Aligning to Drive Value

- Using Data
- Relying on Evidence
- Building on Trust

WASHINGTON HEALTH ALLIANCE

Leading health system improvement

Contents

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This project would not have happened without the support of the purchaser organizations whose combined experience, knowledge, and leadership are essential to driving change in the complex health care ecosystem. The willingness to use their data to identify common problems, engage with one another to agree on a shared priority, and eagerness to collaborate with provider and health plan organizations on a plan for action are the reasons the Washington Health Alliance (Alliance) is able to do the work described here.

The Alliance wishes to thank all of the purchasers that participated in the Driving Value Project, including those listed below.

SOUND HEALTH & WELLNESS TRUST

City of Seattle

AWC ASSOCIATION OF WASHINGTON CITIES

WASHINGTON TEAMSTERS WELFARE TRUST

CARPENTERS TRUSTS of Western Washington

King County

SEIU HEALTHCARE NW HEALTH BENEFITS TRUST

These Alliance Board members participated with the purchasers in the multi-stakeholder convening as representatives of the provider and health plan perspectives:

Lloyd David, Western Washington Group President, Optum Pacific Northwest
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The Driving Value Project described in this white paper was supported by a grant from Arnold Ventures, a philanthropy established in 2010 with a straightforward mission: to improve lives through evidence-based solutions. This work is done as part of **Arnold Venture's low-value care portfolio** that seeks to eliminate the delivery of low-value care—heath care services in which the potential for harm to patients outweighs the possible benefits when delivered inappropriately.

[1] The **Washington Health Alliance (Alliance)** is a place where stakeholders work collaboratively to transform Washington state's health care system for the better. The Alliance brings together organizations that share a commitment to drive change in our health care system by offering a forum for critical conversation and aligned efforts by purchasers, providers, health plans, consumers, and other health care partners. The Alliance believes strongly in transparency and offers trusted and credible reporting of progress on measures of health care quality, value, and price. The Alliance is a nonpartisan 501(c)(3) nonprofit organization with more than 185 member organizations. Learn more about the Alliance at **www.wahealthalliance.org**. For the *Community Checkup* reports visit: **www.wacommunitycheckup.org**.

[2] **The University of Michigan Center for Value-Based Insurance Design (V-BID Center)** led by A. Mark Fendrick, MD is the leading advocate for development, implementation, and evaluation of clinically nuanced health benefit plans and payment models. Since 2005, the V-BID Center has been actively engaged in understanding the impact of innovative provider facing and consumer engagement initiatives, and collaborating with employers, consumer advocates, health plans, policy leaders, and academics to improve clinical outcomes and enhance economic efficiency of the U.S. health care system. You can find more information and follow their work at **www.vbidcenter.org** and **@UM_VBID**.

Introduction

The Washington Health Alliance (Alliance) is a purchaser-led multi-stakeholder organization that uses its position as trusted convener to bring together those who get, give, and pay for health care to create a high quality, affordable system of care for the people of Washington state. Alliance members have been working to improve the quality of care in Washington state through their support of public reporting on a variety of health care cost and quality measures for many years. The Alliance recently published its 15th ***Community Checkup*** using its voluntary All Payer Claims Database (APCD). The Alliance's APCD includes extensive de-identified claims information related to enrollment, utilization, and cost for over four million Washingtonians with Medicaid and commercial insurance coverage dating back to 2008, when the first *Community Checkup* was published. Data contributors include commercial and Medicaid health plans in Washington state, as well as self-funded employers and labor union trusts, including those participating in this initiative.

The specific aims of this project were to use data to inform and motivate purchaser action, both individually and collectively, to improve the value of care for their plan participants. We undertook this initiative with the voluntary participation of eight Alliance purchaser members, which included large public and private employers, union trusts, and a multi-employer plan who collectively purchase health benefits on behalf of approximately 550,000 individuals in Washington state. We also invited senior leaders from Alliance member health plans and provider organizations, representing approximately two million additional lives across the state, to strategize with the purchasers on ways to improve the value of care. Data analysis provided by the Alliance that identified low- and high-value improvement opportunities for the purchasers was the foundation for many rich conversations between the purchasers and in a multi-stakeholder convening facilitated by the Alliance.

This paper describes the work completed in the collective phase of the project. As this paper is published, the work continues to bring the plan for action described here into reality through the technical assistance work with each organization. The Alliance shares this work with the belief that in the absence of strong policy levers to drive change in specific clinical areas, such as improving care for low back pain, the market will need help to coordinate efforts focused on improving value in health care. It takes organizations like the Alliance AND its members' active participation to bring about meaningful change. We hope that others will learn and find motivation to take similar actions.

The challenge of using claims data

It is important to acknowledge that defining low- and high-value services is challenging and the tools readily available for measuring "value" are based on a complex set of algorithms that rely on claims data, the most comprehensive data resource available that documents how individuals access health care services. Claims data are fundamentally an artifact of the fee-for-service payment system that was not designed with analytic use cases in mind. It is an imperfect source of truth, but the best that we have and has proven to be reliable for the purpose of understanding trends or making comparisons across populations. There are many shortcomings associated with using claims data, one of which is the absence of data elements that identify important equity issues related to race and ethnicity or social determinants of health. The Alliance shares with our members a strong commitment to address health equity and social determinants of health in all that we do and are striving to incorporate these dimensions into future analyses in ways that provide actionable insights for all.

