## State Workgroup on Reducing the Overuse of Ineffective or Unnecessary Medical Care

### Agenda

**Co-Chairs:** CalPERS, DHCS, and Covered CA  
**June 3rd 1:00PM-5:00PM**  
CalPERS Headquarters, Lincoln Plaza, 400 Q Street, Sacramento

<table>
<thead>
<tr>
<th>Time</th>
<th>Items</th>
<th>Leads/Presenters</th>
<th>Meeting Materials</th>
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<tbody>
<tr>
<td>1:00 PM</td>
<td><strong>Welcome and Introductions</strong></td>
<td>Ann Boynton, CalPERS</td>
<td>• Participant list</td>
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<td>1:20 PM</td>
<td><strong>Workgroup Purpose and Scope</strong></td>
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<td>• Perspectives of the Co-Chairs on Workgroup origins and goals</td>
<td>Julia Logan, DHCS; Anne Price, Covered California; Ann Boynton, CalPERS</td>
<td>• Workgroup Charter</td>
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<td>1:40 PM</td>
<td><strong>Related Efforts</strong></td>
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<td>• IHA-led project: Decreasing Inappropriate Care in California with Choosing Wisely®</td>
<td>Jill Yegian, IHA; Marge Ginsburg, CHCD</td>
<td>• Article about Choosing Wisely® in <em>Academic Medicine, 2014</em></td>
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<td>• CHCD Project: Doing What Works</td>
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<td>• Decreasing Inappropriate Care – Project Description</td>
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<td>2:00 PM</td>
<td><strong>Addressing Overuse in California</strong></td>
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<td>• Doing What Works – Project Description</td>
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<td>• Selecting target tests &amp; treatments</td>
<td>Scott Weingarten, MD, Cedars-Sinai Health System; Ann Marie Giusto, RN, Sutter Health; Marcus Thygeson, MD Blue Shield of California</td>
<td>• Choosing Wisely® Examples: Cedars-Sinai, UCSF, Virginia Mason, Swedish Medical Center</td>
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<td>• Designing interventions</td>
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<td>• Working in Concert: A How-To Guide to Reducing Unwarranted Variations in Care</td>
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<td>• Implementing change</td>
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<td>• Choosing Wisely™ - 5 Questions to Ask Your Doctor</td>
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<td>• Monitoring progress</td>
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<td>3:00 PM</td>
<td><strong>Break</strong></td>
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<td>3:15 PM</td>
<td><strong>Workgroup Activities in Year I</strong></td>
<td>Ann Boynton, CalPERS</td>
<td>• Discussion Document: Opportunities to Reduce Overuse in California</td>
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<td>• Assess current state and identify</td>
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<td>opportunities (areas of overuse)</td>
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<td>• Identify Approaches, Interventions</td>
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<td>• Representation on Workgroup -- who else</td>
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<td>should we be bringing in?</td>
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<td>4:45 PM</td>
<td><strong>Wrap-Up/Next Steps</strong></td>
<td>Ann Boynton, CalPERS</td>
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<td>• Meeting summary to be produced</td>
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<td>• Additional WG meetings in year 1</td>
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<td>half-days, alternating NorCal and SoCal</td>
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<td>• Scheduling polls to follow</td>
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Charter for Multi-Stakeholder California Work Group (WG) on Reducing the Overuse of Ineffective or Unnecessary Medical Care

**Purpose**
To develop, initiate, monitor and evaluate approaches to reducing the overuse of selected unnecessary and wasteful medical services in CA. These approaches may apply to services affecting individuals within Medi-Cal as well as commercially-insured health plan members.

**Sponsor**
This body functions as an ad hoc stakeholder work group (WG) coordinated by the CA Department of Health Care Services (DHCS) in conjunction with Covered California and CalPERS. Professional WG support will be provided by funding from the California HealthCare Foundation.

The WG will be comprised of individuals from multiple stakeholder groups whose active input and participation is essential to the success of this effort to improve healthcare quality and affordability in the state.

**Scope/boundaries**
This WG will focus its efforts on reducing overuse in CA of selected medical interventions across public and private delivery systems. Initial work will target specific tests and procedures identified in the Choosing Wisely ® Campaign (CWC) that particularly impact the needs of CA plan members, e.g., interventions that are disproportionally frequent, jeopardize the quality of care, and/or whose high cost may impact access to beneficial services. The WG may expand its focus to non-CWC and/or particular preference-sensitive interventions, tests and procedures.

**Activities**
The WG will:
1. Establish an inclusive, multi-stakeholder structure for addressing the issue of overuse of unnecessary and/or ineffective medical services in California.
2. Identify specific overused services that will be the focus of initial efforts, with particular attention to those that target patient safety/harm reduction.
3. Develop a plan for accessing data of current levels of overuse of select interventions.
4. With available funding or pro bono resources, collect relevant data and conduct an analysis for future comparisons.
5. If feasible and relevant, determine how best to present differences in overuse, e.g., by counties, by types of plan members, by health plans and/or by providers.
6. In association with the Center for Healthcare Decisions, research and report the priorities and values of public and private sector health plan members related to specific strategies for reducing potentially harmful and/or wasteful medical interventions.
7. Propose approaches to reducing overuse that take into consideration consumers’ views and values.
8. Propose and promote effective communication for reaching healthcare professionals and consumers about overuse.
9. Evaluate take-up of CWC educational materials (e.g., number of organizations participating; website metrics) targeted to consumers and/or providers.
10. Assess extent to which overuse has been reduced among those targeted interventions.
11. Consider targeting other interventions that may not be within the CWC domain.

**Deliverables**
The efforts of the WG will be evident by:
1. Development of overarching principles that will govern how the WG functions and its role in broader statewide initiatives, such as the renewal of DHCS's 1115 waiver and the Lets Get Healthy California (LGHC).
2. Identification of one or more specific overused interventions for a state-wide or targeted campaign.
3. Realistic goals for reducing targeted interventions over a specific time frame.
4. Specific plans for disseminating CWC materials oriented to consumers, providers, health plans and the media, on targeted areas of overuse.
5. Highlighting of “success stories” (e.g., Swedish Hospital in WA state) and the types of strategies used that are most effective in reducing overuse among particular providers or consumers.
6. Visible evidence of a culture of “responsible stewardship of resources” across multiple stakeholder groups.
7. Plans for if and how coordinated efforts to reduce overuse will be continued long-term in the state.

**Desired Outcomes**
By the end of this 3-year effort, the WG expects the following:
1. CW materials will be incorporated into the educational programs for providers and consumers in a significant number of local and state organizations, including health plans, medical groups, hospitals, purchasers and consumer organizations.
2. A meaningful number of participating health plans and medical groups will have instituted changes in their oversight or approval processes targeted to overused interventions.
3. There will be measurable evidence of reduction in the overuse of targeted interventions.

**Authority**
The WG is a statewide advisory and leadership body. It does not have the authority to change or to recommend changes in coverage design. Decisions to alter coverage of overused interventions remain the authority of individual private and public sector health plans and/or purchasers.

**Membership**
Members will be recognized leaders within the stakeholder groups most affected by the issue of overuse: purchasers, health plans, healthcare systems and physicians, consumers, and possibly, researchers or other state leaders. Individuals will be invited onto the WG by the three lead organizations. In-person, three-hour meetings will be held quarterly, alternating between Sacramento and southern Calif.

**Reporting**
Written reports will be provided according to an agreed-upon schedule with Calif. HealthCare Foundation (and any other funders), as well as for the benefit of other state-sponsored initiatives whose interests overlap, such as the 1115 Waiver and LGHC. Other
WG members will also be encouraged to include updates on their websites. Resources permitting, the CWG will develop a website – as well as periodic e-newsletters – as a means of keeping all interested parties well-informed.

**Timeframe**
The initial meeting will be held in Sacramento in spring 2015; it will meet quarterly over a 3-year period. Among its roles is to determine if, after three years, it should be either 1) extended as an ad hoc committee; 2) incorporated into the permanent structure of DHCS or another organization; or 3) discontinued.
Engaging Physicians and Consumers in Conversations About Treatment Overuse and Waste: A Short History of the Choosing Wisely Campaign

Daniel Wolfson, MHSA, John Santa, MD, MPH, and Lorie Slass, MA

Abstract

Wise management of health care resources is a core tenet of medical professionalism. To support physicians in fulfilling this responsibility and to engage patients in conversations about unnecessary care, tests, and procedures, in April 2012 the American Board of Internal Medicine Foundation, Consumer Reports, and nine medical specialty societies launched the Choosing Wisely campaign. The authors describe the rationale for and history of the campaign, its structure and approach in terms of engaging both physicians and patients, lessons learned, and future steps.

In developing the Choosing Wisely campaign, the specialty societies each developed lists of five tests and procedures that physicians and patients should question. Over 50 specialty societies have developed more than 250 evidence-based recommendations, some of which Consumer Reports has “translated” into consumer-friendly language and helped disseminate to tens of millions of consumers. A number of delivery systems, specialty societies, state medical societies, and regional health collaboratives are also advancing the campaign’s recommendations. The campaign’s success lies in its unique focus on professional values and patient–physician conversations to reduce unnecessary care. Measurement and evaluation of the campaign’s impact on attitudinal and behavioral change is needed.

On April 4, 2012, the American Board of Internal Medicine Foundation (ABIMF), Consumer Reports, and nine medical specialty societies launched the Choosing Wisely campaign. Each participating society announced evidence-based lists of five tests or procedures in its clinical domain that are performed too often. Encouraged by the successful reception of this release, 17 societies announced new lists of tests and procedures in February 2013. Although our ultimate goal is to reduce wasteful care, our immediate goal was to encourage physicians and patients to have conversations about what care is truly needed, and to debunk the notion that more is better.

As leaders of the campaign at ABIMF and Consumer Reports, we aim through this article to provide a first-person perspective on the background and purpose of the Choosing Wisely campaign, the structure and approach of the initiative, and lessons learned and future plans.

Background and Purpose of the Campaign

The Choosing Wisely campaign’s origins date back to the 2002 publication of Medical Professionalism in the New Millennium: A Physician Charter, coauthored by the ABIMF, the American College of Physicians (ACP) Foundation, and the European Federation of Internal Medicine. The charter provides a new set of professional responsibilities that physicians must uphold in return for the privilege of self-regulation.

