RESEARCH CONSORTIUM
for Health Care Value Assessment

No Value Care Framework

Defining and Identifying No Value Care

@ValueConsortium

https://www.hcvalueassessment.org

Welcome and Housekeeping

- Thank you for joining us!
- Please submit questions through the chatbox via the Virtual Meeting Platform
- Remember, this is a discussion, we want to hear your thoughts on:
  - Defining No-Value Care
  - The scoring elements we have used
  - The list of services that could potentially be No-Value

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Why Do We Need a No Value Care Definition

Difference Between Low Value and No Value

Have been talking about low-value care for a decade

Choosing Wisely

Milliman Waste Calculator

USPSTF

Academics and Other Scholars

Low Value Isn’t Always No Value, or Even Low Value

Exceptions and exclusions can make it difficult for decisionmakers to operationalize a policy regarding Low Value Care

- Very few examples (Insurers not paying for blanket Vitamin D testing)

Go Past Low Value to No Value

- To make progress on reducing what we spend on services that provide no value, we need to create an operational definition that includes:
  - Rigorous scientific evidence that demonstrates no clinical benefit for a service in a specific clinical scenario (e.g., antibacterial agents for viral infection)
  - Services that have no/low patient demand (i.e., patient pressure to overcome clinician reluctance to use a no value service)
  - Services that almost always no value in a specific clinical scenario (i.e., minimal clinical nuance)

Operationalizing No-Value Care

- Demonstration project, funded by PhRMA
- Utilized several sources for potential No-Value Care services
- One important source is the Cost-Effectiveness Analysis Registry

Cost-Effectiveness Evidence on Health Care Services

- Cost-effectiveness analyses can provide strong evidence regarding the value of clinical services
- CEA Registry
  - What it is
  - Why it is useful for No-Value Care identification
  - Four quadrants of cost-effectiveness