Driving to Action One Step at a Time

1. RECRUITING PURCHASER PARTICIPANTS

Approximately half of all Americans get their health insurance coverage as an employee or union member.[1] Spending on employer-sponsored health insurance (whether provided directly to employees or through a union agreement), along with the out-of-pocket and premium expenses borne by individuals receiving services through employer-sponsored plans, represent almost half of the national health expenditures in the United States.[2] Despite this apparent market power, employers have yet to realize their collective impact as health care purchasers to improve health care cost, quality, and experience. While some have tried, far too many sit on the sidelines for reasons outlined in a 2018 Harvard Business Review article from the Commonwealth Fund calling on employers to work together. The challenges noted by the authors include the following:

- Employers view the health benefit offering as an important feature that supports attraction and retention of their workforce and are reluctant to make changes that may produce employee dissatisfaction.
- The sophistication and the resources required to do the work of acting as a change agent in the health care system are well beyond the scope and interest of the typical employer or union trust leader.
- Employers generally have little in common other than an interest in improving health care on behalf of their covered population. They often prioritize different areas of care or prefer different strategies.
- The growing consolidation of the insurance and provider markets places employers at a growing disadvantage even when working in collaboratives because they are limited in their scope due to antitrust laws.[3]

As a purchaser-led organization, the Alliance benefits from the leadership and vision of many innovative organizations that procure health care on behalf of their workforce or union members. We do not act as a purchasing collaborative and strictly adhere to all applicable antitrust requirements and guidance when working with our purchaser members in groups.

The vast majority of the Alliance's services are paid for by the generous annual support of its members. Custom reporting using the Alliance's voluntary APCD is offered at an additional cost commensurate with the level of effort involved. For the purpose of this initiative, support from Arnold Ventures allowed the Alliance to leverage its convening strength to activate collective purchaser action, facilitate multi-stakeholder collaboration, and offer a comprehensive suite of value-added services to participating purchasers. These enhancements include customized reports describing the value of care received by plan participants, as well as individual technical support to interpret these reports and design interventions/strategies to improve the value of care in the areas of their highest priority. The group convenings and technical assistance included support from external advisor A. Mark Fendrick, MD, Director of the **Center for Value-Based Insurance Design** at the University of Michigan (V-BID Center).

In exchange for participation, purchasers were asked to a) share the de-identified organizational results on a detailed basis with other participating purchasers, b) participate in meetings with other purchasers during which they would agree to work together on a common area of opportunity, and c) collaborate with provider and health plan leaders to identify ways that each can act differently to make improvements.

Finalizing purchaser participation in this initiative occurred in the summer of 2020 in the midst of the COVID-19 pandemic. This effort relied on clear and concise written communication, as well as many individual phone calls and meetings—all held virtually due to COVID-19. Despite the additional burden the pandemic represented for human resources and benefits leaders, most of the eight purchasers agreed quickly and enthusiastically to engage. A few that joined were a bit unsure of what they were signing on to, but acted, in part, based on their confidence and trust in the Alliance.

The eight self-insured purchasers that voluntarily chose to participate in this initiative with the Alliance represented a cross-section of public, private, and union trust perspectives. Together, they purchase health care on behalf of more than 550,000 covered lives across Washington state. While their perspectives, geographies, and populations may be quite distinct, their desire to provide access to high-value, evidence-based care to their plan participants served as an important and unifying motivator.

2. USING DATA TO INFORM ACTION

Developing a clear consensus on what constitutes "value" in health care can be challenging given the many contexts in which health care is delivered and the differing perspectives of patients, clinicians, and those who pay for health care, including health plans, private and public employers, and federal and state governments.[4] For the purpose of this initiative, the aim of improving value is synonymous with eliminating wasteful or unnecessary care defined as low-value while also encouraging high-value, evidenced-based care. The degree to which health care spending in the United States is unnecessary or wasteful has been well-documented using the six domains of waste established by the Institute of Medicine (now the National Academy of Medicine): failure of care delivery, failure of care coordination, pricing failure, fraud and abuse, administrative complexity, and overtreatment or low-value care.[5] In this context, low-value care is defined as "waste that comes from subjecting patients to care that, according to sound science and the patients' own preferences, cannot possibly help them—care rooted in outmoded habits, supply-driven behaviors, and ignoring science." Quite simply, it is the delivery of health care services from which the potential for harm is greater than the potential benefit.[6]

Despite many years of recognition, research, and discussion about the importance of delivering care that is consistent with evidence, overtreatment and low-value care persist with direct annual spending for these services estimated to be between $75 to $100 billion annually.[7] The **U.S. Preventive Services Task Force** (USPSTF) created in 1984 and **Choosing Wisely®** created in 2012 represent two initiatives that rely on provider recommendations to make high-value evidence-based care delivery a reality in the U.S.

The Alliance has been working closely with its members to shine a bright light on low-value care improvement opportunities for several years. In the ***First, Do No Harm*** reporting series using Milliman's MedInsight Health Waste Calculator™ (Health Waste Calculator), the Alliance highlighted the nature of low-value treatments, tests, and procedures that do not help, and may harm, patients in significant ways—physically, emotionally, and financially. The Health Waste Calculator uses claims data to identify potentially wasteful services and

considers specific clinical circumstances when services may not be appropriate, using evidence-based guidelines that rely heavily upon USPSTF and Choosing Wisely® recommendations.

The most recent ***First, Do No Harm***, released in October 2019, reported on important dimensions of low-value care at the medical group level. This level of transparency is supported by the clinical leaders of Alliance member organizations included in these reports. This degree of trust, commitment to quality improvement, and shared learning are foundational elements that must be in place for the kind of multi-stakeholder health care improvement work we have been tackling in Washington state since the Alliance's founding in 2004.

KEY LEARNING

Trust-building is a foundational and essential element of collective action. It takes time.

Each of the purchasers participating in this initiative received a customized report with results specific to their population using 48 measures of low-value care included in the Health Waste Calculator (Appendix B) as well as a subset of ***Community Checkup*** measures representative of high-value services (Appendix C). These reports compared each purchaser's individual results to the Washington state commercial average, as well as to the other purchasers on a blinded basis.