The charter’s three core principles are the primacy of patient welfare, patient autonomy, and social justice. The 10 commitments that set it apart from previous professional declarations, such as the Hippocratic Oath, include managing conflicts of interest, improving the quality of care, improving access to care, and promoting the just distribution of finite resources. The charter’s major contribution was to provide a new “job description” for physicians that included responsibilities beyond caring for the individual patient. The principles of social justice and patient autonomy were the most progressive elements of the charter. The social justice principle directly relates to the just distribution of finite resources.

When the Charter and related articles were initially published, a challenge cited by some physicians was that the “Primacy of Patient Welfare” principle was in direct conflict with the call for physicians also to manage finite resources. Since the creation of the Hippocratic Oath physicians have been directed to work single-mindedly as their patient’s advocate. The counterargument was that managing resources was not to happen at the bedside but through clinical guidelines, appropriate use criteria, and comparative effectiveness research developed by professional organizations and other non-conflicted organizations, including government-sponsored entities.

The charter serves as the underlying framework of the Choosing Wisely campaign. Since the charter’s publication, the ABIMF has worked to fulfill its principles and commitments, including conflict of interest, quality improvement, care coordination, and teamwork. Through those activities, the ABIMF developed relationships with several
society that built the mutual respect and trust necessary for them to join the Choosing Wisely campaign.

Ultimately, Choosing Wisely is focused on supporting conversations between physicians and patients about what care is truly necessary. While physicians aspire to embody the goals of the charter, we learned from research by Campbell and colleagues that there was a large gap between physicians' aspirations and their actual behavior. Ninety percent or more of respondents in Campbell and colleagues' survey agreed with specific statements about principles of fair distribution of finite resources, improving access to and quality of care, managing conflicts of interest, and professional self-regulation. However, when asked how they'd behave in specific situations, 36% said they would accommodate a patient who badly wanted a test, even if the physician knew it was unnecessary. Addressing this gap between aspirations and actual professional behaviors served as one of the guiding aims when constructing the Choosing Wisely campaign.

In 2009, the ABIMF engaged consultants to explore the language physicians use in describing medical professionalism, and their motivations to engage in professionalism ideals embodied in the charter, including the principle of "just distribution of finite resources." This exploratory constituency communications research, intended to inform the foundation's program development, involved interviews (12 practicing physicians and 2 trainees), focus groups (two groups in Baltimore in 2011), and a national survey of physicians (502 physicians, conducted from August 30 to September 15, 2011). The research found that the primary drivers for physicians to embody the behaviors articulated in the charter are activities that enhance patient well-being, achieve personal and professional well-being and fulfillment, and improve quality of care for their own patients.

When physicians were presented with language that moved away from the interests of the patient or their own well-being, and toward society's need for a sustainable health system, they were less motivated to take action. The physicians agreed that phases such as "Wise choices" accurately reflected their desire to empower their patients to make informed decisions about their treatment, while encompassing the ideals of the charter they sought to live up to.

**Structure and Approach: Engaging Physicians**

In 2009, the National Physicians Alliance (NPA), a physician organization dedicated to professional integrity and health justice, received an ABIMF grant to develop an operational concept of "five things to question" that was ultimately the centerpiece of the Choosing Wisely campaign. Through a peer review process of its members, the NPA created lists of five interventions in internal medicine, family medicine, and pediatrics that should not be performed, as part of their Good Stewardship Project. Around the same time, Howard Brody, an ethicist from University of Texas at Galveston, called on specialty societies to identify five tests and procedures as a way for physicians to constructively address the cost and waste issue during the health care reform debate. Writers such as Shannon Brownlee, in her book *Overtreated*, Rosemary Gibson and Janardan Prasad Singh in *The Treatment Trap*, and Deborah Grady and Rita Redberg in the “Less is More” section of the *Archives of Internal Medicine* laid down an important foundation that began a dialogue with the public and physicians about the ill effects of too much care.

Building on the success of the NPA's project, the ABIMF believed the concept of creating lists of unnecessary tests and procedures could be broadened to a wide range of specialty societies—with three critical elements:

- the things on the list needed to be within that society's clinical domain;
- they needed to be done frequently in practice and incur real costs; and
- they must be evidence-based recommendations.

In early 2011, ABIMF staff began presenting the campaign to specialty society leadership. In this first recruiting stage, we argued that societies should join the campaign to show

- professional obligation to provide appropriate care; and
- continued leadership in evidence-based medicine;

- their recognition of escalating health care costs;
- their commitment to transparency and shared decision making; and
- the importance of taking proactive measures to address waste.

At the same time, we acknowledged that their members could view the campaign as a threat to their revenue, and that it did not offer a "magic bullet" against heavy-handed intervention by public and private payers. We also recognized that the campaign might fail to garner media attention, or might even draw a negative reaction from consumers.

After the initial outreach, nine societies—from within and outside internal medicine—agreed to join the campaign. Each society was free to develop its own method to create its list, although each was required to document the process and make it publicly available. Most societies used existing quality and safety committees to develop their lists and solicited feedback from their members through surveys or mailings, and many presented their lists to their governing boards for final approval. Table 1 shows examples of Choosing Wisely recommendations from the more than 50 currently participating specialty societies. To date, 16 societies have published journal articles on the science behind their recommendations.

**Structure and Approach: Engaging Patients**

As we worked with the medical societies, it became clear that an important component was missing in the campaign. Our research told us that we needed to focus on the physician/patient interaction, and the nine societies reached nearly 375,000 physicians. But we still needed a way to engage patients in this effort so they would be empowered to understand what was on the specialty society lists and engage in conversations with their physicians about potentially unnecessary tests and procedures. The ABIMF found a patient engagement partner in Consumer Reports.

Consumer Reports began focusing more resources on health in 2007. Consistent with its 78-year mission, it launched major activities to compare health services, products, institutions, and practitioners. Variation in performance...
**Table 1**

**Sample Recommendations Aimed at Reducing Unnecessary Health Care Tests and Procedures, Developed From the Choosing Wisely Campaign, 2012**

<table>
<thead>
<tr>
<th>Specialty society</th>
<th>Recommendation</th>
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<tr>
<td>American Academy of Family Physicians</td>
<td>Don’t do imaging for low back pain within the first six weeks, unless red flags are present.</td>
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<td>• Red flags include, but are not limited to, severe or progressive neurological deficits or when serious underlying conditions such as osteomyelitis are suspected. Imaging of the lower spine before six weeks does not improve outcomes, but does increase costs. Low back pain is the fifth most common reason for all physician visits.</td>
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<td>American Academy of Hospice and Palliative Medicine</td>
<td>Don’t delay palliative care for a patient with serious illness who has physical, psychological, social, or spiritual distress because they are pursuing disease-directed treatment.</td>
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<td>• Numerous studies—including randomized trials—provide evidence that palliative care improves pain and symptom control, improves family satisfaction with care, and reduces costs. Palliative care does not accelerate death, and may prolong life in selected populations.</td>
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<td>American Academy of Pediatrics</td>
<td>Antibiotics should not be used for apparent viral respiratory illnesses (sinusitis, pharyngitis, bronchitis).</td>
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<td>• Although overall antibiotic prescription rates for children have fallen, they still remain alarmingly high. Unnecessary medication use for viral respiratory illnesses can lead to antibiotic resistance and contributes to higher health care costs and the risks of adverse events.</td>
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<td>American College of Obstetricians and Gynecologists</td>
<td>Don’t schedule elective, nonmedically indicated inductions of labor or cesarean deliveries before 39 weeks 0 days gestational age.</td>
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<td>• Delivery prior to 39 weeks 0 days has been shown to be associated with an increased risk of learning disabilities and a potential increase in morbidity and mortality. There are clear medical indications for delivery prior to 39 weeks 0 days based on maternal and/or fetal conditions. A mature fetal lung test, in the absence of appropriate clinical criteria, is not an indication for delivery.</td>
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<td>American College of Physicians</td>
<td>Don’t obtain screening exercise electrocardiogram testing in individuals who are asymptomatic and at low risk for coronary heart disease.</td>
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<td>• In asymptomatic individuals at low risk for coronary heart disease (10-year risk &lt; 10%) screening for coronary heart disease with exercise electrocardiography does not improve patient outcomes.</td>
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<td>American College of Surgeons</td>
<td>Avoid admission or preoperative chest X-rays for ambulatory patients with unremarkable history and physical exam.</td>
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<td>• Performing routine admission or preoperative chest X-rays is not recommended for ambulatory patients without specific reasons suggested by the history and/or physical examination findings. Only 2% of such images lead to a change in management. Obtaining a chest radiograph is reasonable if acute cardiopulmonary disease is suspected or there is a history of chronic stable cardiopulmonary diseases in patients older than age 70 who have not had chest radiography within six months.</td>
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<td>American Geriatrics Society</td>
<td>Don’t recommend percutaneous feeding tubes in patients with advanced dementia; instead, offer oral assisted feeding.</td>
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<td>• Careful hand-feeding for patients with severe dementia is at least as good as tube-feeding for the outcomes of death, aspiration pneumonia, functional status, and patient comfort. Food is the preferred nutrient. Tube-feeding is associated with agitation, increased use of physical and chemical restraints, and worsening pressure ulcers.</td>
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<td>American Society of Clinical Oncology</td>
<td>Don’t use cancer-directed therapy for solid tumor patients with the following characteristics: low performance status (3 or 4), no benefit from prior evidence-based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anticancer treatment.</td>
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<td>• Studies show that cancer-directed treatments are likely to be ineffective for solid tumor patients who meet the above stated criteria.</td>
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<td>• Exceptions include patients with functional limitations due to other conditions resulting in a low performance status or those with disease characteristics (e.g., mutations) that suggest a high likelihood of response to therapy.</td>
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<td>• Implementation of this approach should be accompanied with appropriate palliative and supportive care.</td>
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<td>American Society for Radiation Oncology</td>
<td>Don’t routinely recommend proton beam therapy for prostate cancer outside of a prospective clinical trial or registry.</td>
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<td>• There is no clear evidence that proton beam therapy for prostate cancer offers any clinical advantage over other forms of definitive radiation therapy. Clinical trials are necessary to establish a possible advantage of this expensive therapy.</td>
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<td>Society of General Internal Medicine</td>
<td>Don’t perform routine general health checks for asymptomatic adults.</td>
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<td>• Routine general health checks are office visits between a health professional and a patient exclusively for preventive counseling and screening tests. In contrast to office visits for acute illness, specific evidence-based preventive strategies, or chronic care management such as treatment of high blood pressure, regularly scheduled general health checks without a specific cause including the “health maintenance” annual visit, have not shown to be effective in reducing morbidity, mortality, or hospitalization, while creating a potential for harm from unnecessary testing.</td>
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*The Choosing Wisely campaign was developed by the American Board of Internal Medicine Foundation and Consumer Reports, in concert with specialty societies.*
and lack of correlation between quality and cost were prevalent across published comparisons. Overuse and underuse were found to be common. But messaging around these issues met with resistance from industry and consumers. Independent of the ABIMF, Consumer Reports conducted an exploratory review in 2010 of the cognitive psychology literature around messaging related to “What Not To Do,” a literature review and white paper aimed at improving communication to consumers about decision making. Consumer Reports conducted a survey demonstrating that large numbers of consumers were undergoing wasteful heart disease screening tests (as determined by Consumer Reports ratings) while rarely receiving effective explanations from physicians about why they were getting these tests. The survey focused on 1,183 Consumer Reports subscribers, 40 to 60 years old, who did not have high cholesterol or blood pressure, were never diagnosed with any heart condition, never experienced symptoms of heart disease, never smoked, and rated their health as “good” or “excellent.” Of that group, 39% reported receiving an EKG in the last five years, 12% a stress test, and 10% an ECHO. Only 17% knew what problem the test was screening for, 11% what would be done if the test was abnormal, 9% the test accuracy, 4% the potential complications, and only 1% whether the test saved lives.

