# Swimming against the Current — What Might Work to Reduce Low-Value Care?

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Efforts to reduce overuse of health care services run counter to the dominant financial incentives in our fee-for-service system, challenge the cultural assumption that more is better, and raise concerns about stinting on necessary care. Given the evidence that as much as one third of U.S. health care spending is wasteful, however, health care organizations are now embracing explicit consideration of value and turning their attention to overuse. Reducing overuse could theoretically improve quality while slowing spending growth. But we need to determine whether current policy tools — which were designed to address underuse — will work to reduce overuse.

Public acceptance of a role for policy in reducing the use of low-value care in the United States is tenuous but increasing with growing awareness of the burden that health care spending places on federal and state budgets and with patients' increasing exposure to health care costs. Many policy levers might improve the value of care (see table), but all have their limitations. In recent years, the American Board of Internal Medicine Foundation's Choosing Wisely program, the U.S. Preventive Services Task Force, and the National Quality Forum have advanced the dialogue about low-value care by identifying services that deserve that label. Low-value care can be defined in terms of net benefit, a function of the expected (though uncertain) benefit and cost for an individual or group, and is assessed relative to alternatives, including no treatment. This labeling introduces the opportunity to target such care with tools aimed at reducing its use. So how can we effectively use policy to support physicians and patients in making appropriate decisions regarding low-value care?

Demand-side interventions — targeting patients — principally include financial incentives and education. Increasing patient cost sharing is a blunt instrument: research shows that it can reduce use of both low- and high-value care, which suggests that patients do not have the information or skill required to differentiate between the two. Patient cost sharing in commercial insurance has been increasing, but it can diminish use of low-value care in a targeted way only if patients are given enough support to make good decisions. In contrast to cost sharing that is undiscriminating, value-based insurance benefits are designed to communicate to consumers distinctions between high- and low-value services. This benefit structure has been shown to boost use of effective care when out-of-pocket costs are lowered, but its effect on low-value care has been measured only in the domain of prescription-drug tiers.

Most evidence regarding consumer-education campaigns also comes from research on underuse, and findings suggest that such efforts are weak instruments for changing patient behavior. A recent exception was a patient-education intervention — including a self-assessment component and educational material sent to Canadian patients who were long-term benzodiazepine users — that reduced overuse of benzodiazepines.[1] In a similar vein, the Choosing Wisely campaign partnered with *Consumer Reports* to create educational materials for patients on low-value care, presenting accessible information on specific services. Patient-information and decision-aid approaches are promising, but their creation and use need to be supported and studied.

Supply-side interventions — aimed at health care providers — hold promise and may be bolstered by attention to providers' role as stewards of health care resources.[2] Like demand-side interventions, supply-side financial interventions to reduce low-value care can be service-specific (e.g., pay for performance and prior authorization) or population-based (e.g., risk sharing, in which providers accept financial responsibility for total costs of care). There are also information-based supply-side interventions. Evidence-based guidelines, for example, can be promoted through continuing medical education or practice-based quality measurement. Practices are working to embed evidence-based decision support into electronic health records (EHRs), and technology companies are developing handheld-device applications aimed at reducing low-value care at the point of clinical decision making. Unfortunately, little evidence exists on the effec-

**Demand-Side and Supply-Side Interventions to Reduce Low-Value Care.**

| Mechanism and Policy | Description | Pros | Cons |
|---|---|---|---|
| **Demand-side mechanisms** | | | |
| **Incentives** | | | |
| Patient cost sharing | Encourages consumers to internalize service costs | Reduces overall health care use; does not require service-level measurement of overuse | Patients do not discriminate between effective and low-value care; potentially harmful for vulnerable groups |
| Value-based insurance design | Communicates relative value of services to consumers through differential cost sharing, discouraging low-value care while promoting effective care | Successfully used to encourage effective care | No evidence regarding effect on overuse; requires complex benefit design, varying payment rates, and adequate appeal process |
| **Information** | | | |
| Patient education | Supports patients to make informed decisions based on service value, possibly through structured shared decision making, use of decision aids, or public education campaigns | Decision aids have been shown to reduce elective procedures; patient education has been shown to reduce overuse of benzodiazepines; little risk of adverse consequences | Depends on precise population targeting, health literacy, and patient engagement and activation |
| Provider report cards | Gives patients or referring physicians value profiles of hospitals or clinicians; promotes competition through publicly available data on low-value care | Public reporting may draw further attention to and motivate physicians to address overuse | Little evidence that patients use quality data to choose providers; requires precise measurement and effective dissemination |
| **Supply-side mechanisms** | | | |
| **Incentives** | | | |
| Pay for performance | Encourages providers to consider value of health care services with bonuses for reducing low-value care | Effective at priority setting; encourages physicians to focus on most harmful or costly forms of overuse | Requires precise measurement; blunt instruments may reduce use of effective care; narrow focus on a limited set of services |
| Prior authorization | Requires approval from health plan to use service that may be low-value | Systems already in place for most insurers | Requires complex design; potentially reduces physician autonomy |
| Risk sharing | Encourages providers to consider value of services delivered, because of financial exposure for costs incurred (e.g., shared savings, capitation, bundled payments) | Does not require precise measurement; preserves physician autonomy; encourages provider-level use of other mechanisms; physician practices with capitated payment have been shown to be more likely to measure overuse | May reduce use of effective services; may foster patient backlash |
| **Information** | | | |
| Clinical decision support | Supports clinicians with evidence-based care cues and cost information within electronic health record | Shown to improve performance for some targets, including appropriateness of outpatient imaging | Requires complex design and updating; under fee-for-service system, there is little financial incentive to invest in it |
| Clinician education | Supports clinicians with continuing education on evidence-based care and cost-conscious care delivery | Success depends on educational intervention; use of clinical pathways has been shown to reduce costs and improve outcomes; little risk of adverse consequences | Little evidence regarding effect on overuse |
| Clinician feedback | Supports clinicians with feedback on use of low-value care, suggestions for change, achievable benchmarks, and tools for improvement (e.g., Lean, Six Sigma) | Shown to modestly improve use of effective services, especially among poor performers | Little evidence regarding effect on overuse |