The Health Waste Calculator measures low-value services in terms that describe how many individuals are exposed to low-value care and the spending directly associated with delivery of those services. Also reported is the "waste index" which represents the degree to which potentially wasteful services occur based on a nuanced analysis of each potentially wasteful service and the specific individuals receiving them. Appendix A includes a more detailed description of the Health Waste Calculator.

When considering the prevalence of low-value services, such as how many individuals are impacted and how frequently each wasteful service occurs, the top ten services (based on the rate/1000 members for the commercial population included in this analysis) account for:

- 92% of all low-value services measured,
- 56% of the spending on low-value services, and
- 1,575,061 individuals impacted by receiving at least one low-value service.*

The disproportionately high rate of services delivered relative to overall spending is consistent with other findings that low-cost, high-volume services are significant drivers of low-value care.[8] The analysis also revealed that the rate of low-value services was notably higher for the participating purchasers compared to the commercial state average across all of the dimensions of low-value care shown in Table 1. The rich benefit designs common among the participating purchasers were discussed as a potential factor in the higher rate of low-value services delivered to their plan participants.

*Individuals are counted once for each low-value measure in which they received at least one service and may be represented in more than one measure. For example, an individual receiving both an opiate for acute low back pain and an unnecessary antibiotic for an upper respiratory or ear infection would be counted twice.

Table 1: Key Indicators of Low-Value Care

	Commercial State Average	Participating Purchasers
Percent of individuals receiving one or more low-value service	38%	43%
Rate of low-value services per 1,000 enrolled individuals	337.9	374.9
Percent of services measured found to be wasteful or likely wasteful	44%	47%

More insight into the downstream implications of low-value care is an important aspect of understanding and measuring its overall impact.[9, 10] Physical harm is not the only consideration. There are financial and emotional implications of low-value care as well.[11] With ever-increasing co-pays, co-insurance and deductibles, individuals are frequently faced with mounting health care expenses.

The potential for high-value improvement was identified using a subset of 24 widely accepted primary and preventive care measures from the Alliance's *Community Checkup*. This report includes established measures that examine the degree to which individuals are receiving high-value services. All measures included in this analysis are part of the **Washington State Common Measure Set**. A comparison of the eight purchasers to the Washington state average and the national 90th percentile for the commercial market is included as Appendix C. The 90th percentile is included as it is the long-standing goal of Alliance members for Washington state to reach that level of performance on standardized measures of care quality.

The financial toll of low-value care on individuals

Patient out-of-pocket spending on low-value care ranges from 15% to 19% based on estimates from three state APCDs.[12] This is especially concerning in light of the difficulty many Americans face paying for unexpected expenses as noted in a recent report on economic well-being from the Federal Reserve.[13]

- Three out of ten adults report that they were either unable to pay their monthly bills or were one modest financial setback away from failing to pay monthly bills in full.
- Forty percent cannot pay for an unexpected expense of $400 with savings or a credit card.
- Twelve percent of U.S. adults report being unable to cover their regular monthly expenses if faced with an unexpected $400 expense.

This is an undesirable outcome in any situation, but particularly so when the health care service that inflicts financial harm delivers little or no value in terms of health improvement.

The purchasers' customized reports provided the foundation upon which to build common understanding and served as an important precursor to collectively identifying and agreeing on a plan of action around one of many potential improvement opportunities.

3. CHOOSING A PRIORITY FOR ALIGNED ACTION

Shortly after the purchasers received their customized reports, the Alliance convened the first joint meeting with the primary aim of selecting a common area of opportunity to work on together. This initial meeting was organized to help the purchasers get to know one another better, to review the common low- and high-value improvement opportunities identified in the data, and to agree on principles to guide the selection of a collaborative value-improvement opportunity. While the purchasers readily came to agreement around the shared principles that would guide their group decision-making (Figure 1), it was apparent that selecting a specific opportunity to address together would require more than just one meeting.

KEY LEARNING

Agreeing on a set of principles is easy. Deciding what to work on together is challenging.

Figure 1: Principles for Identifying Collective Improvement Opportunities

Actionable

- Levers for change are clear and there is a role for all.

Doable

- There is broad agreement on the need for change and willingness to act.

Meaningful Impact

- Eliminating low-value care reduces risk of harm—physically, financially, emotionally.
- High-value care improvements enhance quality of life and/or avoid unnecessary downstream costs.

Maximizing engagement in this kind of collaborative, multi-organizational work requires a high degree of mutual trust. While the purchasers and the Alliance team were well known to each other, some of the purchasers were less familiar with each other and more time was required to forge the degree of trust required for collective decision-making. The original plan to hold three meetings with just one as purchaser-only was changed to four meetings, with three designated as purchaser-only.

KEY LEARNING

Be willing to adjust the plan as you go. Sometimes you have to go slow to go fast.

There were many low- and high-value improvement opportunities common across most purchasers. It was challenging for them to coalesce quickly on only one area to pursue together, perhaps because there were so many aligned opportunities from which to choose or because of underlying differences in the purchasers' priorities and purchasing strategies. The participants were also reluctant to select just one opportunity for collective action and wished this to be the start of many such initiatives facilitated by the Alliance. It was agreed that the purchasers would select the first opportunity to prioritize at this time.

The Health Waste Calculator does not directly measure the provision of subsequent tests or treatments resulting from an initial low-value service, often referred to as care cascades. However, an indicator of potential harm (low, medium, or high) is assigned to each low-value service measured. When considering many possible opportunities, the degree of potential harm associated with low-value services received a great deal of attention and engendered important discussions among the purchasers. For example, the high degree of potential harm associated with inappropriately prescribed opiates for acute low back pain drew their attention as an opportunity for improvement more so than the potential savings associated with eliminating this relatively low-cost service.

