

Running the Numbers

*A Periodic Feature to Inform North Carolina Health Care Professionals
About Current Topics in Health Statistics*

Capitalize on the Moment: Leveraging the COVID-19 Experience to Spur Low-Value Care Reduction in North Carolina

The COVID-19 pandemic has highlighted a myriad of opportunities to improve health and health care in the United States. One area ripe for improvement is reducing the occurrence of low-value care, or services that provide insufficient clinical benefit and increase health care costs. Use of such services is pervasive, accounting for more than \$100 billion in wasted health care spending annually [1]. These costs are likely much greater if downstream implications, such as medical and psychological harms to patients, are considered. Although low-value care is prevalent throughout the country, a recent analysis ranked North Carolina as one of the worst-performing states in terms of use of 20 different low-value services [2].

Various efforts have been introduced over the last decade to spur awareness and action on low-value care. Perhaps the most prominent to date is the Choosing Wisely campaign, which has engaged medical specialty societies in generating lists of unnecessary interventions, with the aim of activating provider and patient conversations about avoiding such services [3]. However, despite these initiatives, significant and sustained reductions in low-value care have proven difficult to achieve for a number of reasons, including clinical inertia, persistent cultural norms, and misaligned financial incentives. The COVID-19 pandemic, however, has presented a unique situation in which many types of care that are often unnecessary or overused have plummeted as a result of stay-at-home orders and the need to protect frontline workers. For example, in the early months of the pandemic, outpatient care and elective admissions dropped dramatically, with some estimates suggesting an almost 60% reduction in various services as patients avoided in-person visits and medical providers cut availability [4]. While some of this decline involves clinically appropriate care, it also includes low-value

care, such as routine cancer screenings, laboratory tests, and diagnostic imaging for which there is little evidence of benefit [5, 6].

Despite these initial shifts in practice, some health services have rebounded to prepandemic levels. Total hospital admissions were back to 94% by December 2020 [7], and weekly instances of outpatient care were close to early March 2020 levels by the end of 2020 [2]. Given these trends, it is clear that COVID-19 will not be a panacea for eliminating low-value care, particularly considering that many of the drivers of low-value care remain deeply rooted in the health care system. However, there are clear opportunities to leverage some of the health policy and public health learnings from the pandemic to make more progress. Doing so will involve prioritizing strategies that afford patients safe, high-quality, and equitable care, while deterring low-value services from fully resuming, or reducing their use over time. Providing less low-value care could avail resources that could be redirected to services that benefit population health or other important policy priorities, which will be critical in an uncertain postpandemic world. Although a range of such strategies can be considered [8], four complementary pathways for action are outlined here.

First, during the pandemic, telemedicine enabled clinicians to safely triage and treat patients. Supported by changes in provider payment and other regulatory flexibilities, telehealth use grew

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rapidly in the United States over the course of the pandemic [9]. Nonetheless, uptake varied considerably across specialties. At the end of 2020, the proportion of visits using telehealth was robust in behavioral health (56%), but very low in orthopedics (2%), cardiology (5%), oncology (6%), pediatrics (8%), and adult primary care (12%) [2]. In most of these areas, the uptick in telehealth use has not been high enough to fully offset any declines in in-person care, particularly in the early months of the pandemic [9], with potential short- and long-term health and economic consequences [10]. Moving forward, it will be important to revise and/or adopt telehealth policies in ways that encourage the resumption and use of necessary high-value care and discourage overuse. Such strategies could include permanently continuing many of the waivers extended during the pandemic, such as the waiver of the requirements that providers have an in-person visit before a telehealth visit and that telemedicine visits be hosted at a clinical facility. Moreover, telehealth policies should evolve to reflect evidence of value or significant population health need. For example, telehealth coverage and reimbursement could be extended for adult primary care and well-child visits, behavioral health, and care in federally qualified health centers, community centers, or long-term care facilities. This could aid recovery of primary and preventive services and reach high-risk patient populations. Conversely, telehealth coverage and reimbursement could be eliminated or reduced for known low-value services, especially those known to set off cascades of costly and preventable downstream care (e.g., emergency room use, specialty referral, imaging) often fueled by the desire to avoid even the smallest risk of a serious condition [11, 12]. This succession of medical services can follow from incidental or marginal findings on screening and diagnostic tests, some of which are themselves of low value. They can be difficult to stop once initiated, often leading to harms for patients, clinicians, and the health care system at large. More research is needed to measure this phenomenon.

Second, effectively responding to the pandemic required new avenues for public and private collaboration, from harmonizing efforts to provide personal protective equipment (PPE), COVID-19 testing, and vaccines to developing the necessary

data and analytic infrastructure to monitor the pandemic spread. There are numerous examples of such collaboration in North Carolina over the last year, such as fast-tracked implementation of the digital coordinated care network NCCARE360 and the development of the Latinx Advocacy Team & Interdisciplinary Network for COVID-19 (LATIN-19). This same energy, investment, and infrastructure should continue to be leveraged to deliver high-value, non-COVID care and services to patients and communities around the state and bolster ongoing health care and public health system transformation.

In the future, these multistakeholder and multi-sectoral efforts should include initiatives to reduce low-value care. There are several existing models of state leadership for addressing low-value care, including Virginia, Washington, and Minnesota [14, 11]. These states have developed multiyear initiatives and pilots to measure and track low-value care use in the state and engage health systems, employers, and payers in reducing low-value services through performance measurement, benefit design and contracting, and education. All of these initiatives are embedded within broader state actions to accelerate value-based care. As part of North Carolina's value-based care transformation efforts [15], the state should pursue new multi-payer data initiatives, such as an all-payer claims database (APCD) [16], and leverage or expand existing resources (e.g., North Carolina Health Information Exchange Authority) to bring together comprehensive data on health care utilization, quality, outcomes, and costs. These data resources served as a critical foundation for measuring and tracking low-value care use in the aforementioned states. In the interim, stakeholders should capitalize on existing data analytic capabilities to evaluate the impacts of delayed and foregone care and new modes of care delivery (e.g., telehealth, community-based care) during the pandemic. This evidence is vital for achieving a better understanding of the circumstances in which health care services are necessary and when they are not, and in what contexts care can be delivered more efficiently, equitably, and locally. In parallel, multistakeholder coalitions or collaboratives should be developed to translate ongoing evidence generation into practice and policy reforms in the state.

