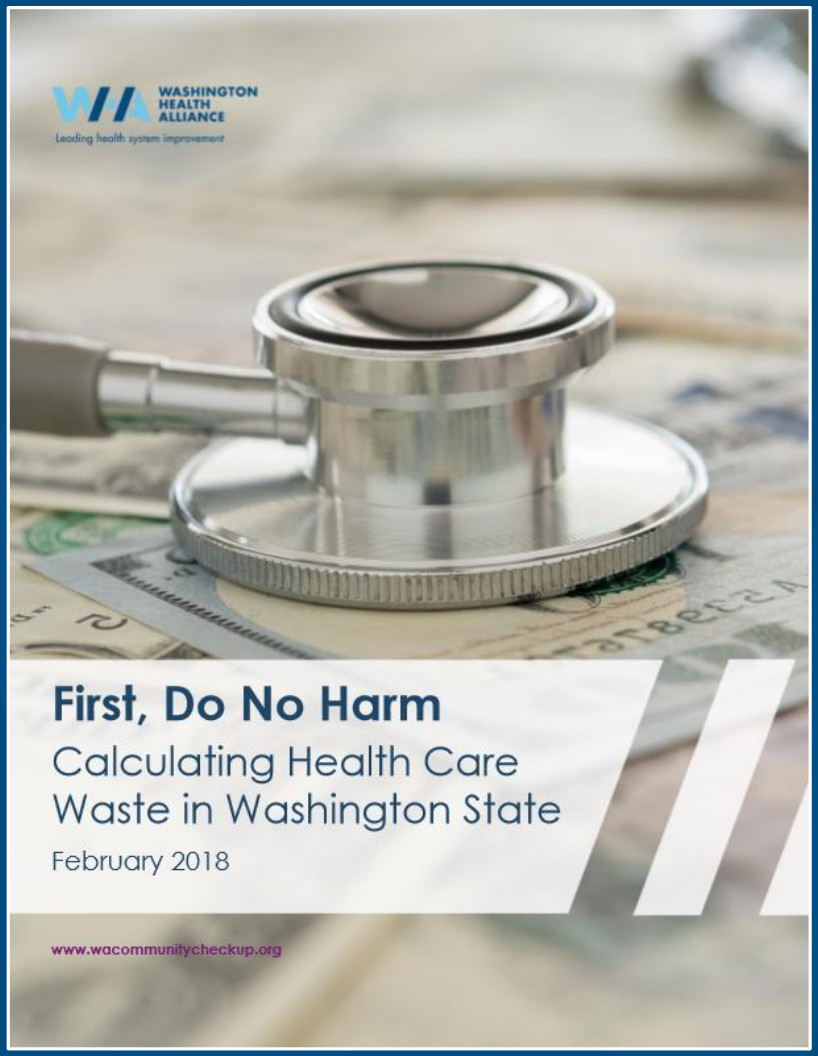


Analytic Tools and Methods: Assessing Waste in Health Care

NAHDO's 33rd Annual Meeting
October 2018

Susanne Dade, Deputy Director
Washington Health Alliance
Seattle, WA

WASHINGTON HEALTH ALLIANCE
Leading health system improvement

Finding Health Care Waste: Why do we care?

5.5%

Annual increase in national health care spending thru 2026

$5.7 Trillion

Total spend on health care by 2026

19.7%

Percentage of GDP spend on health care by 2026

47%

Percentage of health care spend borne by federal, state and local governments

25% - 30%

Estimated Amount of Waste in Health Care Overall

WASHINGTON HEALTH ALLIANCE

And,
we are harming people.

Physical Harm

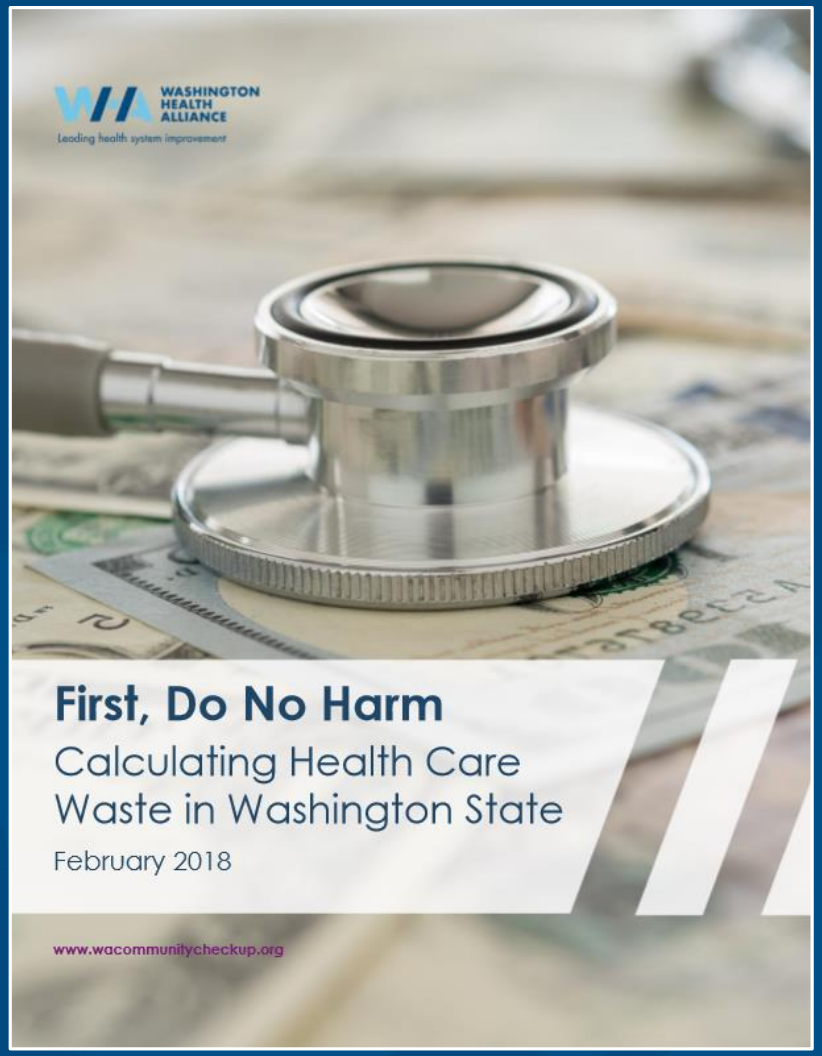
Healthcare acquired infections
Surgical errors
Medication errors
Excessive radiation
False positives resulting in MORE . . .