tiveness of supply-side interventions in reducing low-value care. An exception is guideline-based cancer care: the U.S. Oncology Network, for example, incorporated its "Pathways" recommendations for lung cancer into an EHR decision-support system to promote adherence to standardized care. In eight practices, patients treated according to the guidelines had lower drug costs than other patients and similar 1-year survival.[3]

Theory suggests that we can have strong, targeted, service-level financial incentives only in cases in which we have precise, up-to-date measurement. Measurement of low-value care is not yet robust enough to inform service-level interventions. In many instances, care is low-value only for patients with specific characteristics and preferences; since services that have low value for one patient may have high value for another, measurement must be nuanced. Although it's feasible to measure some uses of low-value care by means of EHRs for the purposes of case review and peer comparison, this approach has not yet been broadly linked to payment incentives. Claims-based methods may be useful because they are inexpensive, widely available, and population-based, but they're limited by a lack of detailed clinical information.

Moreover, the deliberate process by which quality measures are developed and deployed may slow the adoption of emerging evidence, since technical-panel deliberations, comment periods, and dissemination all take time. This delay can produce a mismatch between evidence and performance measures — which suggests that service-level approaches for reducing low-value care may be too rigid. Highly granular measures may therefore need to give way to broader quality measures that are less subject to the evolution of evidence.

Population-based, supply-side incentives with outcome monitoring may prove to be our best alternative. They reduce reliance on blunt payment instruments or service-level coverage decisions and performance-based payment. Such incentives, like those in accountable care contracts, may reduce use of low-value care through partial capitation or shared savings paired with meaningful outcome monitoring and broad quality measurement. Accountable care contracts encourage physicians to consider value, since incentives are explicitly aligned with quality and cost. In a national survey, 92% of physicians said they felt responsible for ensuring that patients avoid unnecessary tests and procedures, and 58% believed that physicians were best positioned to do so. Thus, physicians may be ready for a stewardship role in an environment where quality and payments are aligned.[4] Although we have little evidence on whether accountable care contracts will affect low-value care, such population-based incentive structures may have the best potential to promote within-clinic experimentation to find approaches that increase effective care and reduce low-value care. Accountable care contracts should encourage investment in practice policy setting and other approaches — patient decision aids, clinical decision support, and clinician education and feedback.

Advances in three areas could boost the potential of population-based incentives to reduce low-value care: strengthening of risk-adjusted outcome measurement; development of new measures that support reduction of low-value care, such as measures of decision quality; and increased financial support for developing and disseminating strategies. Transitioning to a population-health focus will be complex and expensive, and available approaches require substantial refinement of existing systems or development of new ones. Recently, the Centers for Medicare and Medicaid Services has taken the lead in these areas; I believe that other payers also need to support providers through this transition.[5]

Current performance in delivering effective services reflects decades of progress made through quality-improvement efforts aligned with incentives inherent in fee-for-service reimbursement. To address overuse, we now need to work against the current of culture and payment models that still largely reward volume over value. Accountable care contracts encourage providers to tackle overuse, but few providers currently share risk with payers for substantial numbers of patients. Providers participating in accountable care contracts should prioritize internal strategies for reducing use of low-value care.

Much work remains, but the combination of shared risk and efforts such as Choosing Wisely may prove catalytic. The combination of labeling low-value care and beginning to align incentives with value may present the most promising near-term opportunity to accelerate the reduction of use of low-value care.

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