By 2011, Consumer Reports had begun using the findings from this review and other work to develop messaging for consumers around ratings of heart disease screening tests that was met with better understanding and acceptance. Consumer Reports agreed to assist with the ACP’s work on “high-value cost-conscious care,” announced in February 2011. That summer, Consumer Reports published a magazine issue highlighting overuse of testing and care in heart disease, especially in percutaneous coronary interventions. Consumer Reports’ leadership had also decided to disseminate more information outside of its individual subscriber business model in hopes of having more impact.

By the fall of 2011, the ABIMF, Consumer Reports, and the ACP had agreed that the most effective approach was to collaborate on the Choosing Wisely campaign. Consumer Reports agreed to collaborate with the participating specialty societies to “translate” Choosing Wisely recommendations into consumer-friendly briefs. This partnership worked in part because Consumer Reports had a history of collaboration with specialty societies and had a nonprofit and independent culture that aligned well with the specialty societies and the ABIMF. The briefs Consumer Reports produced included primers on allergy tests, children and antibiotics, and when patients should have chest x-rays before surgery. Consumer Reports also organized a network of 14 large organizations with access to millions of consumers, including groups such as the AARP, employer coalitions, labor, Wikipedia, and others. These organizations committed to distribute Choosing Wisely information to at least one million consumers each.

Lessons Learned
A set of hopefully enduring principles has guided the Choosing Wisely campaign to date. They include:

- “Choosing Wisely” resonates with physicians and patients because it consists of using respectful conversations to make informed care choices. The societies’ recommendations promote conversation because they are not absolutes but are instead tests and procedures that patients and physicians should question.
- Framing unnecessary care as waste also draws the attention of patients and physicians. Waste is disrespectful of patients’ time and money and puts them unduly at risk for harm. Waste is a quality and safety issue, and removing waste makes health care better.
- Professional values and responsibilities are a potent motivator for physicians to improve the delivery of care and address resource use.
- The physician leadership of the specialty societies and the participation of highly respected consumer/patient groups are essential to establishing the credibility and trustworthiness of this effort.
- While the lists provide a starting point for discussions, many physicians require guidance in how to communicate effectively about potentially unnecessary care.

The Achievements of the Choosing Wisely Campaign

We are not aware of a health campaign in recent memory that has attracted more attention than Choosing Wisely in the consumer and medical trade media (especially medical journals). We estimate that tens of millions of consumers and hundreds of thousands of physicians have likely read about Choosing Wisely based on widespread coverage in consumer publications, more than 160 journal articles on the campaign and its recommendations, and hundreds of thousands of visits to www.chosingwisely.org. As of September 13, 2013, more than 50 specialty societies have joined the campaign, including all primary care specialties and most medical and surgical specialties. The campaign’s timing—focusing on overuse at a time of ever-escalating health care costs—surely played a major role in galvanizing attention.

At this stage of the campaign, we intentionally focused on changing physician and patient attitudes rather than embarking on specific strategies to change behavior, believing that “culture trumps strategy.” Our belief is that reform of the delivery system in the 1990s failed in part because of a lack of attention to culture and professional engagement with consumers.

Critics are concerned that we have not emphasized measurement enough and as a result cannot report that the campaign has successfully changed behaviors, which is correct. None of the organizations involved in the campaign, including the ABIMF, Consumer Reports, and the more than 50 professional societies, has the data or the resources to take on this task. But we have urged others to do so, including health systems and other delivery sites that have the resources and data necessary for this type of measurement, and we look forward to their results.

Nonetheless, the outcomes seen in its short history include:

- The creation of a coalition of more than 50 professional societies and at least 14 consumer/patient/employer groups dedicated to addressing waste in the health care system. This coalition supported and reflected a nonpartisan consensus among policy makers and
health care stakeholders about the need to remove waste.

- The development of more than 250 evidence- and expertise-based recommendations by specialty societies to avoid wasteful tests and procedures. This is substantially more than what has been previously reported.46
- The strong commitment of physician and consumer leaders to promote better care, removing waste and protecting patients from harm.
- The campaign has “softened the ground” for conversations about waste and prepared the nation for more difficult conversations.
- In the first year of the campaign, 106 peer-reviewed journal articles were published mentioning the campaign and examining the evidence for the recommendations—a number that has since grown to more than 160.
- In the first year of the campaign, close to 100 million consumers were reached with the Choosing Wisely message through hundreds of stories and millions of readers.

Everyone agrees that patient welfare must come first. That welfare is currently threatened by the unpredictable financial future of our health care system. But if patients and physicians choose wisely, trusting each other as they do so, our shared future may improve.

Going forward, the major responsibility of the ABIMF and Consumer Reports will be to “ignite” efforts by others, such as having delivery systems and clinical practices apply the principles of the campaign and implement the recommendations in practice, while continuing to assert the basic principles of the campaign: waste’s effect on quality of care, patient harm, and resource use.

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The Future

In addition to the development of new specialty society lists of procedures or tests to question, we will continue to support efforts to engage physicians and consumers in these important conversations. Through a grant from the Robert Wood Johnson Foundation, the ABIMF is funding specialty societies, state medical societies, and regional health collaboratives to work on the local and regional levels to increase awareness of the recommendations and promote informed conversations. Learning networks will also be formed among these groups to share innovative ideas and best practices.

We also know that physicians don’t necessarily have the communication skills to discuss “what not to do” with their patients.47 To support physician learning in this area, the ABIMF engaged Drexel University School of Medicine to produce Web-based educational modules on communication skills. Consumer Reports will focus, as it has for 78 years, on the needs of consumers. The Choosing Wisely consumer partners will continue to reach out to their audiences and educate patients about what care they truly need.

References


25 Society of General Internal Medicine. Five things physicians and patients should question.


Decreasing Inappropriate Care in California in Partnership with Choosing Wisely®

According to the Institute of Medicine, waste accounted for 30% of the $2.5 trillion spent in the U.S. on healthcare in 2009. Misuse and overuse of services accounted for 27% of the total waste, or $210 billion. Choosing Wisely® is an initiative of the ABIM Foundation to help clinicians and patients engage in conversations about overuse of tests and treatments and support physicians’ efforts to help patients make effective care choices. As momentum continues to grow across the nation toward higher-value health care, California has a timely and strategic opportunity to align the interests of diverse stakeholders towards a common purpose: reducing overuse through a Choosing Wisely campaign.

The Integrated Healthcare Association is a statewide multi-stakeholder leadership group focused on improving quality, accountability, and affordability of health care in California through performance measurement and aligning incentives. With funding from the ABIM Foundation, IHA has convened a multi-stakeholder team including Sharp Rees-Stealy Medical Group, Sutter Health, the American College of Physicians (California Chapter), the Center for Healthcare Decisions, and Blue Shield of California. The team plans to target overuse through clinical interventions, consumer engagement strategies, and communication efforts targeting physicians, provider systems, health plans, purchasers, consumers, and policymakers across the state.

**Delivery System Partners** – Each delivery system partner will be responsible for implementing interventions to reduce three key targeted areas of overuse by 20%. Each system will report on progress against baseline data every six months, and results will be publicly available. Both systems will focus on use of antibiotics for acute bronchitis, and each will also target two additional tests or treatments:

- **Sharp Rees-Stealy Medical Centers**, which has 21 locations throughout San Diego, will address imaging for nonspecific low back pain and preoperative stress testing.
- **Sutter Health**, serving broad areas of Northern California, will tackle imaging for uncomplicated headache and repetitive CBC and chemistry testing for inpatients.

**American College of Physicians, California Chapter** – ACP’s primary role will be provider engagement. Through its member network, ACP will foster professional values consistent with the culture of Choosing Wisely, and contribute to dissemination of Choosing Wisely resources and project results. The timing and content of its communications will be coordinated through the project partners. Particular emphasis will be given to the geographic regions of the delivery system partners – Sacramento, the Bay Area, and San Diego.

**Center for Healthcare Decisions** – CHCD’s primary responsibility will be consumer engagement. Through its separately funded project, Doing What Works, CHCD will gain understanding and insights about strategies to reduce overuse based on the perspectives of Medi-Cal members and those with commercial insurance. CHCD will hold 10-12 deliberative sessions statewide to assure that the public’s
voice – as consumers, patients and citizens – are incorporated into long-term healthcare policy and practice. CHCD will also broadly disseminate the project findings and help coordinate dissemination of Choosing Wisely consumer resources and project results.

Blue Shield of California – BSC’s primarily role will be in a Choosing Wisely communications campaign, targeting members and ACO partners, that complements the provider partner interventions and the provider and consumer engagement activities of the other proposal partners. In order to improve quality and reduce overuse and misuse, BSC plans to share CW content with members, and engage ACO partners to share CW content with patients at the point of care.

Statewide Workgroup on Reducing Overuse (WG)—California’s Department of Health Care Services, Covered California, and CalPERS are launching a new statewide initiative intended to reduce overuse across the State of California, with an initial focus on the Choosing Wisely® campaign as the primary approach. The WG complements the efforts of this project; the synergy between the project and the WG will magnify both the short-term and long-term impact. The role of the WG on this project will be alignment and coordination of efforts, as well as communication and dissemination; some project members will also be active WG members.