Selecting the specific opportunity for this initiative required substantial time working with the purchasers both collectively and individually. Outside of group meetings, individual communications between Alliance staff and the individual purchasers, as well as input obtained via a short survey (Figure 2), served as important inputs to gaining agreement. The survey also provided an important mechanism that allowed the purchasers to express their priorities for action in a way that the Alliance could document and apply to future collective improvement efforts.

Figure 2: Purchaser Survey Results

Low-Value Reduction Opportunities (in order of priority)
1. Opioid prescribing for acute low back pain
2. EKG screenings for asymptomatic individuals
3. Imaging tests for eye disease
4. Antibiotics for URI and ear infections
5. Screening for vitamin D deficiency
6. PSA screening for prostate cancer in men

High-Value Improvement Opportunities (in order of priority)
1. Non-opioid pain management alternatives
2. Cancer screening per guidelines
3. Vaccines–flu, pneumonia
4. Eye exam for diabetes
5. Remote blood pressure monitoring
6. Immunizations–child and adolescent
7. Asthma management
8. Hyperlipidemia and hypertension medication management

With the benefit of many inputs, including shared principles for decision-making, analytic insights, meeting discussions (both collectively and individually), and survey results, the purchasers selected low back pain as the improvement opportunity to work on together, in collaboration with providers and health plan partners.

Low back pain is one of the most common conditions in the U.S. affecting nearly every individual, directly or indirectly, at some stage in their life.

- Low back pain is a pervasive health issue in the U.S. with most care occurring in ambulatory settings.[14]
- Low back pain sufferers often seek relief in primary care settings where it is second only to upper respiratory conditions in frequency.[15]
- When looking at health expenditures by health condition, low back pain combined with neck pain is the most expensive at $134.5 billion with private payers footing the majority of the bill (57%), followed by public insurance (34%), and individuals (9%).[16]
- Low-value services, such as opiates and unnecessary imaging, are frequently delivered to address low back pain, despite broad agreement for evidence-based care that includes a host of non-invasive, non-opioid alternatives, including cognitive behavioral therapy.[12, 17, 18, 19]

The proposed aims of the collective efforts to improve the value of care associated with low back pain include the following:

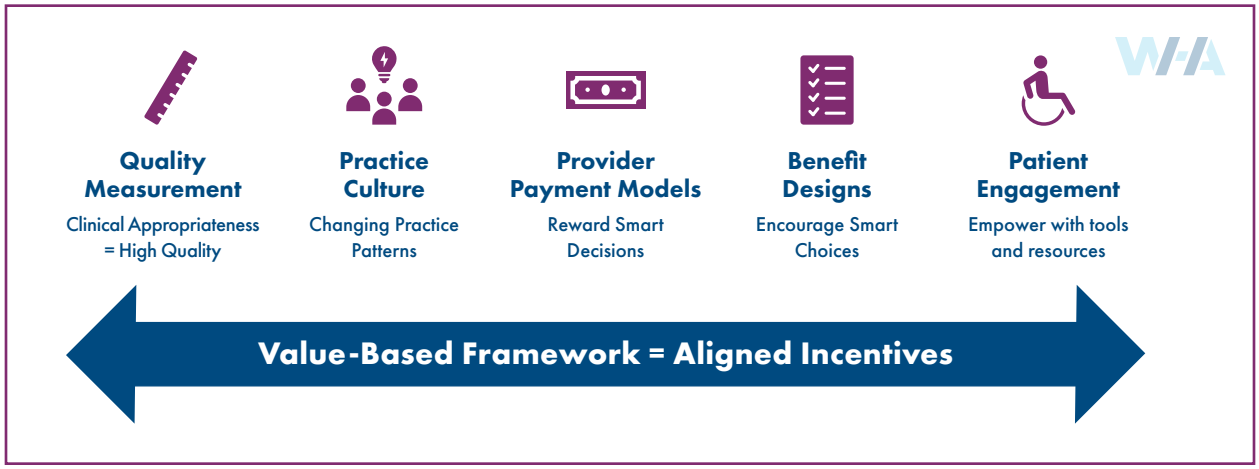
- improve the accessibility and use of evidence-based non-opioid, non-invasive care options;
- reduce inappropriate opioid prescribing; and
- avoid unnecessary invasive services, such as surgeries, imaging, and injections.

Central to the purchasers' desire to prioritize acute low back pain was the degree of potential harm associated with inappropriate opioid prescribing and unnecessary imaging. These factors, in combination with the high prevalence of low back pain across their populations, served as important motivators. Understanding that the management of patients with chronic versus acute low back pain may differ, it is understood that acute low back pain is the primary, but not exclusive, focus of the collective efforts of purchasers, providers, and health plans described in this paper.

4. TRANSLATING EVIDENCE INTO ACTION

Early in the project, the purchasers were introduced to the "Tools in the Toolbox" that represent levers for change that would be a central focus of determining how to make desired improvements together (Figure 3). While policy (notably absent from this list) acts as an important and necessary change agent for many of health care's toughest problems, for the purpose of this initiative, the focus is on the levers within the direct control of purchasers, health plans, and provider organizations. Orienting the purchasers to how each of these tools is used in a value-based framework designed to align incentives for patients and providers was foundational to helping them also see how they can act as change agents beyond their own organizations—as the isolated actions of any single actor in the complex health care ecosystem are insufficient to drive meaningful change on their own.[20, 21, 22, 23] The importance of "mutually reinforcing activities" to achieving success draws on the learnings around the collective impact model as a mechanism for achieving large-scale change.[24]

Figure 3: Tools in the Toolbox for Change



With the decision to focus on low back pain and the aims for improvement determined, the next step was to strategize together with senior leaders representing health plans and provider organizations on a plan for action. Unfortunately, wide gaps between evidence and implementation exist, especially as it relates to linking evidence to benefit coverage and design. Incorporating clinical evidence in practice settings is a well-known and documented challenge in health care. A key role that the Alliance staff played in this initiative was to translate the evidence for the care of low back pain into specific steps for each stakeholder that maximized the use of each of the "Tools in the Toolbox" for change.