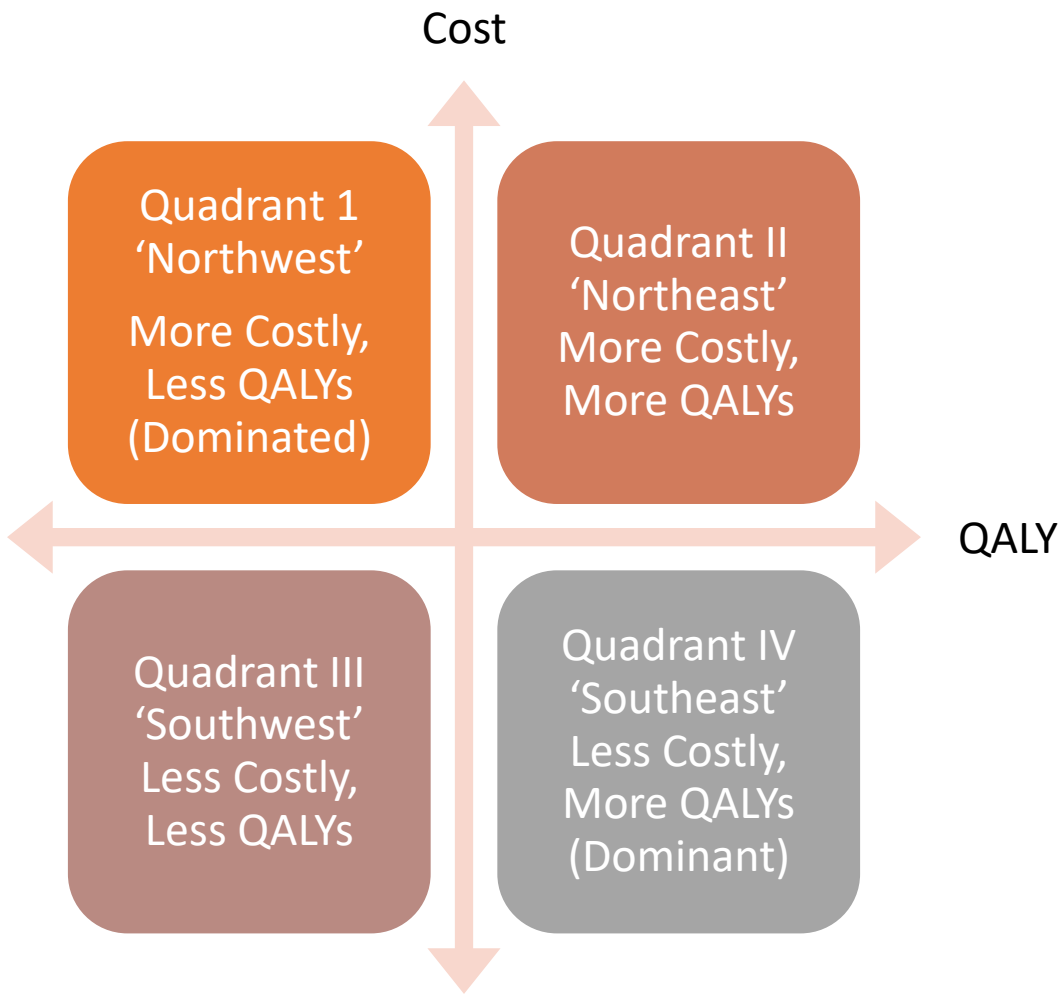
CEA Registry

- The Cost-Effectiveness Analysis (CEA) Registry –
  - Housed at the Center for the Evaluation of Value and Risk in Health (CEVR) at Tufts Medical Center.
- A comprehensive database containing detailed information on over 9,000 cost-utility analyses published from 1976 to 2020.
- Health-related CEAs estimate the resources used (costs) and the health benefits achieved (effects) for an intervention compared to an alternate treatment strategy.

CEA Objectives

- The objectives of the Registry are:
  - to help decision-makers identify society's best opportunities for targeting resources to improve health;
  - to assist policymakers in healthcare resource allocation decisions; and
  - to move the field towards the use of standard methodologies.

Four Quadrants of Cost-Effectiveness Plane



Source: CEA Registry User Guide

Emphasis on Northwest Quadrant

Quadrant 1 ‘Northwest’

More Costly, Less QALYs (Dominated)

Utilization of the CEA for No-Value Services

- Filtered the CEA database by the following criteria:
  - Country of study: United States
  - Publication date: 2011-2021
  - Quality of Analysis: Rating of 4 – 7 (Higher quality studies)
  - Intervention Impact Ratio: Dominant Northwest - Quadrant 1 (Increases Cost/Worsens Health)
  - Services Limited to: Medical Procedures, Screenings, Surgical and Pharmaceuticals
  - Results: 290 potential services for review

No Value Care Definition Demonstration Project

- Identify a list of services already determined to be low-value
- Push the list through the No Value Care Definition filter
- Results in a list of No Value Care services – “The Services We Shouldn’t Buy Even if They Are Free”
- Estimate the potential annual savings if these services did not occur
  - Commercially insured population