For more information, contact Jill Yegian, PhD, SVP for Programs and Policy at IHA, at jyegian@iha.org or 510.281.5612.
Doing What Works

Project Objectives
The purpose of Doing What Works (DWW) is to identify the perspectives of insured Californians on ways to reduce the use of medical services that are harmful and/or wasteful. This project will inform the work of the Statewide Work Group on Reducing Overuse; its results will also be relevant in implementing California’s ABIM project Decreasing Inappropriate Care in California in Partnership with Choosing Wisely. DWW objectives:

1. Engage a representative number of Medi-Cal, Covered California and CalPERS members across the state in deliberative discussions on the topic of reducing overuse.
2. Using quantitative and qualitative methods, identify the approaches that are most acceptable to insured residents for effective and fair limit-setting pertaining to overuse.
3. Provide the basis for CA healthcare leaders to establish specific, meaningful, and measurable approaches to reduce overuse that are congruent with the public’s perspectives and values.
4. Assess the impact of the deliberative process for establishing a precedent of civic participation relevant to healthcare policy and practice.
5. Contribute to state and national understanding on the public’s response to reducing overuse as a strategy for improving patient care and healthcare affordability.

Project Background
As referenced by the Dartmouth Atlas and the Institute of Medicine, most policy experts believe that 30% of health care dollars are not used productively. With the goal of reduced overuse falling within the Calif. Dept. of Health Care Services’ strategic plan, DHCS pursued and received a Robert Wood Johnson technical assistance grant to have Bailit Health Purchasing research how DHCS should approach the topic of overuse. Its findings and recommendations to DHCS were released December 2013.

DHCS’s interest in pursuing the problem of overuse was joined by leaders at CalPERS and Covered Calif., the other large state purchasers. In 2014, Neal Kohatsu, MD, Medical Director of DHCS; Ann Boynton, Director of Health Benefits for CalPERS; and Jeff Rideout, MD, then Senior Medical Advisor for Covered California, agreed to collaborate in forming a statewide work Group. These leaders also recognize the importance of capturing the public’s voice as a critical step in designing strategies that take into account the principles and values of those they serve.

Center for Healthcare Decisions
Established in 1994, CHCD is a nonprofit, nonpartisan organization based in Sacramento. Its purpose is to bring an informed public voice to complex issues in healthcare policy and practice. Recognizing that healthcare dilemmas are typically steeped in conflicts of individual and societal values, remedies to existing problems must take into account the perspectives of the lay public, not just healthcare and business leaders. Towards this end, CHCD uses deliberative small group discussions to engage residents in interactive problem-solving that captures the issues of greatest concern, the approaches most likely to be supported and the core values that underlie priority setting and trade-offs in healthcare.
DWW Project Description
There will be 10 deliberative sessions, each 4½ hours long, conducted by two CHCD facilitators in multiple regions of the state. Each session will have 10‐12 participants, including a Spanish‐only group. The discussion groups will be designed to answer the over‐arching question: While preserving and improving the health and healthcare resources of Californians, what strategies are most acceptable for reducing the use of medical care that is harmful and/or wasteful?

Four case scenarios will form the basis of the discussions, at least two of which will be tests or treatments that are included in the Choosing Wisely ® campaign. The goal is to learn how and why certain steps to reduce the use of specific interventions are more or less acceptable.

Project planning started in April 2015; the sessions will be conducted between September and December 2015; and the results analyzed in early 2016. The project will be reviewed/approved by the state’s IRB. An extensive communications plan will be developed and implemented to bring the results to healthcare professionals, policy makers, community leaders and the general public in spring 2016.

Advisory Committee
Input to all aspects of project design is being provided by the following advisory committee members:
• Desiree Backman, DrPH: Chief Prevention Officer, DHCS: CHAIR
• Sally Covington: Co‐founder Community Campaigns; Senior Health Care Advisor, SEIU 1021
• Kathy Glasmire: community member
• June Isaacson Kailes: Disability Policy Consultant; Associate Director, Harris Family Center Disability/Health Policy
• Elizabeth Landsberg, JD, Western Center for Law & Poverty
• Marion Leff, MD, family practice physician, Sutter Health
• Crystal Tarver, Medi-Cal member
• Giennah Trochet, MD, retired family practice physician/county health officer

Project support
DWW is being funded by the California HealthCare Foundation and Kaiser Permanente National Community Benefit Fund.
Cedars-Sinai Alerts Its Docs to Choosing Wisely

June 5, 2014

With a focus on stimulating physician and patient conversations, there is perhaps no more appropriate environment in which the Choosing Wisely® campaign could take hold than the examining room. Cedars-Sinai Health System has taken an important step in ensuring these conversations happen by becoming the first system in the nation to incorporate dozens of specialty society campaign recommendations into its electronic medical records (EMR) system.

Cedars-Sinai programmed its CS-Link EMR, which is made by Epic, to include 180 Choosing Wisely recommendations. A pilot, launched last summer in some of Cedars’ outpatient clinics, resulted in statistically significant reductions in the use of medications that had been questioned by specialty societies such as:

- the use of antipsychotics for elderly patients with dementia;
- butalbital for patients with migraine headaches; and,
- benzodiazepine as a first-line treatment for sleep in the elderly.

Cedars has since expanded this effort throughout its health system, including Cedars-Sinai Medical Group and Cedars-Sinai Medical Center.

Cedars programmed its EMR to alert physicians who attempt to order a test or treatment that is referenced on the Choosing Wisely lists to provide more information before physicians can proceed. For example, if a physician attempts to order an electrocardiogram or other preoperative test before a minor surgery, an alert will warn that such tests do not lower operative risks. A physician ordering an antibiotic for a patient suffering from bronchitis will be reminded that antibiotics are ineffective for healing viral illnesses.

Each alert contains links to citations provided by the specialty society that issued the recommendation. Through the EMR, physicians can also access consumer-friendly materials produced by Consumer Reports that explain why a particular test or procedure may not be appropriate.
“We’re hard-wiring in protections for patients to reduce harm and to eliminate wasteful spending that does not provide a benefit,” said Glenn D. Braunstein, MD, Vice President of Clinical Innovation at Cedars-Sinai. “We want to give doctors a GPS of sorts that will lead to the best quality care at an affordable cost.”

Understanding that each patient presents a unique case, physicians can override the alerts if they still believe their proposed intervention is appropriate; the system will allow the order to be entered once the physician includes a reason for disregarding the recommendation.

Although the proliferation of alerts that have been inserted into electronic medical records has led some researchers to highlight “alert fatigue” in which physicians disregard alerts due to their frequency, Scott Weingarten, MD, Senior Vice President and Chief Clinical Transformation Officer at Cedars-Sinai, said that it had not been a problem at this point in the implementation because of the specialty society involvement. He said that Cedars is tracking the frequency with which alerts are “fired” and how often they are heeded, and analyzing information to provide a more detailed picture to Cedars-Sinai physicians. False-positive rates for the alerts have been low, according to Weingarten.

Dr. Weingarten said that Cedars-Sinai made the decision to lead in this area both because it was the right thing to do to ensure that patients received the right care, and because it helped the system’s physicians respond to patient requests for services that will not benefit them.

“This is a dramatic change in the paradigm of how medicine is practiced,” said Daniel J. Stone, MD, Medical Director of Cedars-Sinai Medical Group and a primary care physician. “It is changing the medical record into a tool to assist physicians, and it will make a difference in the quality of care in people’s lives. You can look at it and see where the future is headed.”
Choosing Wisely Inspires Quality Improvement Initiatives at UCSF

September 4, 2014

Three years ago a team of residents and hospitalists at the University of California, San Francisco (UCSF) began thinking of ways to improve care across the institution. Led by then-resident Dr. Christopher Moriates, the High Value Care Committee set out to:

- raise awareness of the cost of health care;
- reduce unnecessary resource utilization;
- increase efficiency and patient throughput; and,
- create and support stewards of high-value, responsible health care in the Division of Hospital Medicine at UCSF.

"When the Society of Hospital Medicine [SHM] Choosing Wisely® list came out in early 2013 it fit in very well with what we were doing. We wanted to move from simply educating physicians about these concepts to operationalizing them into projects," said Dr. Moriates, Assistant Professor, UCSF School of Medicine and Co-Chair of the High Value Care Committee.

Staff at UCSF reviewed SHM’s recommendations and determined how well they performed in five areas. A review of baseline data revealed good performance related to some of the recommendations, such as avoiding urinary catheterization for non-critically ill patients. Other areas, such as unnecessary blood transfusions or continuous telemetry outside the ICU, were identified as opportunities for improvement.

Baseline data revealed that 30 percent of patients admitted to the hospital medicine service had blood transfusions when their hemoglobin level was above 8g/dl, despite increasing evidence that a strategy limiting most blood transfusions to lower hemoglobin levels is better for patients. To reduce unnecessary blood transfusions, the committee created a campaign for better Blood Utilization Stewardship.

http://www.choosingwisely.org/resources/updates-from-the-field/choosing-wisely-inspires-quality-improvement-initiatives-at-ucsf/
The committee educated physicians about when transfusions are appropriate – using real case examples from their hospital and summaries of the current evidence – and provided regular feedback on blood utilization via a monthly newsletter to all staff. Over a 12-month period, the rate of blood transfusions given to patients with hemoglobin levels above 8g/dl decreased to well under 20 percent, and in several months had fallen below 10 percent.

Reducing unnecessary use of telemetry proved to be a more difficult area to define.

“We can all quibble about exactly how long people should be on telemetry, but it’s pretty hard to argue that someone should be on real-time cardiac monitoring one hour and then be at home relaxing the next. That just doesn’t make sense,” said Dr. Moriates.

SHM’s Choosing Wisely recommendation states, “Don’t order continuous telemetry monitoring outside of the ICU without using a protocol that governs continuation.” Baseline data revealed 44 percent of patients admitted to the hospital medicine service at UCSF for more than 48 hours were on telemetry until they were discharged.

Led by hospitalist Dr. Nader Najafi, resident champions were enlisted to create and disseminate materials among their colleagues explaining the initiative and how decreasing telemetry usage benefitted patients. Similar to the Blood Utilization Stewardship campaign, clinicians received monthly reports showing rates of telemetry and how the institution was performing as a whole. After implementing the initiative, rates consistently fell below 30 percent.