Emotional Harm

Worry
Anxiety
Lower productivity
Absenteeism

Financial Harm

Debt
Bankruptcy
Devastating trade-offs: food, medication and other health care, education, housing, employment



Find this report:
www.wacommunitycheckup.org

MedInsight Health Waste Calculator™

- Software that analyzes claims data to identify wasteful services as defined by national initiatives such as Choosing Wisely® and the U.S. Preventive Services Task Force
- Analysis done at the claim line level; includes facility and professional services
- Situational intelligence creates "degree of wasteful certainty" (Necessary, Likely Wasteful, Wasteful)
- Version 5: **47 measures, all based on Choosing Wisely recommendations**
- Our results based on 2.4 million commercially insured lives in WA
- Measurement year: July 2015 – June 2016
- Utilization is actual, costs are estimated

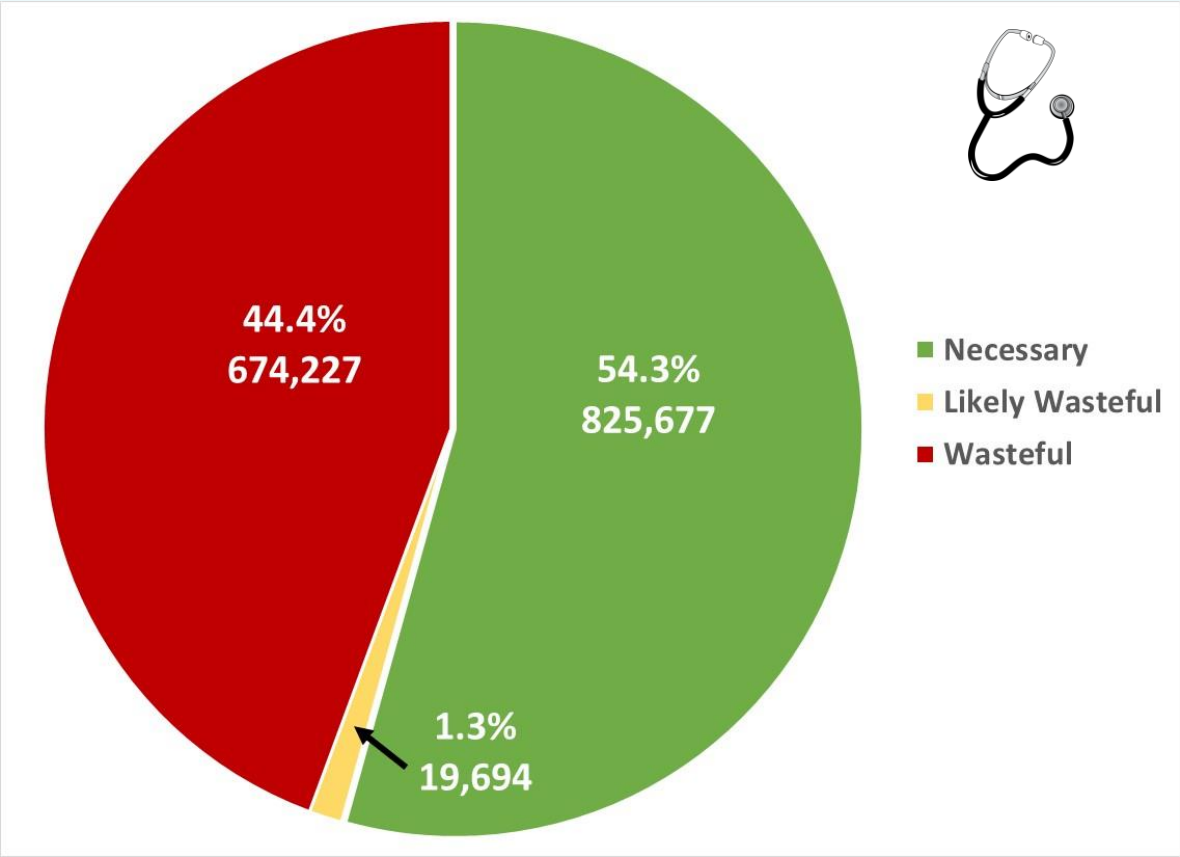
"Waste or Low Value Services"

Medical tests and procedures that have been shown to provide little benefit in particular clinical scenarios

and in many cases

have the potential to cause physical, emotional and/or financial harm

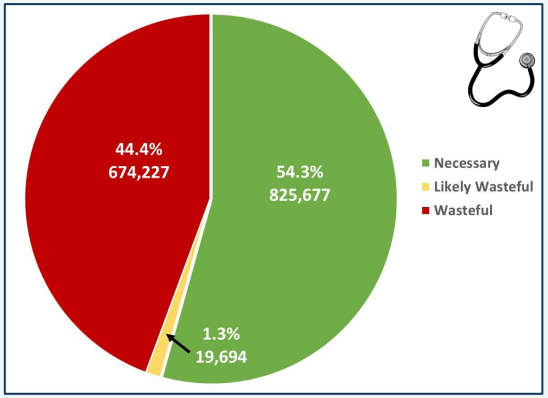
Our Results in Washington



- 1.52 million services were examined (47 measures)
- 45.7% of examined services were determined to be low value (likely wasteful and wasteful)