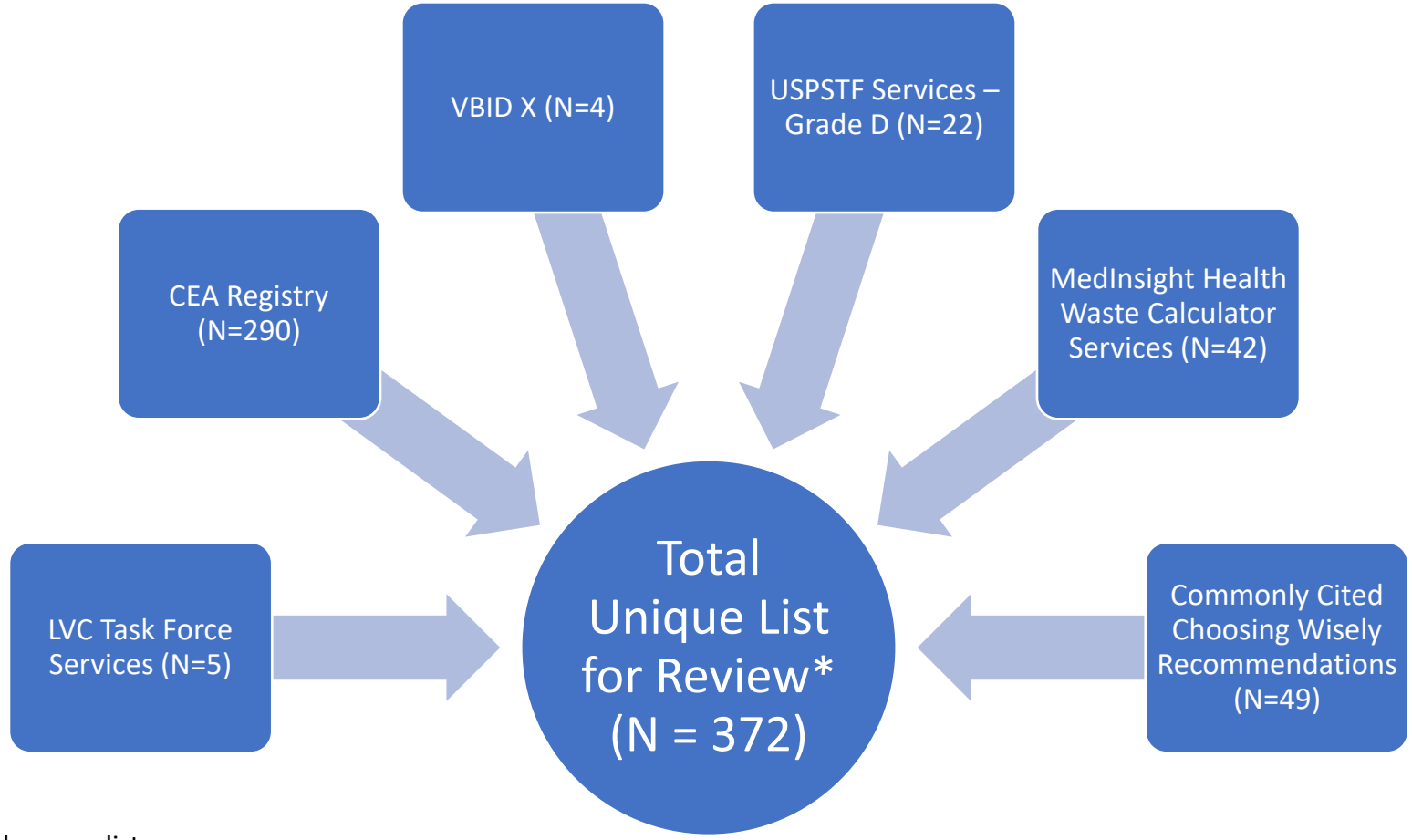
Sources of Initial Services

- Commonly cited Choosing Wisely Services: Over the past decade, many authors have published findings on several Choosing Wisely services.
- U.S. Preventive Services Task Force: The Task Force works to improve the health of people nationwide by making evidence-based recommendations about clinical preventive services.
- Cost-Effectiveness Analysis Registry: Health-related CEAs estimate the resources used (costs) and the health benefits achieved (effects) for an intervention compared to an alternate treatment strategy.

Sources of Initial Services, Continued

- Low-Value Care Task Force from VBID Health: The Task Force aims to accelerate concerted action to reduce low-value medical care and thereby reduce pressure on payers and consumers.
- V-BID X – University of Michigan VBID Center: The aim of the V-BID X project is to design a feasible VBID plan that could be adapted for individual markets and demonstrate the tradeoffs in building a V-BID plan.
- MedInsight Health Waste Calculator: This software helps identify wasteful services as defined by initiatives such as Choosing Wisely and the U.S. Preventive Services Task Force using algorithms to analyze claims, billing, or electronic medical records data.

