

Use of Evidence and Technology to Improve Quality and Eliminate Low-Value Care

Kenneth Cohen, MD

The US health care system provides suboptimal outcomes at costs that are twice the average of those of other wealthy nations. The 4 major drivers of excess cost are administrative overhead, pharmaceutical pricing, overuse of low-value care, and the cost of medical, hospital, and imaging procedures.¹ The first 2 cost drivers may be beyond the control of physicians. However, physicians and other health care providers can have influence over the latter 2 by eliminating low-value care and choosing the most efficient site of service. These last 2 drivers account for 27% of the excess spending in our health care system, although this may be an underestimation, as the Institute of Medicine has suggested that low-value care represents about one-third of all health care expenditures.

A 2018 study of Medicare, Medicaid, and commercial claims in the state of Washington placed the magnitude of low-value care at 44% of all care delivered.² However, the term “low-value care” diminishes the significance of the problem; in reality, this care is wasted at best and is quite often harmful. Choosing Wisely 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 do not have supporting data showing 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 score 6 prostate cancer and papillary thyroid cancers, the overuse of lumbar spinal fusion, and the overuse of cardiac catheterization and coronary interventions, to name but a few.

The current reimbursement model creates perverse incentives that foster the persistence of low-value care. Therefore, 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 in which providers and health systems are responsible for the total cost of care. A necessary element of this transition is the development of an infrastructure supporting this new model. The Optimal Care model has been designed to meet this need.

Optum Care is the national, physician-led, ambulatory care delivery system of Optum, and the Optimal Care model is a key component

TAKEAWAY POINTS

A new care model is needed to rescue our struggling health care system. The Optimal Care model propels health care transformation through the use of evidence, technology, and data. It deploys the following strategies to drive improvements in care quality while simultaneously reducing low-value and harmful care:

- ▶ Cultural transformation at the provider and physician group levels.
- ▶ Development of an educational curriculum to promulgate evidence-based medicine.
- ▶ Point-of-care technology embedded in the electronic health record.
- ▶ Patient engagement via interactive shared decision-making and patient-reported outcomes.
- ▶ Transparently reported quality and efficiency metrics for both primary care and specialty providers.

of its care delivery infrastructure. The fundamental tenet of this program is the rapid transition of high-quality evidence-based medicine (EBM) into daily practice, with the simultaneous goals of improving patient outcomes, eliminating low-value and harmful care, and reducing the cost of care. Historically, the delay from publication of high-quality research to practice implementation is 5 to 10 years. The Optimal Care model is designed to reduce this to 12 weeks. The key components of the program include:

1. The creation of a cultural transformation at the provider, physician group, and national levels, driven by physician thought leaders across Optum Care.
2. The development and promulgation of a foundational educational curriculum for EBM focused on the elimination of low-value care. Continuing medical education (CME)-accredited lectures are created for each of the specialty areas. Because the evidence base is rapidly evolving, these are supplemented by the Optum Care Forum for Evidence-Based Medicine. The forum takes recent high-quality studies with results that should inform daily practice and distills them into easily deployed recommendations in a CME-accredited periodical. Supporting the evidence base is a collection of short clinical briefs and patient-facing handouts

to facilitate evidence-based conversations with patients so that they are in lockstep with their providers.

3. Point-of-care technology embedded in the electronic health record and available to the patient and the primary care provider at the time of the encounter. These tools include straightforward algorithms focused on the use of high-quality evidence in the delivery of optimal care. They 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.
4. Patient engagement is inherent in the redesign of the health care system. Interactive shared decision-making modules are used to teach patients about real-world outcomes of various medical interventions such that they, along with their provider, can choose the best care that aligns with their values and preferences. On the back end, a patient-reported outcomes platform is being built, which will feed back into the shared decision-making modules to further refine clinical decision-making and drive improved patient outcomes.
5. The collection, normalization, and transparent reporting of quality and efficiency metrics for both primary care and specialty providers. The primary care metrics compare performance at the provider and medical group levels. They look at utilization of low-value tests and procedures stratified against the performance of the provider's peers, as well as other medical groups and national Optum Care benchmarks. 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. Specialists' utilization of low-value care measures is highlighted. Regular meetings are conducted at the national and market levels to share and analyze these data; they focus on highlighting best practices to support both primary care providers and specialists in their efforts to reduce low-value and harmful care and improve patient outcomes. The choice of specialists to whom primary care providers refer is informed by these data.

The implementation of Optimal Care is not without its challenges.

- Cultural transformation is a difficult process. It requires a history of trust and success with prior initiatives. It will not succeed if it is the "initiative of the month."
- Provider engagement around EBM can face barriers. It will sometimes conflict with community standards and patient expectations, and it will often conflict with revenue generation in a fee-for-service (FFS) model. This is particularly true for those providers who are still largely practicing in an FFS model and just beginning to venture into value-based care. Choosing the most efficient site of service may be difficult when providers are employed by a health care system or hospital if they are not free to choose alternative care settings.

- Accurate comparative reporting requires sophisticated health care economic analytics, which need to be consistently applied across what are 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 and number needed to treat.
- Aligning patients around Optimal Care requires an educational initiative that teaches them how to choose evidence-based care and describes the potential harms of choosing low-value care. This initiative needs to use enhanced communication tools and should occur in settings other than just the provider office.

Part of the challenge also lies outside of the medical group. Most health plan benefit designs are not specifically oriented to align incentives around decreasing the total cost of care. For example, lower patient coinsurance (or shared savings) for optimal care decisions would serve to better align patients with their providers around the choice of high-value care, the best-performing providers, and the most efficient sites of service. Additionally, health systems must 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 compel providers and health systems to focus on lowering the total cost of care. The Optimal Care model supports providers on this journey.

Collectively, the major stakeholders within our health care delivery system have failed to control rising health care costs. Our patients and employers cannot afford our current health care system, and they deserve one 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 and harmful care. As this occurs, the reduction in total cost of care will be large enough to reverse the trend of continually rising health care costs. Despite the challenges described above, the Optimal Care program has been successfully deployed and has demonstrated improvements in health care outcomes while reducing total cost of care. ■

Author Affiliations: Optum Center for Research and Innovation, Minnetonka, MN.

Source of Funding: None.

Author Disclosures: The author reports no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.

Authorship Information: Concept and design; acquisition of data; analysis and interpretation of data; drafting of the manuscript; critical revision of the manuscript for important intellectual content; and statistical analysis.

Address Correspondence to: Kenneth Cohen, MD, Optum Center for Research and Innovation, 5995 Opus Pkwy, Minnetonka, MN 55343. Email: ken.cohen@optum.com.

REFERENCES

1. Emanuel EJ. The real cost of the US health care system. *JAMA*. 2018;319(10):983-985. doi:10.1001/jama.2018.1151
2. Brown DL, Clement F. Calculating health care waste in Washington state: first, do no harm. *JAMA Intern Med*. 2018;178(9):1262-1263. doi:10.1001/jamainternmed.2018.3516

Visit ajmc.com/link/88693 to download PDF