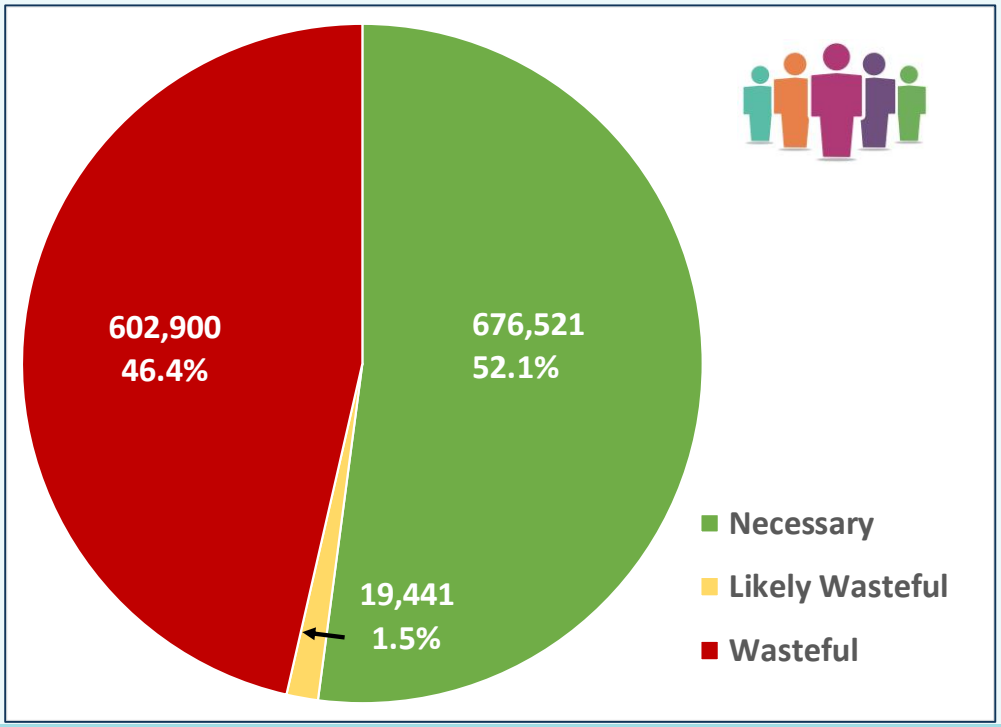
Our Results in Washington

SERVICES



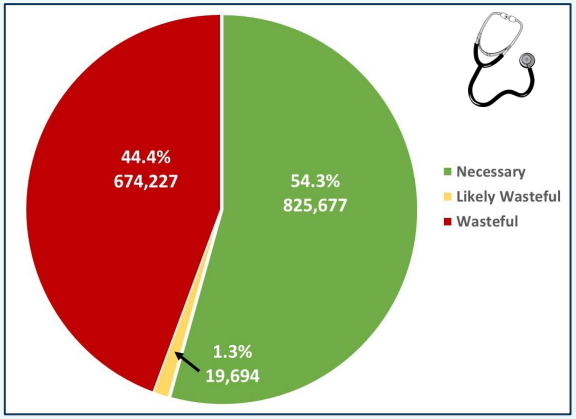
1,298,862 individuals received services (47 measures)