Third, while the experience and impacts of COVID-19 may slow North Carolina's ongoing value-based care transformation efforts, payers and other stakeholders should accelerate their development and adoption. COVID-19 showed that providers practicing within value-based payment models were better able to respond to the pandemic and weather ongoing economic uncertainties as a result of more predictable financial structures and associated investments in staff, data, and care coordination aimed at improving population health and care delivery [17, 18]. These are many of the same capabilities required to eliminate low-value services. Moreover, these models offer more flexibility for implementing alternatives to low-value care, such as the use of telemedicine or coordinating timely referrals to physical therapy for patients who are not appropriate candidates for joint replacement. Payers and employers should build a range of financial and nonfinancial levers into these reforms to help guide clinicians and patients toward high-value care and away from low-value care. These levers may include curated high-quality provider networks, value-based insurance design, clinical and patient decision support tools, performance measurement and reporting on low-value care use, patient-reported outcome measurement, and provider rewards or penalties. To the latter, a clinician could share in the savings of an avoided low-value service, while being reimbursed less or not at all for ordering or using a known low-value test or procedure. An easy place to start is to refuse to pay for US Preventive Services Task Force Grade D services, Task Force on Low-Value Care "Top Five" low-value services, or a subset of Choosing Wisely recommendations (Table 1).

Fourth, given the pervasive impact of COVID-19 on the health and economic livelihood of the population, the pandemic afforded new opportunities to engage the public around their health. Existing research suggests that the public has limited understanding or regard for low-value care due to different interpretations of the term "low-value" or because they equate it with costs only [19]. Riding on the learnings and success of North Carolina's "You Have a Spot. Take Your Shot" COVID-19 vaccine campaign, similar efforts could be designed to raise public aware-

ness and action on low-value care. In fact, some of the aforementioned states have adopted statewide educational campaigns around certain low-value care services, such as "Drop the Pre-Op!" in Washington State [20]. Current understanding of public perceptions of low-value care suggests that such campaigns need to highlight the physical, emotional, and financial harms of low-value care; engage a range of trusted messengers including providers, caregivers, advocacy groups, and community organizations; and not be divorced from broader messages on high-value care [21]. It is also imperative that these efforts be developed and disseminated with health equity in mind by considering what low-value care and resulting harms mean to different populations; health literacy; and structural inequities in access, process, and outcomes. Communication strategies that involve members of African American, Latinx, and other racial and ethnic communities must also be employed. A statewide campaign in North Carolina would allow clinicians and other stakeholders to engage patients and consumers in conversations and shared decision making on low-value care.

In many ways, North Carolina has been an exemplar of public and private innovation and action to fight COVID-19. The time is now to use the resources, knowledge, and collective action harnessed during the pandemic to enhance the value of health care and longer-term health for North Carolinians by reducing low-value care. **NCMJ**

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3. Choosing Wisely: An initiative of the ABIM Foundation.

TABLE 1.
Recommendations for Reducing or Eliminating Low-Value Care

Low-Value Care Recommendations	Description	Examples
US Preventive Services Task Force Grade D Services	USPSTF issues evidence-based recommendations on the use of preventive services, using a letter grade system based on the balance of benefits and harms. The list includes ~20 Grade D “discourage use of service” recommendations.	<ul style="list-style-type: none"> • Screening for cervical cancer in women younger than 21 years • Screening for asymptomatic bacteriuria in nonpregnant adults • Screening with ECG to prevent cardiovascular disease events in asymptomatic adults at low risk of CVD events • Screening for thyroid cancer in asymptomatic adults • Routine screening for abdominal aortic aneurysm (AAA) with ultrasonography in women who have never smoked and have no family history of AAA
Choosing Wisely	Developed by professional societies, Choosing Wisely lists over 600 commonly used tests and procedures by clinical area whose necessity should be questioned. Offers education materials to facilitate conversations between providers and patients on low-value care.	<ul style="list-style-type: none"> • Routine use of opioids for treatment of knee osteoarthritis, hip osteoarthritis, low back pain, or rotator cuff injury • Annual cervical screening on asymptomatic patients who have had adequate and normal screening • Routine use of breast MRI for breast cancer screening in average-risk women • Antibiotics use for upper respiratory infections • Knee arthroscopy as initial/management for patients with degenerative meniscal tears and no mechanical symptoms • Routine stress testing after percutaneous coronary intervention (PCI) without specific clinical indications • Cancer screenings in adults with life expectancy of less than 10 years • Routine preoperative testing before low-risk surgical procedures • Annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms
Task Force on Low-Value Care	A list of “Top Five” low-value care services based on harms, costs, prevalence, and opportunities for change.	<ul style="list-style-type: none"> • Diagnostic testing and imaging prior to low-risk surgery • Vitamin D screening • PSA-based screening for prostate cancer in men aged 75 and older • Imaging in the first six weeks of low-back pain • Use of branded drugs when generics are available

Sources. https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?category%5B%5D=All&searchterm=Grade+D;
[https://www.choosingwisely.org/clinician-lists/;](https://www.choosingwisely.org/clinician-lists/) <http://www.vbidhealth.com/low-value-care-top-five-services.php>

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