“First, Do No Harm”
Tackling Waste in Health Care
• In health care, we are doing too much unnecessary stuff to patients.

• People are being harmed in multiple ways.

• It doesn’t matter that the harm is not intentional.

• It won’t stop until we address it directly.

• Employers and labor must work together to “demand” change.

• This will take courage, persistence and a new mindset.
A “culture of more” . . . it’s not just one thing

- Physician training and practice culture
- Inadequate information about the patient at the point of care
- Fee-for-service payment, pressure to “produce” widgets
- Aggressive marketing by developers of tests, drugs, procedures
- Defensive medicine (more a persuasive myth than reality)
- Culture preference for technological solutions
- Lack of health literacy and patients’ minimal understanding of health care, benefits and risks
- Very little transparency on the price of health care, and almost none upfront
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

Financial Harm is harm!
Urban Institute: Percentage of people with medical debt in collections (2016)

Nationally:
18% overall, 16% white, 21% nonwhite
Some counties over 50%

Washington:
9% overall, 8% white, 10% nonwhite
Some counties as high as 22%
Financial harm is harm.
In the U.S., we spend more on a per capita basis than everyone else.
Health care spending is outpacing other spending at the federal and state levels.
And for all this spending, quality is lagging.

Compared to many other industrialized nations, in the U.S.:

- Mortality amenable to health care is worse
- Infant mortality is higher
- Life expectancy is lower
- Access is worse
What drives up health care costs?

- Price +
- Utilization
  - Necessary
  - Unnecessary (e.g., tests, procedures when not needed)
  - Potentially Avoidable (e.g., readmissions, inappropriate use of ER, medical errors)
Medical tests, treatments and procedures that *have been shown to provide little or no benefit to patients* in particular clinical scenarios and, in many cases, have the potential to cause harm.
What is the Health Waste Calculator?

• Milliman MedInsight tool
• 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
• Version of the HWC tool used for this report included 47 measures (there are plans to expand the number of measures in the tool over time).
• Analysis done at claim line level; includes professional and facility
• Situational intelligence creates “degree of waste” (necessary, likely wasteful, wasteful)
Our results from the Health Waste Calculator

• Results based on ~2.4 M commercially insured lives in our data base

• Measurement year: July 2015 – June 2016

• Utilization reflects actual

• Costs estimated based on Milliman’s Consolidated Health Cost Source Database for Washington
  
  – Unit prices represent the average cost of each service (commercial sector, Washington state)
• **1.52 million services were examined (47 measures)**

• **45.7% of examined services were determined to be low value (likely wasteful and wasteful)**
High level summary – IMPACTED INDIVIDUALS

- **1,298,862** individuals received services (47 measures)
- **622,341** (47.9%) individuals received low value services (likely wasteful and wasteful)

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High Level Summary – SPEND ON LOW VALUE

- An estimated $785 million was spent on services (47 measures)
- $282 million (36%) was spent on low value services (likely wasteful and wasteful)
Targeting key drivers of overuse

- 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.
11 things to focus on:

- Too frequent cervical cancer screening
- Preoperative baseline laboratory studies prior to low-risk surgery
- Unnecessary imaging for eye disease
- Annual EKGs, cardiac screening in low risk, asymptomatic people
- Prescribing antibiotics for acute upper respiratory, ear infections
- PSA screening
- Population-based screening for OH-Vitamin D deficiency
- Imaging for uncomplicated low back pain in the first six weeks
- Preoperative EKG, chest x-ray and pulmonary function testing prior to low risk surgery
- Cardiac stress testing
- Imaging for uncomplicated headache
In this analysis, a total of 166,860* women received annual cervical cancer screening for an estimated cost of $25.8 million.

73% of these women received wasteful (too frequent) cervical cancer screening for an estimated cost of $19 million.
In this analysis, a total of 108,037* individuals received preoperative lab studies prior to low-risk surgery for an estimated cost of $105 million.

85% of these individuals received wasteful preoperative lab studies for a total estimated cost of $86 million.
In this analysis, a total of 41,747 individuals received preoperative EKGs, chest X-rays or pulmonary function tests for an estimated cost of $41.4 million.

20% of these individuals received wasteful preoperative testing for an estimated cost of $6 million.
In this analysis, a total of 416,225* individuals received annual EKGs or cardiac screening for an estimated cost of $199 million.

23% of these individuals received wasteful annual EKGs or cardiac screening for an estimated cost of $40 million.
In this analysis, a total of 40,546 individuals received cardiac stress testing for an estimated cost of $197 million.

18% of these individuals received wasteful and likely wasteful cardiac stress testing for an estimated cost of $33 million.
In this analysis, a total of 104,744 individuals received imaging for eye disease for an estimated cost of $46.4 million.

74% of these individuals received wasteful eye imaging for an estimated cost of $34 million.
<table>
<thead>
<tr>
<th>Measure</th>
<th>Waste Index</th>
<th>Impacted People*</th>
<th>Est. Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imaging for low back pain during first six weeks</td>
<td>83%</td>
<td>14,000</td>
<td>$4 M</td>
</tr>
<tr>
<td>Imaging for uncomplicated headache</td>
<td>53%</td>
<td>4,900</td>
<td>$7 M</td>
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<tr>
<td>Antibiotics for URI and earache w/in 7 days of diagnosis</td>
<td>98%</td>
<td>75,000</td>
<td>$2 M</td>
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<tr>
<td>PSA Screening - asymptomatic men</td>
<td>62%</td>
<td>48,000</td>
<td>$10 M</td>
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<tr>
<td>Population screening for Vit D deficiency in absence of risk factors</td>
<td>35%</td>
<td>36,000</td>
<td>$12 M</td>
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<tr>
<td>Total</td>
<td></td>
<td>177,900</td>
<td>$35 M</td>
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</tbody>
</table>

*Numbers rounded
1.52 million services examined, 45.7% determined to be low value

622,341 (47.9%) individuals impacted

Estimated $282 million spent on low value

47 measures, 1 year, 2.4 commercially insured people
Call to action in WA

1. Overuse must become central to honest discussions of health care value.

2. Clinical leaders must lead provider efforts to incorporate reduction of overuse into local practice culture.

3. The concepts of choosing wisely and shared decision-making must become the bedrock of provider-patient communication.

4. We need purchasers and payers to keep their collective “foot on the gas” to transition fee-for-service to paying for value.

5. Value-based provider contracting must include measures of overuse as well as measures of access, underuse, experience and total cost of care.
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• This will take courage, persistence and a new mindset.
The Community Checkup is a resource for unbiased, trustworthy data and analysis of the quality of health care in Washington state.

View the results