Initial List of Services



*Some services appear on more than one list

Use of No-Value Care Definition: Filter 1

All Unique Services Identified

- Rigorous scientific evidence that demonstrates no clinical benefit for a service in a specific clinical scenario

Application

- Clinician side of definition – not controversial
- Evidence base shows no clinical benefit

Use of **No**-Value Care Definition: Filter 2

Filter 2

- Services that have no/low patient demand

Application

- Patient side of definition – not controversial
- Demand-side lens of patient preferences, meaning services are not being demanded by patients

Use of **No**-Value Care Definition: Filter 3

Filter 3

- Services that almost always no value in a specific clinical scenario

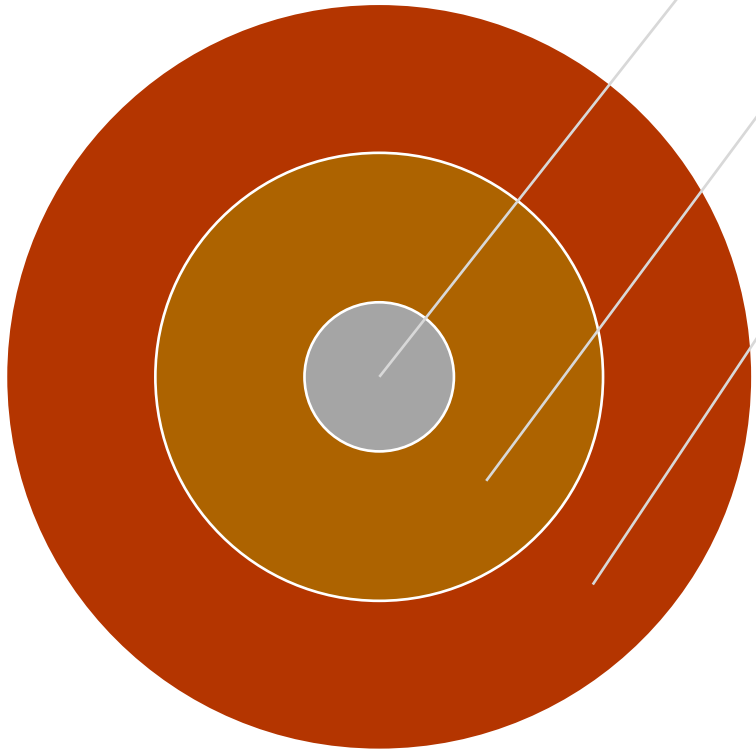
Application

- Clinical nuance – little to none

Scoring Process

- Initial scoring of a subset of the identified services
- Using 1 = Yes and 0 = No – each element of the No-Value Care definition was scored
- For a service to be deemed potentially No-Value it must have a total score of 3 (i.e., meet all 3 criteria)

Scoring Results



Filter 3: Clinical Services that have low variability in net clinical benefits based on patient characteristics (N= 38)

Filter 2: Clinical Services that have low variability in patient demand (N =72)

Filter 1: Clinical Services for which rigorous evidence demonstrates no clinical benefit – N = 78

Example of Potential No-Value Services

- Don’t perform PSA-based screening for prostate cancer in men over 70
- Don’t perform population based screening for 25-OH-Vitamin D deficiency
- 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
- Don’t order unnecessary cervical cancer (Pap Smear and HPV) in women who have had adequate prior screening and are not otherwise at high risk for cervical cancer

Estimated Cost Savings, 2015

Description	Estimated Commercial Cost
Don't perform PSA-based screening for prostate cancer in men over 70	$ 65,896,368.00
Don’t perform population-based screening for 25-OH-Vitamin D deficiency	$ 928,294,066.00
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	$ 25,987,647.00
Don't order unnecessary cervical cancer (Pap Smear and HPV) in women who have had adequate prior screening and are not otherwise at high risk for cervical cancer	$ 782,126,082.00
	$ 1,802,304,163.00

Source: QS2 Project Research Consortium for Health Care Value Consortium

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Thank you!
And
Thoughts?

VBIDHEALTH

ALTARUM