

Smart Care California (SCC)

Co-Chairs: Covered California, CalPERS, DHCS
Summary of October 6, 2017 Meeting -- Meeting #7
October 19, 2017

The October 6th meeting's main focus was to discuss ways in which SCC can support plans and provider groups to adopt an organization-wide opioid safety initiative. Additionally, progress to date on C-section for low risk, first time birth and low back pain was also discussed.

The complete meeting packet, including agenda and presentations, is available at:
<http://www.iha.org/our-work/insights/smart-care-california/meeting-materials>.

I. OPIOIDS

Meeting Recap

Julia Logan, MD, MPH, Chief Quality Officer at DHCS opened the discussion on reducing opioid overuse by acknowledging prescribers and payers all have a role in reversing the opioid epidemic. Dr. Logan discussed the efforts of the 24 Medi-Cal Managed Care plans to reduce opioid overuse highlighting the work of Inland Empire Health Plan, San Francisco Health Plan, Partnership HealthPlan of California and LA Care and provided an update on DHCS's internal opioid overuse workgroup and joint efforts with the CDPH workgroup. One focus of the DHCS opioid workgroup is [increasing access to medication-assisted treatment \(MAT\)](#) with the goal of implementing a "hub and spoke" model, which connects primary care prescribers (spokes) to specialists (hubs), ensuring better, coordinated care. DHCS has seen buprenorphine and naloxone prescriptions double as a result of these efforts.

Dr. Logan and Kelly Pfeifer, MD, Director, High-Value Care at CHCF then facilitated a discussion to obtain endorsement that all health plans and provider groups in California adopt an organization-wide opioid safety initiative. Dr. Pfeifer shared three resources intended to support payers and providers in their efforts to address opioid overuse: an updated checklist of health plan and purchaser approaches to curb the opioid epidemic (which integrates additional items on MAT), and a condensed set of recommended strategies for payers and providers. This led to the discussion of the advantages and disadvantages of enacting legislation versus a coordinated statewide multi-stakeholder approach to curb opioid overuse.

Discussion and Next Steps

- There was strong agreement that inaction on the opioid epidemic is not an option. There was also agreement that reducing opioid overuse requires purchasers, plans, and providers to elevate opioid overuse as a quality improvement priority (if it is not already). CMQCC's efforts to improve maternity care in California should serve as a model for reducing opioid overuse: collaborative improvement efforts require focused metrics with sharing of best practices and mentorship.
- While legislation can sometimes be more effective in prompting change, a majority prefer a collaborative approach that allows some flexibility and supports process improvement. However, SCC should be a content resource for legislators that allows legislators to develop legislation that minimizes unintended consequences.

- The workgroup expressed a need for assistance in developing a business case, specifically ROI, for working on the opioid epidemic. The CHCF [health plan white paper](#) and [MAT paper](#) present information on ROI. One provider representative has shared that they have modeled the savings associated with implementing pain contracts. Showing ROI is still a challenge because addressing the epidemic requires an upfront investment while the ROI occurs years later.
- SCC should be a source for best practices and standard materials across the state so organizations do not have to reinvent the wheel. SCC has compiled [opioid resources](#) but there is greater need for dissemination. CMA also has webinars on pain management and alternatives to therapy that can be shared. There is also a need for more resources to support consumer education. Existing resources include San Diego adopting one standard pain agreement to use with patients. Kaiser has developed a series of videos that walk providers through conversations on how to explain risks of opioids to patients. An additional provider resource mentioned was the UCSF Clinician Consultation Center which provides live consults on substance use issues free of charge and available to all clinicians. There was also interest in working with EHR vendors to integrate an opioid calculator.
- Purchaser alignment on reducing opioid overuse is needed. A joint opioid overuse Quality Improvement Program (QIP) between the three state purchasers (DHCS, Covered California, and CalPERS) was proposed.

II. C-SECTION FOR LOW RISK FIRST TIME BIRTHS

Meeting Recap

Stephanie Teleki, PhD, Director, Evaluation & Impact at CHCF provided context for SCC's consumer engagement efforts. While consumer demand for C-section is low (3-5%), there is still a need for shared decision-making materials and greater consumer awareness of the issue. Consumer Reports, CMQCC, and CHCF have partnered over the past year to develop and test education materials. Eric Antebi, Director of Communications at CHCF provided an update on the consumer research efforts to date and previewed two patient education videos, one featuring a labor and delivery nurse and the other featuring a new mom. Key insights from the consumer research and testing of the videos include:

1. Self-care is a challenge
2. C-sections are scary
3. Shocked by too many C-sections
4. Empowerment message is effective
5. Behavior change should be meaningful and practical

Elliott Main, Medical Director for CMQCC gave an update on the three cohorts of hospitals participating in the CMQCC Supporting Vaginal Birth QI collaborative. The collaborative uses a mentor model which pairs a physician and a nurse who provide QI coaching with a group of five to eight hospitals. Dr. Main also shared information maternity measures from CalHospitalCompare on the Yelp pages of California hospitals.