622,341 (47.9%) individuals received low value services

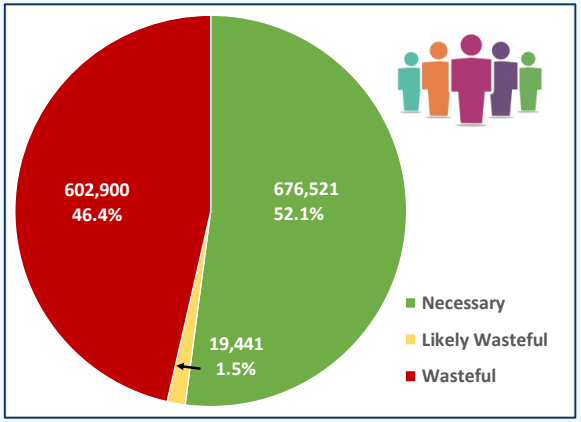


Our Results in Washington

SERVICES

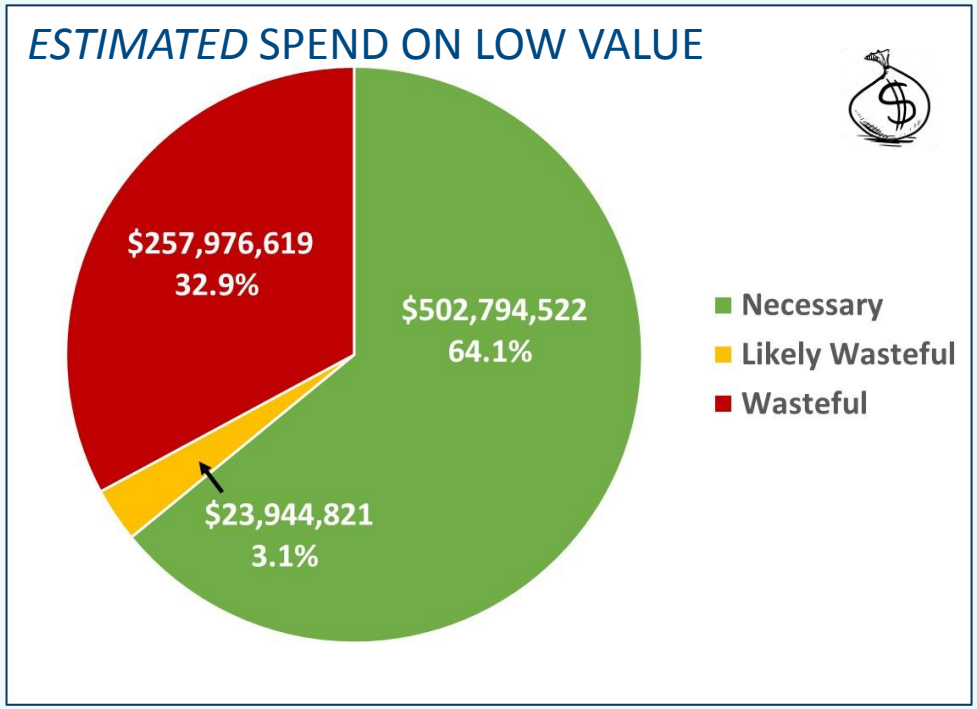


INDIVIDUALS

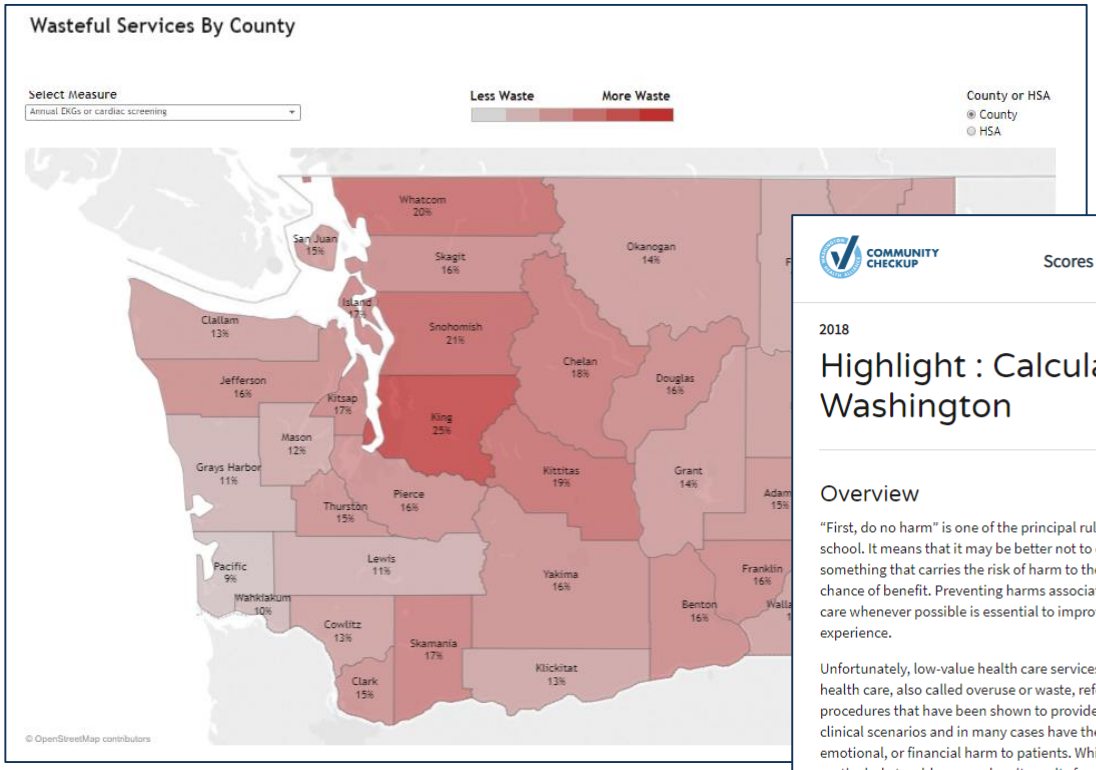


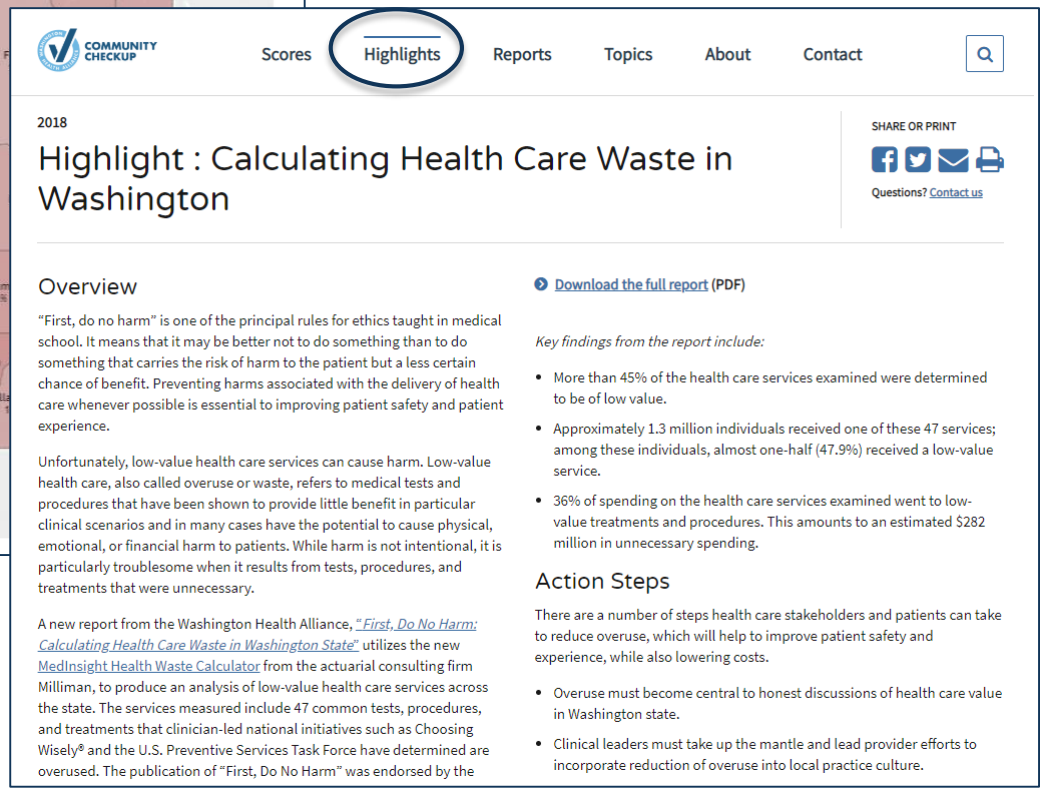
An estimated $785 million was spent on services (47 measures)

~$282 million (36%) was spent on low value services



Results Vary Across Our State





COMMUNITY CHECKUP

Scores | Highlights | Reports | Topics | About | Contact

2018

Highlight : Calculating Health Care Waste in Washington

SHARE OR PRINT

Questions? Contact us

Overview

"First, do no harm" is one of the principal rules for ethics taught in medical school. It means that it may be better not to do something than to do something that carries the risk of harm to the patient but a less certain chance of benefit. Preventing harms associated with the delivery of health care whenever possible is essential to improving patient safety and patient experience.

Unfortunately, low-value health care services can cause harm. Low-value health care, also called overuse or waste, refers to medical tests and procedures that have been shown to provide little benefit in particular clinical scenarios and in many cases have the potential to cause physical, emotional, or financial harm to patients. While harm is not intentional, it is particularly troublesome when it results from tests, procedures, and treatments that were unnecessary.

A new report from the Washington Health Alliance, *"First, Do No Harm: Calculating Health Care Waste in Washington State"* utilizes the new MedInsight Health Waste Calculator from the actuarial consulting firm Milliman, to produce an analysis of low-value health care services across the state. The services measured include 47 common tests, procedures, and treatments that clinician-led national initiatives such as Choosing Wisely® and the U.S. Preventive Services Task Force have determined are overused. The publication of "First, Do No Harm" was endorsed by the

Download the full report (PDF)

Key findings from the report include:

- More than 45% of the health care services examined were determined to be of low value.
- Approximately 1.3 million individuals received one of these 47 services; among these individuals, almost one-half (47.9%) received a low-value service.
- 36% of spending on the health care services examined went to low-value treatments and procedures. This amounts to an estimated $282 million in unnecessary spending.