KEY LEARNING

Data are useful for identifying problems. The evidence is essential for knowing what to do.

The **Dr. Robert Bree Collaborative** (Bree) served as an important starting point for this work. In 2013, a Bree expert workgroup issued a recommendation document on low back pain that underscores the strong agreement in Washington state around the prevailing evidence related to its treatment.[25] The degree of implementation of many recommendations remains limited. The Alliance team reviewed the recommendations with the physician chair of this workgroup to better understand the important role of each stakeholder and the obstacles to implementation. A broader literature search confirmed that the evidence is well-established, enjoys broad support, but still lacks widespread adoption.[17, 18, 19, 26] The strong evidence and lack of adoption were reinforced by a Bree workgroup that addressed Collaborative Care for Chronic Pain in 2018.[27] There are many challenges noted in the literature that were important to recognize as we worked with the purchasers to build a framework for action in collaboration with providers and health plans that will be useful to future implementation efforts.[6, 18]

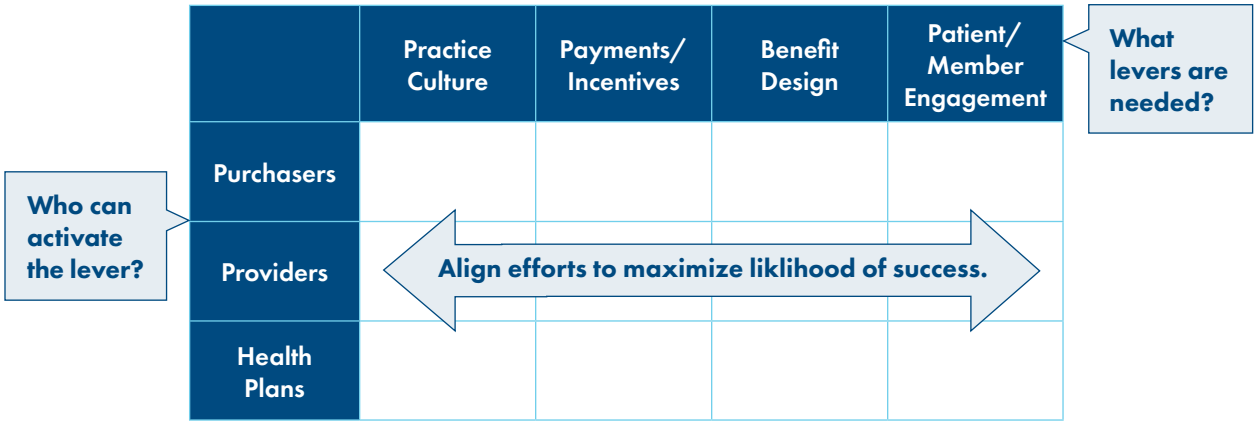
The Bree was established by the Washington State Legislature in 2011 to engage public and private stakeholders to improve health and health care with a focus on health care services that have high variation in the way that care is delivered. Expert workgroups representing a broad range of public and private perspectives review the literature to develop evidence-based recommendations to improve health care quality, outcomes, and affordability. The recommendations are tailored specifically to each of the key stakeholders in health care—public and private health care purchasers (governments, employers, and union trusts), health plans, physicians and other health care providers, hospitals, quality improvement organizations, and patients.

KEY LEARNING

Do not recreate the wheel. Rely on existing work and connect the dots.

Armed with the literature, including the stakeholder-specific recommendations contained in the Bree reports, the Alliance mapped the evidence to action in a framework that identifies how each stakeholder can apply the tools in their toolbox as levers for change as illustrated in Figure 4. The alignment between patient and provider incentives can be clearly delineated using this table. This framework also highlights for each organization how their actions are reinforced by, or reinforcing to, others. This is especially important in the context of a multi-stakeholder initiative, as we know that the likelihood of success is heightened when key stakeholders act in ways that mutually reinforce one another.[23, 28]

Figure 4: Mapping the Evidence to Levers for Change in a Framework for Action



KEY LEARNING

Focusing on what your organization can do is not enough. Stakeholder alignment is essential.

We applied this framework for action to two complementary strategies—one focused on the provider and the other on the patient. The following includes a brief description of each strategy.

1. Patient Activation Empowerment

Inform and empower individuals to successfully manage low back pain with resources and benefits that are consistent with evidence-based recommendations.

- Educate individuals to help them understand the experience of low back pain and how it is best overcome.
- Design benefits and identify or develop resources that increase the likelihood individuals will receive appropriate care that is consistent with the evidence.

2. Provider Incentives and Empowerment

Support provider change efforts with tools and incentives to provide care for low back pain consistent with evidence-based recommendations.

- Implement payment models that reward doing the right thing for patients with low back pain, including referrals to other providers.
- Educate and coach providers and care teams as necessary to implement evidence-based care pathways while also de-implementing outdated or inappropriate care processes.