“We’re continuing to work on systems solutions. For both telemetry and transfusions we have changes to our electronic ordering system that we’ve proposed that will help support the improvements that we have seen with our educational and data feedback campaigns,” said Dr. Moriates. “So we teach our clinicians why they should be doing it, we teach them how to do it, and then we need to create systems that support that work.”

Beyond the tangible metrics of reducing unnecessary interventions, the committee’s work and the Choosing Wisely campaign have inspired others to think about new ways to improve patient care.

A new campus-wide program called Caring Wisely, also led by Dr. Moriates, supports front-line clinicians in creating their own health care value improvement projects by providing funding and resources. For example, a group of surgeons is leading a price-transparency initiative and standardization of operating room supply lists, while in the emergency department work is being done on decision support tools for physicians in decreasing unnecessary CT scans.

“What started as a personal mission amongst a few of us has now become a movement. When we had our first meeting of this academic year, the room was full with resident physicians, fellows and faculty members that brought their own ideas of projects they wanted to drive forward. By far
the biggest metric of our success is seeing the enthusiasm coming forward from other clinicians," said Dr. Moriates.
Charting a Fifty Percent Drop in Antibiotics Use

March 5, 2015

In 2011, staff at Virginia Mason Medical Center in Washington state discovered they had a problem with antibiotic overuse.

Spurred by performance below the community standard in avoiding antibiotics for acute bronchitis, as reported by the Washington Health Alliance’s Community Checkup quality improvement initiative, the Virginia Mason Department of Primary Care examined how often antibiotics were being prescribed for acute bronchitis. As acute bronchitis is a viral illness in healthy adults, it should rarely require treatment with antibiotics. Several specialty societies also have identified overuse of antibiotics as a topic that requires discussion between doctors and patients as part of the Choosing Wisely® campaign.

When a review of primary care department claims data showed that antibiotics were being inappropriately prescribed for 82 percent of acute bronchitis cases, doctors began working to decrease that rate through the Virginia Mason Production System, a quality improvement framework.

The department conducted chart reviews based on billing codes for 2011 and 2012. Chart notes revealed that azithromycin, an antibiotic known as Z-Pak, was the predominant antibiotic used to treat acute bronchitis in healthy adults. Pharmacy claims data confirmed that the Z-Pak was used for little else other than acute respiratory infections. The quality improvement team then used orders for Z-Pak as a marker for a likely case of inappropriate treatment of a viral disease with antibiotics.
Virginia Mason expanded its chart reviews to report on a cluster of antibiotics and diagnoses for upper respiratory conditions, suspecting broader misuse of antibiotics and shifting diagnosis codes use by providers. This helped establish prescribing patterns for each primary care provider for upper respiratory infections, cough, sinusitis and acute bronchitis.

"I would urge everyone to do chart analysis," said Kim Pittenger, Director of Primary Care Quality Improvement at Virginia Mason. "It was amazing how prevalent antibiotic overuse was. Providers wanted to do the right thing. It created a competitive race to change."

As Virginia Mason studied antibiotic overuse, specialty societies released recommendations related to antibiotics as part of the Choosing Wisely campaign. The following were relevant to Virginia Mason's work:

- **American Academy of Family Physicians:** Don’t routinely prescribe antibiotics for acute mild-to-moderate sinusitis unless symptoms last for seven or more days, or symptoms worsen after initial clinical improvement.
- **American Academy of Allergy, Asthma & Immunology:** Don’t order sinus computed tomography (CT) or indiscriminately prescribe antibiotics for uncomplicated acute rhinosinusitis.
- **American Academy of Pediatrics:** Antibiotics should not be used for apparent viral respiratory illnesses (sinusitis, pharyngitis, bronchitis).

Staff also studied antibiotic prescribing patterns by mapping processes of care. The analysis revealed that doctor visits for upper respiratory infections were correlated with the patient being prescribed antibiotics. As a solution, Virginia Mason developed a phone protocol that connected patients requesting appointments for acute respiratory symptoms to nurses, who helped manage symptoms without an office visit.

About six months into the intervention, the team saw increases in patients accepting phone care from the nurse and a reduction in acute respiratory visits in the largest primary care practice. This freed up doctors to treat people with more serious or chronic conditions.

Providers and medical assistants at Virginia Mason also use an electronic medical record (EMR) visit note template for upper respiratory infections. Developed by a team of physicians who systematically reviewed the evidence for the diagnosis and management of acute respiratory illnesses, the note template includes a series of symptom-based checkboxes and various built-in evidence-based recommendations, such as appropriate criteria for diagnosing and treating acute bacterial sinusitis.
“We call that mistake-proofing,” said Norris Kamo, MD, a physician at Virginia Mason Medical Center and member of this team. “To change physician behavior is easier when you change the behavior of those around them, including nurses and medical assistants.”

Last July, Virginia Mason reported that its interventions helped reduce prescriptions for antibiotics commonly prescribed for upper respiratory conditions by more than half—from 41.8 percent in 2011 to 18.6 percent in 2014.

Dr. Pittenger said the interventions were successful because Virginia Mason used a process improvement infrastructure that was already in place and that physicians were familiar with.

“We were also successful because physicians were willing to share information in order to be transparent and honest,” he said.
Swedish Medical Center
Rethinking the practice of ordering daily labs to reduce waste and improve care.

BACKGROUND
Founded in 1910, Dr. Nils Johanson, a surgeon and Swedish immigrant, started Swedish Hospital to provide a modern facility in an era when even simple practices like sterilization were not commonly used. Today, Swedish Medical Center has five hospitals that are part of seven campuses located in Seattle, Edmonds, First Hill, Issaquah, Everett and Redmond. In 2011, Swedish and Providence Health & Services affiliated and Swedish is now part of Providence’s 34 hospitals and 475 clinics located in California, Oregon, Washington, Alaska and Montana.

Health care costs are skyrocketing and up to a third of health care costs are believed to be unnecessary. Sometimes the drivers of health care costs are big, expensive procedures where a single episode carries a big price tag. And sometimes many common, less expensive tests drive cost through volume rather than individual unit cost. Nationally, the Choosing Wisely campaign, sponsored by the American Board of Internal Medicine (ABIM) Foundation, has asked medical societies to look within their specialty fields and provide evidence-based recommendations that address appropriate care. To date, there are over 300 recommendations from over 60 medical societies.

PROBLEM
Dr. Adam Corson is part of Swedish’s team of over 50 hospitalists that currently rotate between four hospitals. Familiar with the Society of Hospital Medicine’s Choosing Wisely recommendations and personally wanting to demonstrate value of hospitalists in improving care, Dr. Corson began by looking into the data to identify potential opportunities for improvement within Swedish. The preliminary results pointed to a glaring issue which had both high rates and a relatively easy solution—daily labs.

What are daily labs? During a hospital stay, a provider can either order lab tests after each evaluation of a patient or schedule tests to be automatically done every day that the patient is in the hospital. The practice of pre-ordering tests, or daily

1 Health Policy Brief: Reducing Waste in Health Care, Health Affairs, December 2012.
labs, is addressed by Choosing Wisely recommendations from two specialty societies that look at how tests are ordered. The recommendations, suggest ordering tests that are clinically relevant versus having them automatically done every day. In fact, some facilities do not have a pre-ordered “daily” option anymore or are reconsidering the practice.\(^2,3\)

**SOLUTION**

In August 2013, Dr. Corson began by emailing the hospitalist team data about who was ordering daily labs. He then provided educational resources and two simple recommendations: 1) Don’t order a test more than 24 hours out, and 2) Don’t order labs at regular intervals, such as daily. In addition to the group email, personal emails were sent to the providers who had particularly high rates. Following the initial communications, updated data was provided regularly and was also made transparent, so everyone on the team could see each other’s results and progress.

**RESULTS**

As seen in figure one, the Swedish hospitalist team’s remarkable efforts to reduce the number of daily labs ordered can be seen in the six-month timeframe after the August intervention, September 2013 to February 2014, compared to the same time period before the intervention, September 2013 to February 2014. In addition, when looking at all ordered labs, the intervention resulted in approximately 25 percent fewer labs ordered overall, which equates to approximately 14,000 fewer tests annually. When looking at labs ordered as daily, the results found an 80 percent decrease in daily labs ordered, originally 30 percent of all labs were ordered as daily and now daily labs only represent six percent of all labs ordered. Depending on how you calculate the costs of lab tests, this is estimated as $160,000–$200,000 in annual savings.

Figure 1. Results from Swedish’s hospitalist team effort to reduce unnecessary daily lab ordering across four hospitals, comparing before the intervention (September 2012–February 2013) to after the intervention (September 2013–February 2014).

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\(^2\) Reducing Unnecessary Inpatient Laboratory Testing in a Teaching Hospital, American Journal of Clinical Pathology, August 2006.

\(^3\) Impact of Peer Management on Test-Ordering Behavior, Annals of Internal Medicine, August 2004.
RESULTS, CONT’D
This effort improves patient safety giving fewer opportunities for medical errors or false positives, while also improving the experience of care for the patient from less “pokes” and disruptions. It also decreases the cost of care for the patient—with approximately 12% fewer lab tests ordered per admission.

CHALLENGES
How do you learn from change and sustain it? This is something that Dr. Corson and Dr. Christopher Dale, Medical Director at Swedish and member of Washington State Choosing Wisely Task Force are grappling with. Can the same strategy be applied to other departments and to other Choosing Wisely recommendations?

Key steps in the successful process:
1) Let objective data guide the focus areas.
2) Educate providers on the clinical evidence and why it’s important.
3) Personally communicate with outliers.
4) Plan regular and transparent audit and feedback steps to track progress.

KEYS TO SUCCESS
• Culture of improvement: The hospitalist team was used to working on improvement projects together, so bringing on another improvement initiative was readily embraced and supported.

• Supportive IT department: Without the timely and responsive support of the IT department, this project may not have been possible. Rather than waiting in a long queue, the IT department collaborated to get the best data to inform the project throughout the process.

• Tenacity: A unique feature is that Dr. Corson was not directly charged to initiate a quality improvement project but rather it came from his personal desire to demonstrate his team’s value. He successfully followed through in answering his own question of “how can we improve?” and in doing so demonstrated that sometimes big impacts can come from small changes—such as rethinking how labs are ordered.