Action Steps

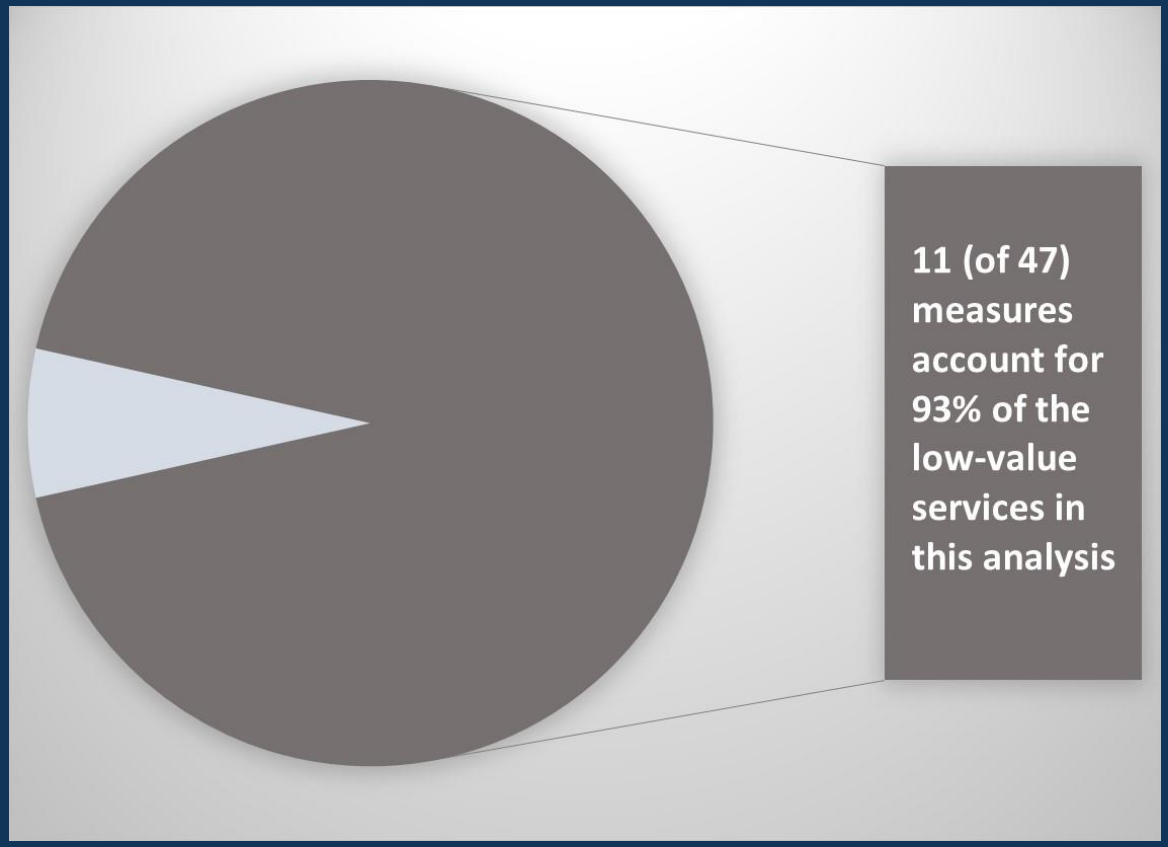
There are a number of steps health care stakeholders and patients can take to reduce overuse, which will help to improve patient safety and experience, while also lowering costs.

- Overuse must become central to honest discussions of health care value in Washington state.
- Clinical leaders must take up the mantle and lead provider efforts to incorporate reduction of overuse into local practice culture.

Detail can be found here:
www.wacommunitycheckup.org

WASHINGTON HEALTH ALLIANCE

Targeting key drivers of overuse in WA



- These same 11 measures account for 89% of the estimated spend associated with low value.
- A total of 578,503 individuals received at least one of these 11 services.

Things to focus on in Washington:

	People Receiving Low Value Services*	Estimated Spend on Low Value Services*
Pre-op lab studies and EKG, chest X-Ray, and PFT before low-risk surgery	100,000	$92.4 M
Cardiac Testing - Annual EKG in low-risk, asymptomatic people - Cardiac Stress Testing	102,600	$73.4 M
Unnecessary Screening - Too frequent cervical cancer screening - PSA Screening for prostate cancer - Vitamin D deficiency screening	205,200	$41 M
Imaging - For eye disease in asymptomatic people - Low back pain, first 6 weeks - Uncomplicated headache	96,400	$44.5M
Antibiotics for URI and ear infection	73,700	$2.3 M

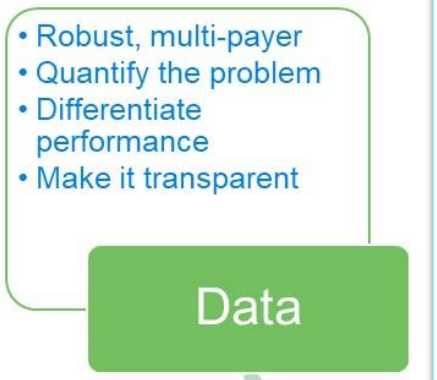
**Numbers rounded; includes wasteful and likely wasteful services*

WASHINGTON HEALTH ALLIANCE

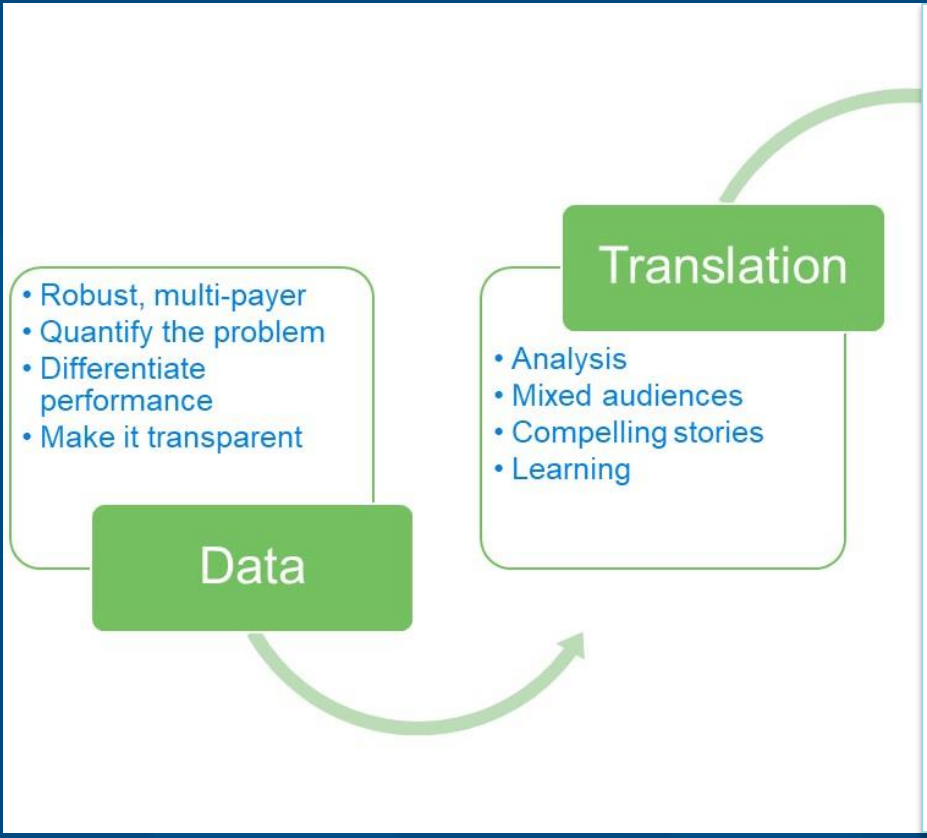
What is the utility of this work?

