FLORIDA ALLIANCE
FOR HEALTHCARE VALUE

Summer Education Series Session #1 – Follow up Q&A

Eliminating Low Value Care While Incentivizing High Value Care **-** July 16, 2020

Speakers:
Beth Bortz, **MPP**, President & CEO, Virginia Center for Health Innovation (VCHI)
Mark Fendrick, **MD**, Director, Center for Value-Based Insurance Design

Q. Why would telemedicine produce fewer unnecessary diagnoses?

A. ***Dr. Fendrick****: Anecdotal evidence from remote visits show decreased levels of lab and other diagnostics compared to in-person visits. This may be driven by the fact that labs and imaging facilities are conveniently located near clinician offices and that it would be less convenient for patients. Also, 'routine' and 'baseline' studies (frequently low value) done during an in-person visit could also decrease since the patient would have to make a special trip.*

Q. Wouldn't it be easier to just recommend that every physician be part of an ACO-type shared savings arrangement, with appropriate incentives?

A. ***Beth Bortz****: Easier? I'm not sure about that. I've found that physicians have responded to our ask to "do the right thing" incredibly well. Asking them to significantly change their payment and practice arrangements might be much harder.*

Q. It seems like some specialties would not have much of an upside outcome here, like radiologists. Is that true? Is it a problem? Might the radiologists just raise their prices on the reduced volume?

A. ***Beth Bortz****: You are correct that of all the medical specialties, radiologists tend to be the least enthusiastic about our work -- since so many of the Choosing Wisely recommendations target imaging. It is why we worked hard when selecting our 7 measures to make sure that not all were imaging -- and thus would impact different specialties. As for changing the prices on reduced volume, that might be able to happen -- if a practice-controlled market share. We are struggling in one market with one large practice that just doesn't want to operate in good faith. Ask me in a year what happens here. The local clinicians are working to problem solve this now.*

Q. Do any of the orders for low-value services originate with hospitals? If so, would global hospital budgeting help?

A. ***Beth Bortz****: Yes. We have seen circumstances where there are standing orders in hospitals for pre-operative testing set by specialists, but the actual tests are ordered by primary care clinicians. That is why we believe it takes all the clinicians in the community to come together to discuss their plans to change behaviors. I believe global hospital budgeting could help - but I don't think it is essential to change this behavior. I have found that just sharing the data and facilitating a conversation can be effective.*

Q. Are there VBID recommendations for low value/high value care for mental health and behavioral health?

A. ***Dr. Fendrick****: As you might expect there are high and low value recommendations for most clinical areas. High value services can often be determined from clinical guidelines and health plan quality measures. There are likely low value services included in Choosing Wisely recommendations, but I have not reviewed them all.*

Q. Do you think of biosimilars as high value?

A. ***Dr. Fendrick****: It depends, but in many cases yes.*

Q. Do you get pushback from providers about the Drop the Pre-Op because of malpractice concerns?

A. ***Beth Bortz****: Interestingly, I had not had one single provider push back, and we've met with hundreds face to face. I believe this is because we are not asking them to eliminate ALL pre-operative labs and imaging, we are asking for a 25% relative reduction of only those deemed unnecessary by the standards set by clinicians. They can still employ clinical nuance. And when you tie your practice to the recommended standards of care, the risk of malpractice should be minimized.*