ABOUT THE ALLIANCE
The Washington Health Alliance brings together those who give, get and pay for health care to create a high-quality, affordable system for the people of Washington state. The Alliance is a nonprofit, nonpartisan organization that shares the most reliable data on health care quality and value in the state to help providers, patients, employers and union trusts make better decisions about health care. Through innovative strategies and initiatives, we help the entire health care system—from exam room to board room—focus on improving quality and value. We are committed to being the catalyst for change for the health care system in Washington. The Alliance is one of 16 organizations that are part of the Robert Wood Johnson Foundation’s Aligning Forces for Quality (AF4Q) initiative.

www.wahealthalliance.org | www.wacommunitycheckup.org
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About the Foundation
The California HealthCare Foundation (CHCF) works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit www.chcf.org.

About California Improvement Network
The California Improvement Network (CIN) is a community of health care professionals sharing techniques to improve the patient experience and the health of populations while lowering the cost of care.

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Introduction

This guide is a collection of lessons from experts in the field — clinicians and organizational staff members who have addressed practice and practitioner variation within their own organizations. This guide is intended to help organizations get started in their work to identify and reduce unwarranted variations in care.

Action Groups Background

Recognizing the historically slow diffusion of innovation within the health care provider community, the California HealthCare Foundation established the California Improvement Network (CIN) to bring public and private health care organizations together to share good, better, and best practices in chronic disease care. CIN’s webinars, workshops, and quarterly meetings are focused on techniques to improve the patient experience and the health of populations while lowering the cost of health care.

CIN’s action groups are made up of individuals interested in collaborating to solve specific care improvement challenges. These small groups allow participants to have deep discussions and share case studies, best practices, and suggested resources and tools with one another. Between meetings, action group members can network with one another and gain access to field experts as needed. The aim is for the group’s participants to develop and enact solutions within their organizations while sharing what they learn along the way with colleagues from other organizations. The intent is to share lessons learned broadly with the California practice community.

CIN’s first action group focused on variations in care. Group participants were actively involved in identifying and reducing unwarranted variations in care in health care organizations in California. Participants met monthly via a facilitated conference call between September 2013 and March 2014. They also met in a one-day face-to-face session to help construct this guide — an overview of the thoughtful, practical exploration of variations in care work conducted by the group. Individual participants are listed as authors, and a description of sponsoring organizations is provided in Appendix A. Resources and tools recommended by the group are included in Appendix B.

Make the Case

Variation in care is defined as the spectrum of approaches used by a defined group of practitioners to address a specific medical condition. These approaches broadly include deciding whether and how to implement an evaluation or treatment such as a lab test, procedure, medication, or medical device; choosing where to deliver care; and deciding to refer a patient to a colleague.

The purpose of variation reduction is to determine the appropriate level of care and to ensure that all patients receive care that is needed — no more and no less. Addressing variations in care supports a triple bottom line — improved quality, increased efficiency, and a better patient experience.

Unnecessary variation in care causes a number of problems. Some practitioners may be underusing needed services, while others overuse unwarranted services. Practices on both ends of the spectrum result in a lower standard of care with significant cost consequences. Overusing an unnecessary service that does not improve health outcomes represents wasted dollars. An unnecessary service could result in a negative outcome, such as a false positive test result, complication of a procedure, or a hospital-acquired infection, subsequently worsening the patient’s health and increasing costs. Underuse, on the other hand, means that patients are being denied needed services, which could also lead to worse health outcomes and increased costs.

The purpose of variation reduction is to determine the appropriate level of care and to ensure that all patients receive care that is needed — no more and no less. Addressing variations in care supports a triple bottom line — improved quality, increased efficiency, and a better patient experience. Organizations will have different reasons for addressing variations in care and will seek outcomes specific to their work.

Working in Concert: A How-To Guide to Reducing Unwarranted Variations in Care 2
Addressing variation may be unfamiliar to organizational leaders, including executives, board members, and respected thought leaders in primary and specialty care. To gain the support of leadership so that they provide the resources necessary to make the variation reduction work possible, your team will need to set the stage. To ensure that leaders understand the purpose of addressing variation, your team will need to:

- **Explain how addressing variation aligns with your organization’s mission.** For example, reducing unnecessary back surgeries saves dollars and prevents potential adverse outcomes for patients.

- **Choose those areas of value to the organization to address first.** For its first project, one organization decided to improve the availability of decision support for practitioners. Proceeds from a project to reduce variation in prescribing branded proton pump inhibitors are now helping to fund additional decision support tools.

- **Start in the settings that are likely to be most successful.** For example, to ensure the greatest chance for success, for its first project, an organization targeted a specialty group with which it already had a productive working relationship.

- **Share evidence that connects the project to measurable quality and financial benefits.** This puts the needed investment in perspective. For example, for a project to reduce the frequency of spinal injections, one group highlighted recent literature demonstrating a lack of benefit of the procedure.

- **Align organizational goals with practitioner goals; motivate busy practitioners to spend time on a proposed project.** For example, to avoid overuse of upper gastrointestinal (GI) endoscopies (EGD), a procedure to view the GI tract, one organization reported rates of referral to gastroenterology for EGDs for patients with gastroesophageal reflux disease (GERD) and focused on educating practitioners about the American College of Physicians recommended indications for the procedure.

Physicians are some of the most effective proponents of addressing variation. As the passionate voice about doing what's best for the patient, clinicians can convince the organization’s CFOs and other senior leaders to fund variation reduction programs. These senior leaders in turn will advocate for active participation from practitioners throughout the organization.

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**Examples of Variation Reduction Projects**

This is a list of selected variation reduction projects for which a standard of care was developed based on evidence and clinical input and that have led to savings at the Palo Alto Medical Foundation. The projects addressed variation in:

- Number of skin tests in the evaluation of allergic rhinitis
- Use of nasal endoscopy for the evaluation of chronic sinusitis
- Interval between initial normal colonoscopy and follow-up colonoscopy
- Time interval for pap smear for cervical cancer screening
- Criteria for patients who receive immunomodulating medications for multiple sclerosis
- Use of G-CSF (granulocyte-colony stimulating factor) in the treatment of patients with stage II breast cancer
- Use of red cell stimulators to treat anemia in patients with end-stage renal disease
- Number of epidural injections for low back pain
- Size of ureteral stones treated by lithotripsy
- Laboratory monitoring intervals in patients receiving nonbiologic disease-modifying antirheumatic drugs (DMARDs)

Source: Palo Alto Medical Foundation variation reduction team.
Create a Core Team

At the heart of any effort to address variation in care is a dedicated core team of content experts, facilitators, and support staff. This team crafts the approach for engaging leadership and providers, and for securing their support either directly or behind the scenes via champions. From there, the core team identifies areas within the organization that are good candidates for variation reduction work, initiates conversations with leaders in these areas, and provides the counsel and logistical support for the physicians engaged in variation conversations.

Core team members are responsible for creating a blame-free environment that supports a diversity of opinion, respect for the involvement of multiple disciplines, and a commitment to quality improvement — the infrastructure for success.

Involve the Right People

Members of the core team should understand the value of addressing variation and be able to articulate this to organizational leaders. Team members must also be able to provide on-the-ground support to participating physicians and other staff.

The core team may include the following roles:

► Program director to lead the strategy for leadership engagement, physician recruitment, and communication with organizational leadership.

► Facilitator to manage the conversations and meetings with departments. A program director may also serve in this role. The facilitator ensures that the core values of the project are incorporated into project work, and addresses process issues within and outside the group with the project manager.

► Project manager to provide administrative support, track schedules and project plans, and manage meeting logistics.

► Champion to promote group’s principles and recommendations to practitioners. A respected leader from the targeted specialty group or department, this person attends selected meetings.

► Analytics staff member to help create reports, help define specifications for analytics, and respond to data requests from the team and from practitioners.

The time commitment for each role and the number of individuals serving in these roles will change over time as the program grows.

Establish Team Communication

Ground Rules

As the heart of the effort in an organization, members of the core team should:

► Use a bottom-up approach that values the input of people from all levels of the organization.

► Speak with a unified voice to leadership and physician participants.

► Maintain open communications with other teams within the organization.

► Provide honest, constructive feedback.

► Avoid judgmental terms like “outlier” and “extreme.”

Provide Support to the Core Team

► Offer ways for core team members to learn while they are participating. For example, analytics staff members may be interested in hearing patient perspectives, even though this is not a usual part of their work. A medical director may want to be more involved in data analysis. Encouraging team members to learn new skills and explore new approaches can help increase motivation and enthusiasm for the work.

► Invite an experienced facilitator to provide support to the core team. Mentors skilled in facilitation and communication can train core team members in how to react to practitioners’ emotions and how to respond nonjudgmentally to practitioners’ questions and concerns. An outside perspective can offer new insights into tough situations.
When the Sutter Health network launched its system-wide variation reduction program in 2007, the network asked a well-respected clinician and trained facilitator within the organization to lead the program.

**Accountable and collaborative team members**

After experimenting with varying models, we learned that a successful variation reduction program requires one accountable leader and depending upon the size of the program, one to several team members with very specific skills:

- **Data analytics expert.** Sutter Health relies on the unique skills of these vital staff members who understand SQL coding and how to operate large data sets.

- **Project manager.** With equally strong data analysis skills, dedicated project managers act as the glue between practicing clinicians and the raw data collected by data analytics experts.

- **Trained coach/facilitator.** Specially trained facilitators collaborate with practicing clinicians and efficiently guide them through the data analysis process so that variation reduction projects are identified and launched.

**A black belt in facilitation**

Sutter Health credits part of the success of its program to structured and facilitated group meetings with physicians. Always held in person, initial meetings bring together doctors interested in variation reduction work by the specialty so they can partner on common projects of interest. Over time, as groups become more comfortable with the work, our variation reduction team members participate in joint department meetings to address potential projects that cross specialties. For example, ob/gyn and family medicine clinicians came together to explore data and to have a discussion regarding cervical cancer screening and together, reached variation reduction standards.

Over the years, Sutter has learned that a skilled and trained facilitator is most successful addressing variation reduction during department meetings. An effective facilitator gains interest and engagement from potentially ambivalent physicians. For example, a skeptical physician may say to a facilitator, “All you care about is money.” The appropriate response by a facilitator would be to ask, “What does the rest of the group think of that?” Effective facilitators learn to steer the conversation away from themselves and toward the goals of the group. The facilitator also ensures that clinicians identify and start a specific variation reduction project.

In Sutter Health’s current model, three trained facilitators travel across the network to facilitate variation reduction meetings.

**Recruiting clinician project leads**

Recruitment of and collaboration with clinician project leads is another important ingredient to a successful variation reduction program.