It's not enough just to produce data and put it on a website or in a report. . .

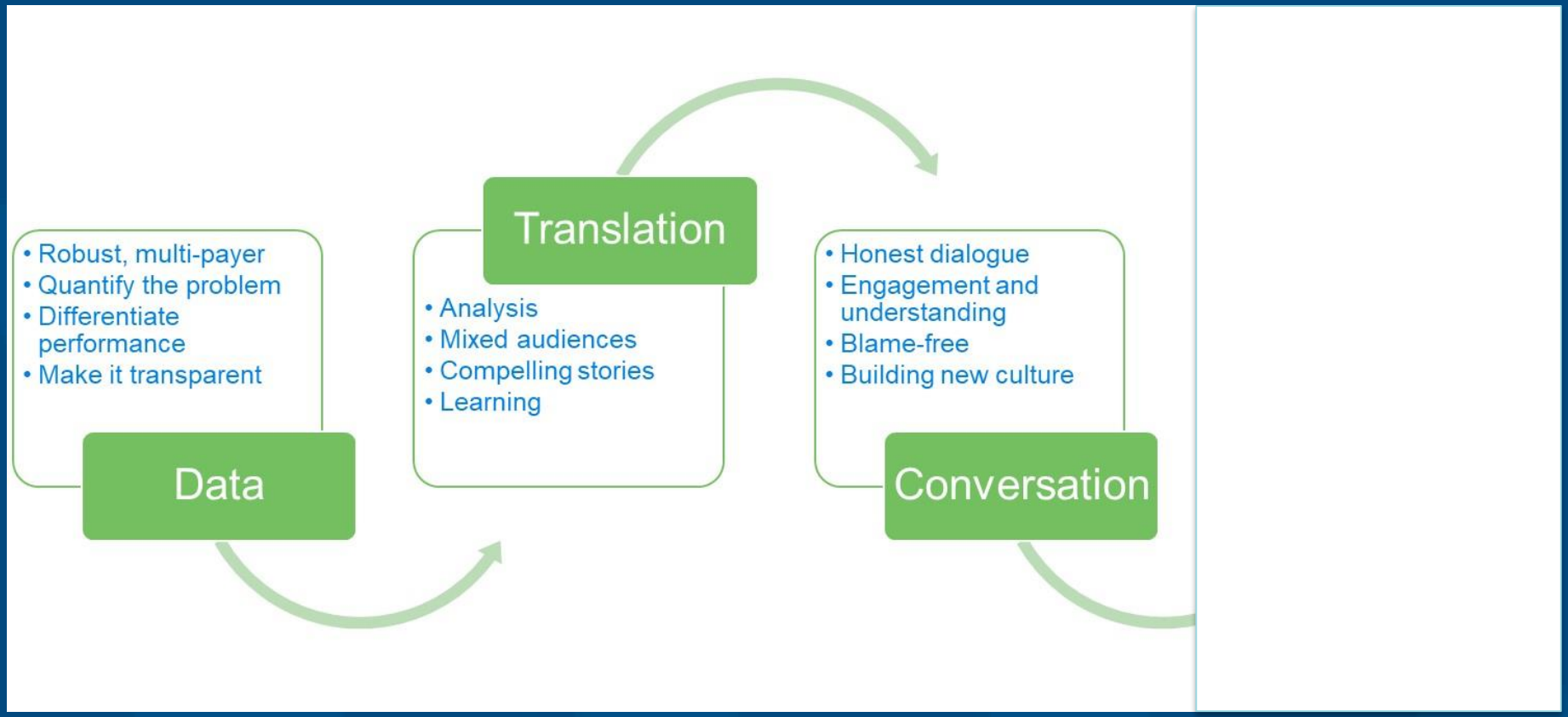
What is the utility of this work?
Yes, data is really important, foundational



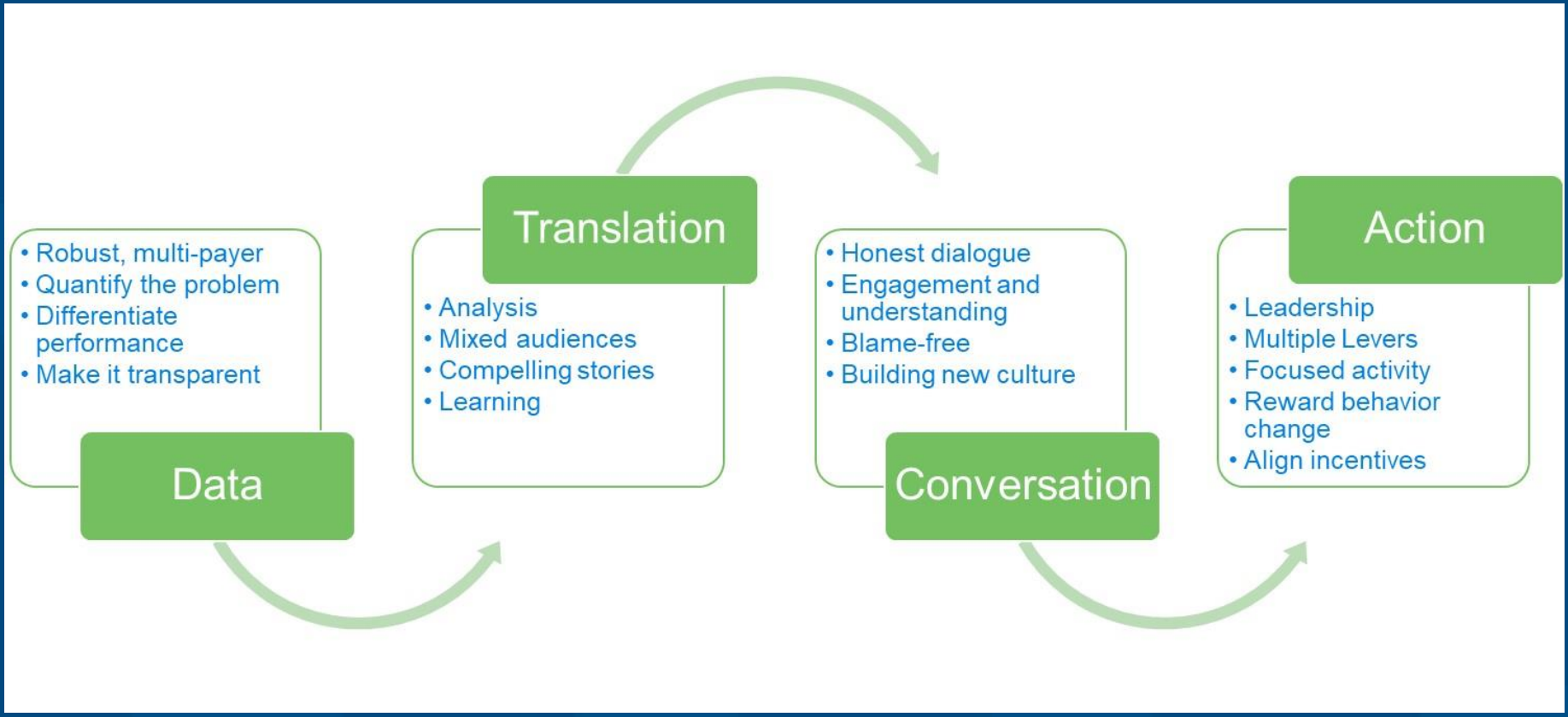
What is the utility of this work?
But we have to USE the data . . .