5. MOVING FORWARD WITH A PLAN FOR ACTION

The purchasers agreed to use these two aligned strategies when extending the invitation to providers and health plan partners to join them in building a plan for action. Improving the value of care for low back pain is clearly a shared aim held by purchasers, providers, and health plans based on the multi-stakeholder conversations convened by the Alliance. It is also clear that each stakeholder faces different obstacles and enablers to achieve that shared vision. Some of the levers for change sit directly within the control of the purchasers, such as benefit design, while others are more elusive to them, such as financial incentives created by different payment models which must be agreed to by providers and health plans. What all share is a desire to help individuals get good care for low back pain that is consistent with the evidence that prioritizes the accessibility and use of non-opioid, non-invasive interventions for most instances of low back pain.

What we are learning from the continued study of low-value care is that it is deeply entrenched and seemingly impervious to singular levers for change. As an example, addressing the perverse incentives of fee-for-service payment has long been held out as "the" change that will bring about the desired reductions in low-value care. However, recent insights into the degree of low-value care that persists in situations that are not driven exclusively by fee-for-service incentives signal that modifying payment incentives alone is not sufficient to drive change.[29] We also know that measurement alone is an important, but insufficient, driver of change.[30]

These findings and perspectives reinforce a growing recognition that there are strong cultural forces that influence both clinicians and patients involved in low-value care. Changing deeply embedded beliefs that underlie much of low-value service use, such as "more is better" and "it is better to do something than nothing" must be addressed as part of any effort to reduce low-value care.[29] This is not a quick fix that policy or payment alone can achieve. Addressing cultural factors that influence both provider and patient behaviors that reinforce low-value care is likely to be most successful when done locally. Doing so in very targeted ways using a "bottom up" approach is an important complement to pursuing payment transformation or policy as levers for change.

Building on the foundation of trust gained over many years, the Alliance and its members are moving forward to improve the adoption of evidence-based care for low back pain by working collaboratively and relying on the evidence to inform collective action. We are eager to improve the care of low back pain for all in Washington state, as well as to serve as a model for others who choose to work collaboratively to improve the value of care.

Key Learnings

1 Trust-building is a foundational and essential element of collective action. It takes time.

Trust-building is an essential step in the process that cannot be rushed. The Alliance and the purchasers were well known to each other and there was a high-degree of trust established between the purchasers and the Alliance team prior to the start of this project. What we learned fairly quickly is that the purchasers needed time to build trust with each other to realize the benefits of working together.

2 Agreeing on a set of principles is easy. Deciding what to work on together is challenging.

While agreeing on the principles of being actionable, doable, and meaningful was quite easy, selecting a specific value improvement opportunity to work on together was surprisingly challenging. The challenge is two-fold; first, there are many opportunities that meet these criteria, secondly, each purchaser has different priorities. The establishment of shared principles provides an important framework for collective decision-making when buy-in from all involved is desired.

3 Be willing to adjust the plan as you go. Sometimes you have to go slow to go fast.

The original plan made many assumptions about how the work would progress when we started bringing the participants together. It was important to "read the room" (yes, you can even do this virtually) and assess readiness for the next steps in the process. In our case, we quickly realized that we needed more time with the purchasers (collectively and individually) at the front end of the project than anticipated. Adjusting for this was an important contributor to gaining the ultimate agreement to work on low back pain together.

4 Data are useful for identifying problems. The evidence is essential for knowing what to do.

The information derived from reports that benchmark and compare elements of both high- and low-value care were used to identify common improvement opportunities. Reports such as these do not also tell you what to do about the problem. Charting a course for improvement requires an understanding of the clinical evidence in a way that is not easily accessible to benefits leaders. Linking evidence to action in a way that is relatable for those focused on benefit design and workforce health is an important knowledge gap and barrier to progress if not overcome.

5

Do not recreate the wheel. Rely on existing work and connect the dots.

Once the purchasers selected low back pain as their priority for improvement, we turned to a well-established resource in Washington state, the Dr. Robert Bree Collaborative (Bree). Relying on Bree's earlier work that focused on the evidence-base for low back pain improvement, including the role of each stakeholder, was an invaluable starting point for our collective work.

6

Focusing on what your organization can do is not enough. Stakeholder alignment is essential.

The inertia of the broad and complex U.S. healthcare ecosystem cannot be overstated. The shared aims around improving the value of care for low back pain expressed by all involved in this project is an important starting point but is not enough. It will require organizations like the Alliance to continue to act as the connective tissue and take a bold stance to bring otherwise disparate (and sometimes competing) organizations together to translate shared aims into tangible and aligned actions.

Appendix A

ABOUT THE MILLIMAN MEDINSIGHT HEALTH WASTE CALCULATOR™

The Milliman MedInsight Health Waste Calculator™ (Health Waste Calculator) is a standalone software tool. The tool is designed to analyze insurance claims data to identify and quantify overused low-value health care services as defined by national initiatives such as the U.S. Preventive Services Task Force and the Choosing Wisely® campaign. The Milliman team also collaborates with the **University of Michigan Center for Value-Based Insurance Design** (V-BID Center) and its national thought leaders, A. Mark Fendrick, MD, and Michael Chernew, PhD, who are continuously evaluating national and global initiatives to inform current and future measures included in the Health Waste Calculator.

This Health Waste Calculator adds important insights that can help health care purchasers identify and target specific strategies to reduce inefficient and/or ineffective care that does not add value and may introduce the potential for harm to covered members.

Through its detailed algorithms, the Health Waste Calculator defines each service reviewed with a degree of appropriateness for care, as follows:

- **Necessary:** Data suggests that clinically appropriate services were administered by a healthcare provider.
- **Likely Wasteful:** Data suggests the need to question the appropriateness of the services delivered.
- **Wasteful:** Data suggests the service was not well-supported by clinical evidence and probably should not have occurred.

Version 7 of the Health Waste Calculator was used for this analysis. The Health Waste Calculator includes 48 measures of common treatments, tests, and procedures that are known by the medical community to be overused; grouped into six categories by type of care.