To prepare for an initial meeting with clinicians, members from our variation reduction team work closely with a lead, typically a department chair or another key clinician leader, to explore nuances in care practice. For example, we will ask the following questions:

- Where do you think there is variation?
- Why are we seeing these codes in the data?
- What are alternatives to those drugs?

Sutter Health has successfully established relationships with clinician leaders across multiple specialties and disparate geographic locations as project leads because this role requires minimal time but brings great reward.

**Building skills and improving the team**

Sutter Health looks for continued opportunities to grow and improve its variation reduction program. The team debriefs after every meeting to provide feedback to each other, and asks for comments from practicing clinicians to further improve the model and process.

What makes our team gel are the project managers that manage our variation reduction process from start to finish. While they may not have clinical training, each manager has worked in the health care environment in an analytic capacity. Our project managers take volumes of raw data and make sense of it. They coordinate meetings and collaborate directly with the practicing clinicians as well as with our analysts.

Over my career, I have been able to participate in courses from the Institute for Healthcare Improvement, and in various trainings specific to group facilitation, leadership, and communication. But it all comes down to the same things: respectfully bringing stakeholders together, managing people’s expectations with honesty, and being able to effectively communicate. As the facilitator, it is never about me. It’s easy when it becomes about the patient. We are very lucky to spend every day trying to make this a better place.
Work with Clinicians

A bottom-up, physician-led approach is key to creating a robust, meaningful, and sustainable variation reduction effort. A clinician’s motivation to participate is strongly influenced by the degree to which the clinician feels involved in selecting areas on which to focus attention, the provision of accurate peer-comparison data, and the freedom to develop approaches to improve outcomes. The more clinicians are told what to do and how to do it, the less interested and invested they will be in the process and results. Successful approaches to working with clinicians stay true to the values of transparency, respect, and autonomy.

For example, after being shown data that demonstrated significant variation in the selection of noninvasive cardiac tests, a group of cardiologists chose to make this an area of focus. The specialists met to decide what the standard of care should be and how best to encourage those care decisions among their peers. They were eager to see the three-, six-, and nine-month post-intervention utilization data. If this group had been directed to order one type of test over another, they would likely not have responded as favorably.

Conduct Initial Outreach Thoughtfully

- **When first contacting a department, service line, practice, or individual physician, do it in person.** Face-to-face meetings allow you to establish relationships and address initial concerns in a more intimate setting than an initial large group meeting.
- **Invite all team members to participate** in the initial meeting. Opening the group meeting to all practice staff sends the message that the process is not intended to be confrontational, and is intended to be collaborative, respectful, and collegial.
- **Meet at the practice site** rather than having clinicians come to you.
- **Send organizational information** about the purpose of the variation reduction program in advance of the meeting.
- **Bring food.** This goodwill offering helps break down barriers and sets a collegial tone for meetings.

Give Physicians Reasons to Participate

- **Physicians often do not have access to data** on the quality and frequency of the services they provide, and they rarely have access to specific information about their own practice patterns. Having this personalized, comparative information neutrally presented is often incentive enough for many physicians to participate in variation reduction efforts and to change their behaviors.
- **Many physicians appreciate the professional collegiality** and the chance to talk about how to approach specific cases that this work offers.
- **Many physicians appreciate the opportunity to define their own standards of care**, which can be tailored to their specific situations while incorporating national guidelines and the supporting evidence base.
- **Financial incentives that support appropriate care decisions reinforce the organization’s commitment to delivering high quality, affordable care.** Examples of successful financial include sharing in savings achieved, payments for hitting targets, payments for active participation in committees, and yearly increases tied to achievement of targets. These incentives should always be presented in the context of doing the right thing for patients.

Let Physicians Reach Their Own Conclusions

- **Simply distributing variation charts among physicians can be enough to stimulate physicians to change.**
- **Present the variation data to a physician and ask, “What is your reaction?”**
- **Wait for the practitioners to discuss what they can, might, or should do, or what others are using as indications for the service in question.**
- **Encourage physicians to share their variation data with others and discuss differences in approaches.**

Address Concerns

Physicians may have concerns about discussing variation at first. Anticipate those concerns and be prepared to address them. (See Table 1.)
**Table 1. Addressing Physician’s Concerns about Variation Reduction Work**

<table>
<thead>
<tr>
<th>Concern</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is just about reducing cost.</td>
<td>Variation reduction is about care: providing the most appropriate care, improving care for all patients, and making care more affordable. (If the variation reduction work is portrayed as being about cost alone, physicians may reject the approach because of the possibility that quality could decrease.)</td>
</tr>
<tr>
<td>This is one more task taking me away from patient time.</td>
<td>This investment of time will result in more appropriate and improved care for patients and our success as an organization. Let’s talk about how the work can be done differently in the same amount of time.</td>
</tr>
<tr>
<td>The process will lower my income.</td>
<td>With the provision of more efficient and appropriate care, we will spend less on unnecessary services which will ultimately save patients and the organization money — savings that can be shared with providers and staff.</td>
</tr>
<tr>
<td>The data might be inaccurate or make me look bad.</td>
<td>The data are for discussion purposes only. They will help stimulate discussion about finding the most effective, efficient ways to practice, and ultimately help promote quality improvement. The data are presented to encourage reflection about the necessity of each clinical decision. We evaluate the behavior, not the clinician.</td>
</tr>
<tr>
<td>Waiting until reimbursement rules change is better than starting now.</td>
<td>Payment reform is coming. Acting now will give us the time to craft thoughtful responses so that when changes come, the group will be able to maximize value from the start.</td>
</tr>
<tr>
<td>I just want to do what’s best for my patients. I’m doing everything I can already.</td>
<td>These conversations inject comparative data into everyone’s assessment of what they do. The goal is to help everyone learn from each other and to improve the entire team’s performance.</td>
</tr>
</tbody>
</table>

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**Case Study**  
— Michael van Duren, vice president of clinical transformation, Sutter Medical Network

**Start from the bottom up**

At Sutter Health, a variation reduction project begins when a group of clinicians in a medical practice shows interest in the concept of variation reduction and invites the variation reduction team to their meeting. In the early days, this was a voluntary process, where we waited for invitations from groups who had heard about this work through word of mouth. We also started telling stories about the work at larger, all-group meetings and would end the presentation with a request for invitations to come to local groups. But now that the work is more established, the leaders have set the expectation that all practices should be participating.

**The first meeting**

The unique culture of each medical practice helps dictate the structure of the first group meeting. Our trained facilitators may approach the meeting in a variety of ways.

- **A blank slate.** Facilitators ask, “What do you need? What are you interested in? Let’s go exploring with the data.” This approach may not result in a specific project after one 45-minute meeting. Facilitators may then attend subsequent department meetings to further engage physicians and help them identify a variation reduction project. This approach typically works best among practices that meet monthly.

- **A guided tour.** For departments that meet once a quarter or every six months, a trained facilitator must make the most of the meeting time. In those cases, we will ask the department chair for suggestions on where to begin, or if someone in the department can help identify areas of opportunity. In this second approach, we bring a menu of several suggestions, as well as examples of what other groups have worked on. However, the emphasis is still on the autonomy of the local group, and we emphasize that they are free to work on anything they choose.

We approach first meetings with no set agenda but with data, which have been prepared by the team’s data analytics expert and project manager or both, that help stimulate conversation. We have found that conversation led by the physician participants results in stronger engagement, greater collaboration, and more successful projects. Trained facilitators are vital to this process—they guide discussion around what the physicians want to talk about.

For example, a group of urgent care doctors, who were familiar with Sutter Health’s variation reduction work, requested a meeting with the variation reduction team. We first consulted with the urgent care doctor in charge of quality, who suggested that the group focus on urinary tract infections (UTIs) and the ordering of cultures. However, when our variation reduction team collected and reviewed the data on UTIs, there just wasn’t significant variation and so not much of...
an opportunity to improve quality or reduce costs. The team decided to instead prepare a half-dozen other topics, where data showed more variation and opportunity for improvement. At the first meeting, the team showed the group data on UTIs and also asked for permission to review the other topics. The doctors agreed, and Sutter's trained facilitator asked the group to identify which topics were most important to them.

The group decided to work on abdominal pain. Each doctor had at least 300 cases, and the data showed a five-fold variation in costs. Among the biggest drivers of variation was the ordering of CT scans. The data showed that one doctor ordered CT scans for patients with abdominal pain 35% of the time, most doctors ordered CT scans at a rate of 10%-15%, and a few doctors ordered CT scans as low as 1%-2% of the time. The doctors at the low end of the spectrum had as many patients as the doctors at the high end.

Unblinded data
During the meeting, the facilitator projected a graph visualizing this variation and waited for the group of physicians to react. The graph included doctors’ names, and they had powerful reactions to the displayed data. There is the potential for doctors at the extreme ends of the spectrum to feel disappointed, angry, attacked, or criticized, but Sutter's trained facilitators sensitively helped physicians work through their strong emotions and guided the group in an important conversation about how to change this variation by changing physician behavior.

Sutter Health has learned that unblinding data, or attaching names to the data, is necessary to reducing variation in care, as this transparency helps drive changes in behavior. If a group cannot accept unblinded data, then they are not ready for the concept of variation reduction.

We assure doctors that the data shared at these meetings are confidential — they won't be shared with the public or go into a physician file or be shared with an administrator. The data are only displayed for this group to stimulate discussion.

Setting the tone of the meeting
Physicians often have varying levels of knowledge about variation reduction. To help ensure effective conversation, our team may begin a meeting by asking, “You’ve heard about variation reduction. You’ve heard that it’s about data and comparing people to each other. Let’s pause right there and go around the room and share not what you think about that, but what your gut is telling you right now.” We might say, “This is not your typical business meeting. The whole process is very emotional, and I want to create a safe space to talk.”

Usually, at least one physician will raise objections such as, “You only care about money. You are trying to force us into standard practice.” We will use this opportunity to guide a discussion about the physicians’ goals with variation reduction and how the information offered in the meeting can help achieve the group’s collective goals. Facilitators will assure doctors that the variation reduction process is rooted in respect for the art of medicine and the physicians’ medical judgment about patient care quality.

Learning from each other
When unblinded data are shared with a group of doctors at the first meeting, the facilitator typically starts by asking physicians on the low end of the spectrum about how they practice.