What is the utility of this work?
But we have to USE the data . . .



What is the utility of this work?
But we have to USE the data . . .



What are the levers?

Patient-Facing (Demand)

- Education (broad-based and individual)
- Transparent information (quality and cost together)
- Value-based insurance design
- Network design
- Prior authorization

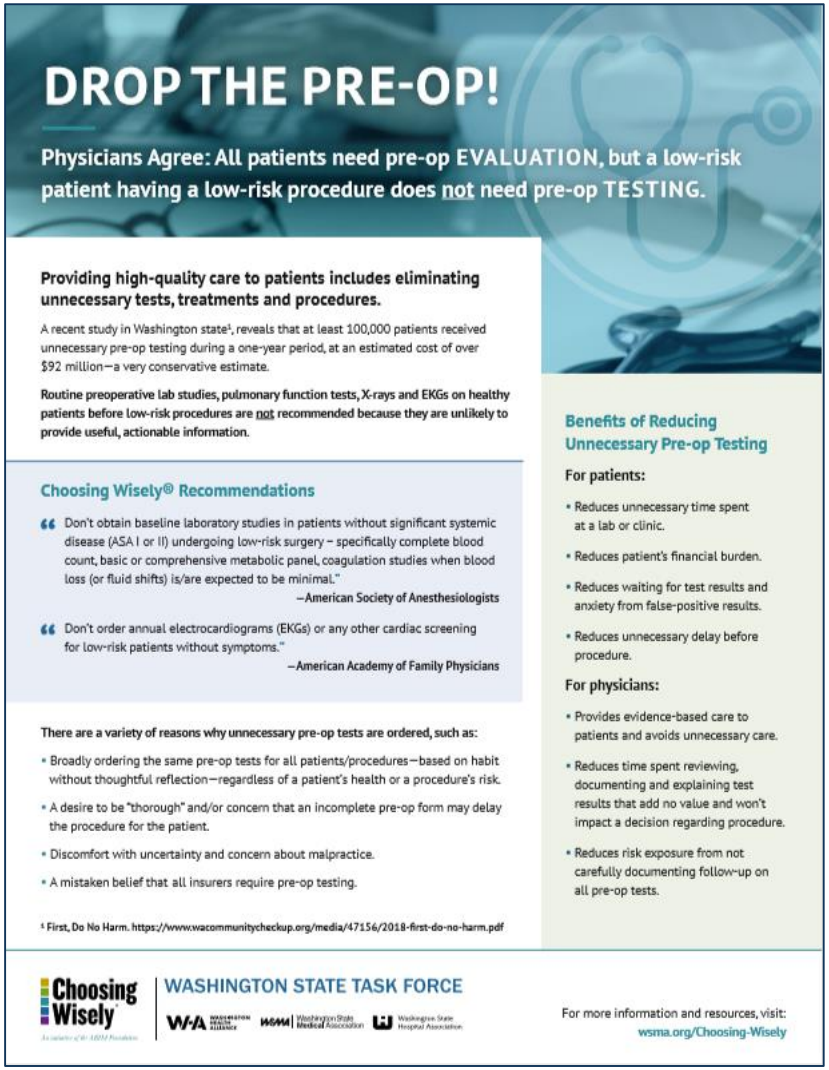
Provider-Facing (Supply)

- Education
- Clinical decision support at the point of care
- Coverage policies (medical necessity)
- Payment rates
- Payment models (risk sharing)
- Provider profiling (private or public)

Examples of what we are working on now in Washington:

- Washington State Choosing Wisely Task Force
  - ~25 organizations/large delivery systems represented
- NEW statewide results for Washington due out VERY SOON
- We are producing purchaser-specific results, e.g.:
  - WA Health Care Authority (for public employees, Medicaid)
  - The Boeing Company (for their ACOs)
- Specific strategies to reduce preoperative evaluation before low-risk surgery
  - Don't obtain baseline lab studies, EKG, chest X-ray, or Pulmonary Function Test in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery

Reducing Unnecessary Preoperative Testing



DROP THE PRE-OP!

Physicians Agree: All patients need pre-op EVALUATION, but a low-risk patient having a low-risk procedure does not need pre-op TESTING.

Providing high-quality care to patients includes eliminating unnecessary tests, treatments and procedures.

A recent study in Washington state[1], reveals that at least 100,000 patients received unnecessary pre-op testing during a one-year period, at an estimated cost of over $92 million—a very conservative estimate.

Routine preoperative lab studies, pulmonary function tests, X-rays and EKGs on healthy patients before low-risk procedures are not recommended because they are unlikely to provide useful, actionable information.

Choosing Wisely® Recommendations

> "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."
>
> —American Society of Anesthesiologists

> "Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms."
>
> —American Academy of Family Physicians

There are a variety of reasons why unnecessary pre-op tests are ordered, such as:

- Broadly ordering the same pre-op tests for all patients/procedures—based on habit without thoughtful reflection—regardless of a patient's health or a procedure's risk.
- A desire to be "thorough" and/or concern that an incomplete pre-op form may delay the procedure for the patient.
- Discomfort with uncertainty and concern about malpractice.
- A mistaken belief that all insurers require pre-op testing.