- Common Treatments (prescriptions), 5 measures
- Screening Tests, 8 measures
- Diagnostic Testing, 19 measures
- Pre-operative Evaluation, 4 measures
- Disease Approach, 11 measures
- Routine Monitoring, 1 measure

The Health Waste Calculator does not provide a comprehensive analysis of all health care.

Clinical experts associated with Milliman and V-BID Center provide an assessment of the **potential for physical harm to the patient** with a low (L), medium (M) and high (H) "risk of harm indicator" for each measure. The impact of care cascades or the potential for emotional or financial harm that frequently accompanies the treatment, is not included in this characterization.

Below are the 48 measures included in Version 7 of the Health Waste Calculator, organized by type of care.

Common Treatments (Prescribing)

1. Prescribing antibiotics for adenoviral conjunctivitis (pink eye) (L)
2. Prescribing oral antibiotics for uncomplicated acute tympanostomy tube otorrhea (L)
3. Prescribing cough/cold medicines for respiratory illnesses in children under 4 years of age (L)
4. Prescribing oral antibiotics for upper respiratory infection or ear infection (acute sinusitis, URI, viral respiratory illness or acute otitis externa) (L)
5. Prescribing opioids for acute low back pain within the first four weeks (H)

Prevention/Screening Tests

6. PSA-based screening for prostate cancer in men age 70 and older (M)
7. Unnecessary (too frequent) screening for colorectal cancer in adults older than age 50 (L)
8. Dual energy X-ray absorptiometry (DEXA) screening for osteoporosis in women younger than 65 or men younger than 70 with no risk factors (L)
9. Annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms (M)
10. Population based screening for 25-OH-vitamin D deficiency in the absence of risk factors (L)
11. Use of coronary angiography in patients without cardiac symptoms or high-risk markers present (M)
12. Unnecessary (too frequent) cervical cancer screening (Pap smear and HPV test) in women who have had adequate prior screening and are not otherwise at high risk for cervical cancer (M)
13. Routine general health checks for asymptomatic adults ages 18-64 (no other diagnosis noted other than general health check) (L)

Diagnostic Testing

14. Imaging for low back pain within the first six weeks and no red flags present (M)
15. Imaging for uncomplicated headache (L)
16. Brain imaging studies (CT or MRI) in the evaluation of simple syncope and a normal neurological examination (L)
17. Use of unproven diagnostic tests, such as immunoglobulin G (IgG) testing or an indiscriminate battery of immunoglobulin E (IgE) tests in the evaluation of allergy (L)
18. Routine diagnostic testing in patients with chronic urticaria (hives) (L)
19. Electroencephalography (EEG) for headaches (L)
20. Imaging of the carotid arteries for simple syncope without other neurologic symptoms present (M)
21. Computed tomography (CT) scans of the head/brain for sudden hearing loss (L)
22. Radiographic imaging for patients who meet diagnostic criteria for uncomplicated acute rhinosinusitis (L)
23. Coronary artery calcium scoring for patients with known coronary artery disease (including stents and bypass grafts) (M)

24. Routine head CT scans for emergency room visits for severe dizziness (L)
25. Advanced sperm function testing, such as sperm penetration or hemizona assays, in the initial evaluation of the infertile couple (None)
26. Postcoital test (PCT) for the evaluation of infertility (None)
27. Repeat CT scans of the abdomen and pelvis in otherwise healthy emergency department patients (age <50) with known histories of kidney stones or ureterolithiasis, presenting with symptoms consistent with uncomplicated renal colic (L)
28. Routine imaging tests for patients without symptoms or signs of significant eye disease (e.g., visual field testing, optical coherence tomography testing, neuroimaging or fundus photography) (L)
29. Routine use of voiding cystourethrogram (VCUG) first febrile urinary tract infection (UTI) in children aged 2–24 months (H)
30. Computed tomography (CT) head imaging in children 1 month to 17 years of age unless indicated (L)
31. Stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms or high-risk markers present (M)
32. Use of bleeding time test to evaluate the risk of bleeding (e.g., during planned procedures) (L)

Pre-operative Evaluation

33. Baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery (L)
34. Baseline diagnostic cardiac testing or cardiac stress testing in asymptomatic stable patients with known cardiac disease undergoing low or moderate risk non-cardiac surgery (M)
35. EKG, chest X-rays or pulmonary function test in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery (L)
36. Pulmonary function testing prior to cardiac surgery, in the absence of respiratory symptoms (L)

Disease Approach

37. Prescribing nonsteroidal anti-inflammatory drugs (NSAIDS) for individuals with hypertension, heart failure or CKD of all causes, including diabetes (M)
38. Scheduled elective, non-medically indicated inductions of labor or Cesarean deliveries before 39 weeks, 0 days gestational age (H)
39. Arthroscopic knee surgery for knee osteoarthritis (M)
40. Prescribing antidepressants as monotherapy in patients with bipolar I disorder (M)
41. Use of computed tomography (CT) scans in the routine evaluation of abdominal pain for children aged 1-17 years (L)
42. Renal artery revascularization without prior medical management (H)
43. Vertebroplasty in adults ages 18 years and older (H)
44. Placement of peripherally inserted central catheters (PICC) in stage III-IV patients with nephrology consult (H)

45. Multiple palliative radiation treatments for bone metastases in the absence of specific indications (e.g., spinal cord compression, cauda equine syndrome) (M)
46. Prescribing two or more anti-psychotics concurrently (M)
47. Vision therapy for people with dyslexia (L)