Lance Lang, MD, Chief Medical Officer at Covered California gave an update on the timing for the second annual Hospital Honor Roll. Dr. Lang then reintroduced SCC's proposal for a C-section menu of payment and contracting options, which was first presented at the June 5th meeting, for discussion and

endorsement. See accompanying file, [“Aligning Birth Payment to Reduce Unnecessary C-section: A Menu of Options”](#) (October 2017). The menu provides a short set of payment and contracting options that purchasers and health plans can adopt to support medically necessary use of C-section.

Discussion and Next Steps

- Patient education next steps: CMQCC, Consumer Reports, and CHCF will continue gathering input from key stakeholders. The patient education videos will be finalized in December, along with additional print products. Broad scale dissemination of the materials will begin in early 2018.
- California Health and Human Services Secretary Diana Dooley has agreed to be the sponsor for the hospital Honor Roll on an ongoing basis, hopefully setting a long-term precedent. The Maternity Honor Roll will be announced in early January 2018 to coincide with a new recognition for Hospital Safety based on a composite hospital safety measure.
- There was discussion that the payment strategy which suggests paying less for C-section without an active trial of labor has not been thoroughly tested for efficacy. The menu will be revised so that this payment strategy will focus on paying less for C-sections without medical indication and repeat scheduled C-sections. This strategy will be marked as a “potential strategy” that requires testing and piloting.

Payment Strategies

- 1) Adopt a blended case rate payment for both physicians AND hospitals
- 2) Include NTSV C-section in existing hospital and physician quality incentive programs
- 3) Adopt population-based payment models, such as ACO like arrangements

Potential Payment Strategy (Requires Testing)

- 1) Pay less for C-sections without medical indication and scheduled repeat C-sections

Contracting Strategies

- 1) Require or incent hospital participation in CMQCC’s Maternal Data Center (MDC)
- 2) Implement network quality improvement requirements with a deadline

The menu was endorsed by SCC and the menu will be used to guide model contract for Covered California and PBGH as well as other purchasers.

III. LOW BACK PAIN

Meeting Recap

Richard Sun, MD, MPH, Chief, Clinical Programs and Appeals Section, Health Plan Administration Division at CalPERS led a discussion about the pros and cons of three measures identified for low back pain. The three identified measures are:

1. Use of imaging studies for low back pain: % of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis
2. Adult acute and subacute low back pain: % of patients with low back pain diagnosis who are prescribed opioids.
3. Timely access to physical therapy: Using administrative claims data, for patients with diagnosis of low back pain, identify the number of days between date of request for physical therapy and date of claim for physical therapy.

Discussion and Next Steps

- There are challenges using the HEDIS imaging for low back pain measure including the current specification currently lumps all types of imaging (x-ray, MRI, and CT) together. Health systems who have impaired access to imaging could look like they are performing well on this when in actuality the imaging is still unneeded. There is also an issue of access and delayed diagnosis. LADHS developed a measure that looks at low back pain imaging without red flags regardless of time period; this measure is currently being used as part of PRIME. SCC will follow up with PRIME to explore the LADHS version of the low back imaging measure.
- In general, a measure looking at use of opioids in patient with low back pain is good to track since patients with low back pain have a higher dependence on opioids. There was some concern that looking at opioid use might be a bigger issue in patients with chronic back pain vs acute so it will be important to clearly define acute and subacute. If pursuing this measure, it will be important to identify where opioid treatment was initiated (e.g. ED, pain management specialists, or PCP), as some patients use multiple EDs to obtain opioids for subacute back pain. There are existing best practices to tackle use of opioids in patients with acute and subacute back pain, which include physical therapy in ED or urgent care setting or referral to wellness center (that offers, physical therapy, chiro, yoga, and acupuncture) across the street.
- There was interest in measuring timely access to physical therapy but this will require work to operationalize. A potential way to measure timely access would be to look at percent of patients diagnosed with low back pain with claim for physical therapy within a predefined period. Virginia Mason did a pilot with a purchaser that required access to physical therapy, similar to Stanford CERC model; PBGH will look into details of the pilot. SCC is interested in testing the measure with a volunteer health plan. Kaiser also offers physical therapy in the ER. Although this practice may not be immediately scalable, it may be interesting to explore.
- The three measures identified are all process measures and do not necessarily measure patient outcomes. There was some interest in looking at a patient reported outcomes such as the Oswestry Disability Index.

Next meeting on Monday, January 29, 2018 in Southern California