[1] First, Do No Harm. https://www.wacommunitycheckup.org/media/47156/2018-first-do-no-harm.pdf

Benefits of Reducing Unnecessary Pre-op Testing

For patients:

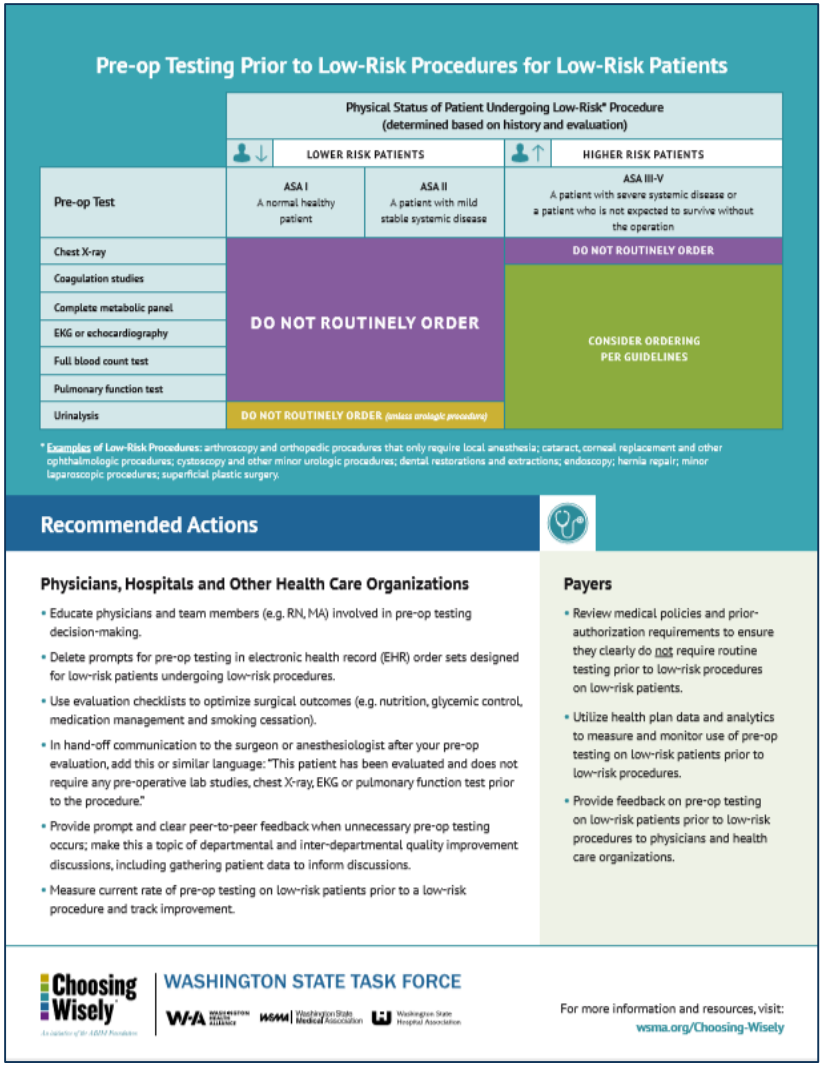
- Reduces unnecessary time spent at a lab or clinic.
- Reduces patient's financial burden.
- Reduces waiting for test results and anxiety from false-positive results.
- Reduces unnecessary delay before procedure.

For physicians:

- Provides evidence-based care to patients and avoids unnecessary care.
- Reduces time spent reviewing, documenting and explaining test results that add no value and won't impact a decision regarding procedure.
- Reduces risk exposure from not carefully documenting follow-up on all pre-op tests.

Choosing Wisely | WASHINGTON STATE TASK FORCE

For more information and resources, visit: wsma.org/Choosing-Wisely



Pre-op Testing Prior to Low-Risk Procedures for Low-Risk Patients

Pre-op Test	Physical Status of Patient Undergoing Low-Risk* Procedure (determined based on history and evaluation)		
	LOWER RISK PATIENTS		HIGHER RISK PATIENTS
	ASA I A normal healthy patient	ASA II A patient with mild stable systemic disease	ASA III-V A patient with severe systemic disease or a patient who is not expected to survive without the operation
Chest X-ray	DO NOT ROUTINELY ORDER		DO NOT ROUTINELY ORDER
Coagulation studies	DO NOT ROUTINELY ORDER		CONSIDER ORDERING PER GUIDELINES
Complete metabolic panel	DO NOT ROUTINELY ORDER		CONSIDER ORDERING PER GUIDELINES
EKG or echocardiography	DO NOT ROUTINELY ORDER		CONSIDER ORDERING PER GUIDELINES
Full blood count test	DO NOT ROUTINELY ORDER		CONSIDER ORDERING PER GUIDELINES
Pulmonary function test	DO NOT ROUTINELY ORDER		CONSIDER ORDERING PER GUIDELINES
Urinalysis	DO NOT ROUTINELY ORDER (unless urologic procedure)		CONSIDER ORDERING PER GUIDELINES

* Examples of Low-Risk Procedures: arthroscopy and orthopedic procedures that only require local anesthesia; cataract, corneal replacement and other ophthalmologic procedures; cystoscopy and other minor urologic procedures; dental restorations and extractions; endoscopy; hernia repair; minor laparoscopic procedures; superficial plastic surgery.

Recommended Actions

Physicians, Hospitals and Other Health Care Organizations

- Educate physicians and team members (e.g. RN, MA) involved in pre-op testing decision-making.
- Delete prompts for pre-op testing in electronic health record (EHR) order sets designed for low-risk patients undergoing low-risk procedures.
- Use evaluation checklists to optimize surgical outcomes (e.g. nutrition, glycemic control, medication management and smoking cessation).
- In hand-off communication to the surgeon or anesthesiologist after your pre-op evaluation, add this or similar language: "This patient has been evaluated and does not require any pre-operative lab studies, chest X-ray, EKG or pulmonary function test prior to the procedure."
- Provide prompt and clear peer-to-peer feedback when unnecessary pre-op testing occurs; make this a topic of departmental and inter-departmental quality improvement discussions, including gathering patient data to inform discussions.
- Measure current rate of pre-op testing on low-risk patients prior to a low-risk procedure and track improvement.

Payers

- Review medical policies and prior-authorization requirements to ensure they clearly do not require routine testing prior to low-risk procedures on low-risk patients.
- Utilize health plan data and analytics to measure and monitor use of pre-op testing on low-risk patients prior to low-risk procedures.
- Provide feedback on pre-op testing on low-risk patients prior to low-risk procedures to physicians and health care organizations.

Choosing Wisely | WASHINGTON STATE TASK FORCE

For more information and resources, visit: wsma.org/Choosing-Wisely

WASHINGTON HEALTH ALLIANCE