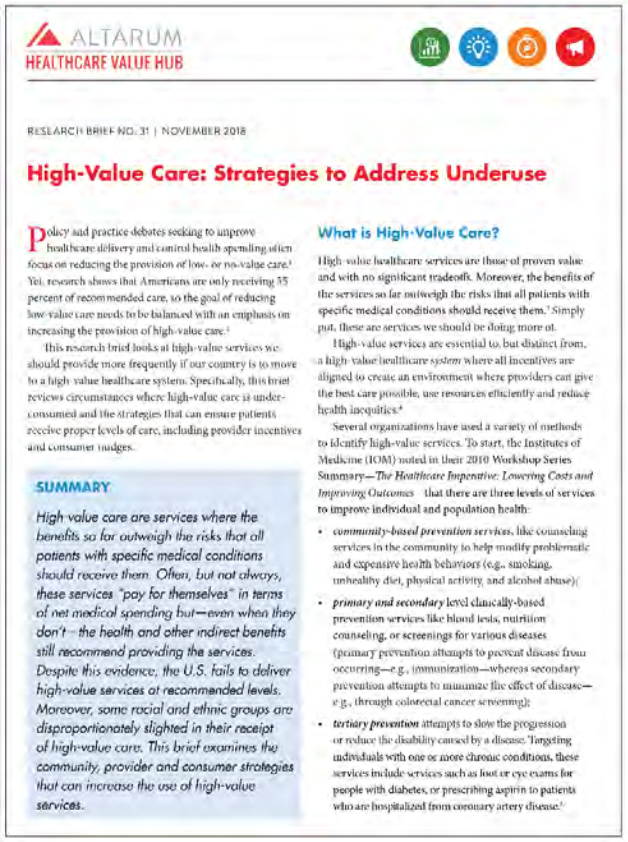
No Single Source Identifies Low-Value Services

There have been many initiatives to identify low-value services and a few researchers have attempted to harmonize these lists, noting that not all recommendations have been translated into well-specified measures.

One comprehensive study of the literature identified these top five, most commonly published low-value care measures:

Too much

LOW VALUE CARE



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RESEARCH BRIEF NO. 31 | NOVEMBER 2018

High-Value Care: Strategies to Address Underuse

Policy and practice debates seeking to improve healthcare delivery and control health spending often focus on reducing the provision of low- or no-value care.[1] Yet, research shows that Americans are only receiving 55 percent of recommended care, so the goal of reducing low-value care needs to be balanced with an emphasis on increasing the provision of high-value care.[2]

This research brief looks at high-value services we should provide more frequently if our country is to move to a high-value healthcare system. Specifically, this brief reviews circumstances where high-value care is under-consumed and the strategies that can ensure patients receive proper levels of care, including provider incentives and consumer nudges.

SUMMARY

High-value care are services where the benefits so far outweigh the risks that all patients with specific medical conditions should receive them. Often, but not always, these services "pay for themselves" in terms of net medical spending but—even when they don't—the health and other indirect benefits still recommend providing the services. Despite this evidence, the U.S. fails to deliver high-value services at recommended levels. Moreover, some racial and ethnic groups are disproportionately slighted in their receipt of high-value care. This brief examines the community, provider and consumer strategies that can increase the use of high-value services.

What is High-Value Care?

High-value healthcare services are those of proven value and with no significant tradeoffs. Moreover, the benefits of the services so far outweigh the risks that all patients with specific medical conditions should receive them.[3] Simply put, these are services we should be doing more of.

High-value services are essential to, but distinct from, a high-value healthcare *system* where all incentives are aligned to create an environment where providers can give the best care possible, use resources efficiently and reduce health inequities.[4]

Several organizations have used a variety of methods to identify high-value services. To start, the Institutes of Medicine (IOM) noted in their 2010 Workshop Series Summary—*The Healthcare Imperative: Lowering Costs and Improving Outcomes*—that there are three levels of services to improve individual and population health:

- *community-based prevention services*, like counseling services in the community to help modify problematic and expensive health behaviors (e.g., smoking, unhealthy diet, physical activity, and alcohol abuse);
- *primary and secondary* level clinically-based prevention services like blood tests, nutrition counseling, or screenings for various diseases (primary prevention attempts to prevent disease from occurring—e.g., immunization—whereas secondary prevention attempts to minimize the effect of disease—e.g., through colorectal cancer screening);
- *tertiary prevention* attempts to slow the progression or reduce the disability caused by a disease. Targeting individuals with one or more chronic conditions, these services include services such as foot or eye exams for people with diabetes, or prescribing aspirin to patients who are hospitalized from coronary artery disease.[5]

Too little

HIGH VALUE CARE

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Strategies to Address High Unit Prices: A Primer for States

and

EXCESS PRICES

LOW-VALUE CARE .vs HIGH-VALUE CARE

LOW-VALUE CARE

EXAMPLES

Unneeded diagnostic testing

Unneeded imaging

Bloodwork for low-risk surgery

Use of branded drugs when generics are available

Elective/unwarrented C-sections

Spending wasted on low-value care is estimated to be more than $340 billion each year.

HIGH-VALUE CARE

EXAMPLES

Getting a flu shot

Cancer screening when appropriate

Coordinating care for complex patients

Prenatal care

Eye screening for diabetics

Providing more high-value care could avoid costly care later, saving more than $55 billion each year.

For details on the strategies, go to:

HEALTHCAREVALUEHUB.org/low-vs-high-value-care

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Thank you!

- **Beth Bortz**
- **Robert Wood Johnson Foundation**

Contact Lynn Quincy at **lynn.quincy@Altarum.org** or any member of the Hub staff with your follow-up questions.

Next Up: *(Tentative)* Medical Devices: Revolutionary but Advocacy Concerns Strongly Parallel Drug Concerns

February 22, 2019, 2 pm ET.

Register at HealthcareValueHub.org/events