Routine Monitoring

48. MRI of the peripheral joints to routinely monitor inflammatory arthritis (L)

Appendix B

HEALTH WASTE CALCULATOR TOP LOW-VALUE SERVICES

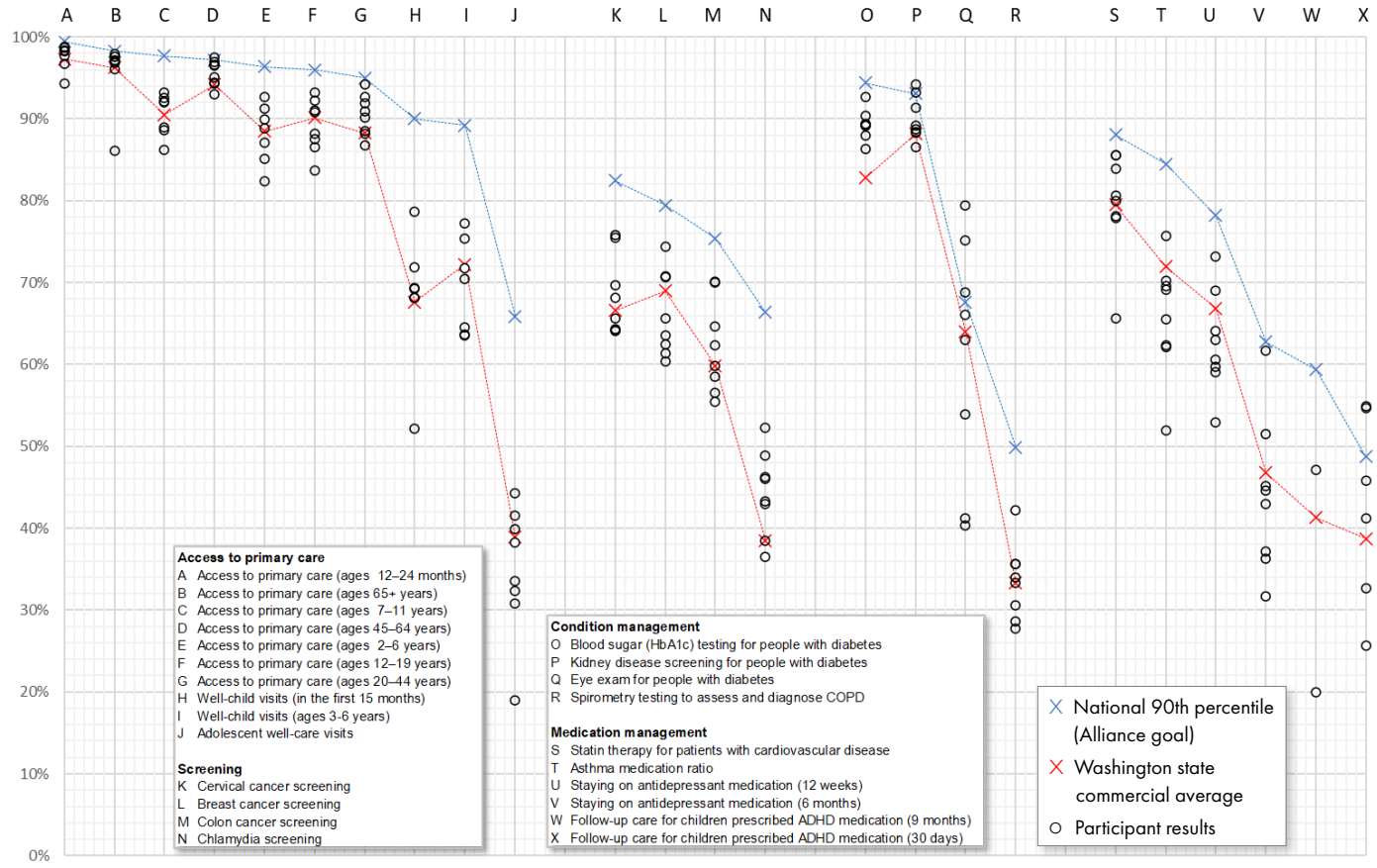
Health Waste Calculator results for the top low-value services ranked according to the number of low-value services delivered and comparing the commercial state average to each purchaser (A-H). The degree of potential harm is indicated by L, M, or H for each measure.

Measure	WA State	A	B	C	D	E	F	G	H
Annual EKG or cardiac screening in individuals who are low-risk and without symptoms (M)	1	1	1	2	3	1	1	2	2
Opiates for acute low back pain (H)	2	2	2	1	1	5	4	1	1
Antibiotics for acute URI and ear infections (L)	3	4	4	4	2	2	2	3	3
Pre-operative baseline lab studies prior to low-risk surgery in healthy individuals (L)	4	5	5	3	5	3	3	4	4
PSA screening for prostate cancer in men (M)	5	3	3	10	4	4	5	5	5
Imaging tests for eye disease (L)	6	6	8	5	6	6	7	10	9
Too frequent cervical cancer screening in women (M)	7	7	7	7	10	8	8	9	7
Routine general health checks in adults 18-64 (L)	8	9	9	15	7	7	9	8	8
Screening for vitamin D deficiency (L)	9	8	6	6	8	9	6	6	6
NSAIDS prescribed for adults with hypertension, heart failure or chronic kidney disease (M)	10	10	11	8	9	11	11	11	10
Imaging for low back pain within 6 weeks of diagnosis (M)	11	11	10	11	11	10	10	7	11
Too frequent colorectal cancer screening adults 50-74 (L)	14	13	16	9	19	15	12	22	16

Appendix C

COMMUNITY CHECKUP RESULTS

High-value measures for each purchaser compared to Washington state average and national 90th percentile, using *Community Checkup* results for the commercially insured from January 1, 2016 to June 30, 2019.



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