Using the earlier example of urgent care doctors ordering CT scans for patients experiencing abdominal pain, the facilitator may say, “It looks like you only use CT scans 1% of the time. How do you manage that?” These doctors may even worry about the infrequency of their use of these treatments. So a good follow-up question might be: “Do some of your patients end up in the ER with a ruptured appendix?” If the doctors answer no, then the response stimulates group conversation. Doctors may ask each other: “How do you manage to order so few CT scans? What is the acuity of your patients?” Ultimately, our variation reduction team hopes that the group will acknowledge that the data show opportunity for improvement and declare the topic a variation reduction project.

Getting results
Successful variation reduction projects hinge on collaborative conversations among doctors. While physicians often consult with each other about complicated cases, they do not typically discuss more common care practices. By creating a safe place to share unblinded data, our team helps doctors learn from each other in a collegial setting. Through facilitated discussion, doctors identify ways to change behavior to reduce variation in care practices.

Change happens quickly when doctors partner on variation reduction projects. For example, one of our urgent care doctors, who ordered large numbers of CT scans for patients experiencing abdominal pain, immediately reduced his use following a meeting during which unblinded data were shared. Even physicians with average use of CT scans ordered fewer scans.

At Sutter Health, we share performance measures monthly with doctors working on variation reduction projects. Physicians use the data to continually reduce care variation.
Facilitate Effective Meetings

Thoughtful meeting facilitation helps create a safe space for physicians and other clinical staff to discuss their role in variation reduction. The facilitator’s role is to keep the meeting participants focused on the data, stimulate a discussion on why the differences exist, and move the group to a decision on an aspect of their practice that would benefit from appropriate variation reduction.

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When meeting with practitioners, anticipate one meeting to introduce the variation work, a second meeting to address concerns and to offer assistance in making changes, and follow-up visits to share data until meaningful change in behavior has occurred and is maintained. The intermediate outcome for these meetings is the creation of a plan to change behavior. The long-term goal is to review results and celebrate improvement.

Establish Trust at the Start

Create a safe space.

Establishing an atmosphere of trust and participant collaboration is essential. If participants feel compelled to defend their reputation and decisions, they will not be able to participate meaningfully. Facilitators can create a respectful, nonjudgmental meeting environment by using the following tactics:

▸ Meet in person the first time the group comes together — trust is more easily achieved face-to-face.

▸ Set ground rules to promote honest discussion about why practitioner behavior differs. For example: “No assumptions about reasons for observed behaviors.”

▸ Avoid using words like “outlier,” “bad,” and “wrong,” which may make participants feel judged and defensive.

▸ Establish a level of discomfort that is “just right” to drive change. The facilitator should be comfortable with participant discomfort, which can be introduced by asking questions like, “Why do you think there is so much variation between physicians?”

▸ Wait for participants to respond to hard, provocative questions. Quietly waiting for a response heightens discomfort without judgment.

▸ Keep meetings collegial by incorporating personal stories and examples.

▸ Bring food to meetings to help create a comfortable, nurturing atmosphere.

Make sure meetings make good use of participants’ time.

▸ Prepare an agenda, share it ahead of the meeting, and stick to it.

▸ Plan meetings so that they last no longer than 45 minutes, and schedule them during times that are convenient to busy physicians — for example, before practice starts, during lunch, or after practice ends.

▸ Debrief with participants at the end of the meeting. Ask participants to share what went well and what could have gone better. Either ask for volunteers, or go around the room and ask everyone to say one thing.

Create meeting environments that encourage interaction.

▸ Arrange rooms to minimize physical barriers to communicating openly.

▸ Begin by checking in — ask everyone how they are doing and if there is anything they would like to share before beginning. This process helps build rapport and trust within the group, demonstrates interest in participants as people, and gives participants the chance to mention something important to them, either positive or negative, that might cause their behavior to be misinterpreted.

▸ Demonstrate that conversations are to stimulate curiosity and collaboration by listening carefully to practitioner’s responses to questions, summarizing what they said, and asking them to expand on their suggestion so you can fully understand their perspective.
Meeting facilitation is part art and part skill. We teach our facilitators the skills. We use a relatively regimented training process that involves role playing and coaching. Facilitators learn to prepare for meetings by researching participants. We have facilitators look at photos and do background research to familiarize themselves with participants before the first meeting. The art of facilitation comes from experience.

Initiating work and communication challenges
The first meetings with any specialty group require a good understanding of how communication happens within the organization. Our organization is very flat—not hierarchical. We are made up of four medical specialty groups that merged over seven years. Decisions are made by consensus across 1,000 physicians. That makes it very challenging to start a new program. There isn’t one central person who disseminates information to everyone else. On top of this, physicians communicate by different methods: email, staff messages in the electronic health record, voicemail, and word of mouth. We’ve found it impossible to use only one way to disseminate information.

We faced these communications challenges when we started working with our obstetricians and gynecologists, who are located at different sites throughout all of our regions. In the beginning, I was driving hundreds of miles to every site to talk with them. Eventually, we devised a simple solution. We held regional meetings that everyone would attend three times a year. From that large meeting, the obstetricians and gynecologists developed committees to work with us on variation reduction and to be responsible for disseminating information to the rest of their peers.

Handling resistance
The first meetings can be sticky. You may have to address resistance. Because we are driven by fee-for-service, many people will question how variation reduction work will affect their bottom line. Even though they support affordability and quality, they have underlying doubts.

When I started working with one department, I introduced the idea of affordability and how it was affecting our accountable care organization contract negotiations. I didn’t foresee how inflammatory this would be. The doctors erupted in anger, and one stormed out of the room. They said, “We’re not going to let insurance companies tell us how to practice!”

Groups go through an engagement cycle. They can be very resistant at the beginning. They don’t want to talk about transparency, practice patterns, or charges. They are very self-conscious and afraid to examine their own costs.

That group ended up working on variation reduction on their own. They discussed the issues that had initially made them so uncomfortable, but they did it in private. Now that they are going to be held responsible for quality metrics by the Centers for Medicare & Medicaid Services, they realize that they need to learn how to become transparent about their pricing and charges, and about the contracting process.

Evolution from first meeting
When we started working with the urology group, they were very cooperative, and they liked getting together. They were suspicious of the data, though. When I showed the group their data on transurethral resection of the prostate (TURP, a common procedure), their response was: “The data are wrong. Look at Dr. X, he’s got a little bar up there, but we know he’s the busiest.” The data were sent to Dr. X, we had a discussion about how he was coding differently, and we revised the data. Physicians sometimes have a workaround, and you have to communicate with them to figure that out.

This group has gone from allowing us only 20 minutes on their meeting agendas, to now spending whole meetings on variation reduction. At one meeting, they had a two-hour conversation about their data and came up with four standards. I just sat back and listened. At another meeting, they got into a controversial topic and couldn’t come to common ground. They turned to the variation reduction team and asked, “What are we supposed to do now?”

Our role as facilitators is to carry data to the meetings, to leave the meeting when they don’t need us, and to know when to step back in when facilitation is needed again.

Case Study
— Wendi Knapp, MD, hospitalist, Palo Alto Medical Foundation

I felt like I had failed as a facilitator. I had wanted them to understand that for us to keep and take care of our patients, we needed to be conscious of affordability and quality. It was a disastrous meeting. The physicians were so angry. I followed up with each one of them one-on-one. Interestingly, after the meeting, multiple people expressed their support. They said, “We have opportunities in affordability. I’m concerned about my friends who come to PAMF, and I want to be responsible with their resources.” I also realized that it wasn’t about me. It was just too soon for the group to start thinking about these things.

Groups go through an engagement cycle. They can be very resistant at the beginning. They don’t want to talk about transparency, practice patterns, or charges. They are very self-conscious and afraid to examine their own costs.

That group ended up working on variation reduction on their own. They discussed the issues that had initially made them so uncomfortable, but they did it in private. Now that they are going to be held responsible for quality metrics by the Centers for Medicare & Medicaid Services, they realize that they need to learn how to become transparent about their pricing and charges, and about the contracting process.
Keep Open Conversation Flowing

Seek facilitation training and mentorship as needed.

Facilitation is a skill. The ideal meeting facilitator is patient, nonjudgmental, and able to elicit conversation. The facilitator can be a staff member who is already skilled at facilitating and who is comfortable seeking help to be more effective. Facilitator tips include:

- Practice responding to anticipated questions.
- Base expectations on what is achievable. Have the group work on something easily achievable at first and establish success, even though you may prefer that the group dive into a more complicated topic.
- Research participant backgrounds and other relevant information before the first meeting to understand the makeup of the group.
- Consider meeting with team members individually before the team assembles to get a better sense of individual wants and needs, and to demonstrate an interest in participants as people.
- Refrain from using the authority of the chair to dominate communication when facilitating. This can be difficult for clinician facilitators. At least initially, bring along a colleague to observe your facilitation skills and offer feedback about what was successful and what could be improved.
- Consider facilitating as a pair (for example, clinician and QI/outreach staff member).

Use data as talking points.

- Use data to spark conversations, not dominate them. While physicians may question data, there is no need to be defensive when showing it. Remind participants that data are used to help discover areas where practice variation exists and to pave the way for understanding that variation. The goal is creating a common set of indications and contraindications together, and knowing where the baseline is serves as the first step.
- Ask for examples to humanize data. Ask participants: “Has a patient come to you about this?” Case studies and stories help personalize discussions and bring the data to life.
- Communicate visually by providing charts and illustrations that synthesize the data and make it easily understood. If physicians can see variations, it will be easier to broach topics with each other without the facilitator having to prompt the group.

When participants talk, the facilitator should be quiet.

Aha moments will occur naturally and will have more meaning if participants arrive at them on their own.

Use Data Judiciously

The purpose of data is to stimulate conversation about differences in practice patterns that might contribute to variation. Having physicians view the data, and learn about each other’s practice patterns from those within the organization, will facilitate the discovery that will ultimately lead to developing internal standards to which they will hold themselves accountable.

Don’t overwhelm participants with too many data charts. Bring only what’s necessary. The less you bring with you, the more you seem interested in understanding the practitioners’ perspectives about why they do what they do.

Be visual with the data.

- Create simple, easy-to-read graphs so physicians get the takeaways quickly.
- Tell a story with the data presentations.
- Make sure the visuals are self-explanatory. Conversation will be sparked quickly if the graphics don’t require explanation.

Physicians may be confrontational about the data . . . at first.

- Physicians may object to the data because they feel as if their reputation is at stake. Rather than defending the data, facilitate “no shame, no blame” conversations about what to do about what the data show.
- The data are not intended to judge the overall quality of a clinician’s care, but the clinician may see it that way. The data are meant to help the group focus on a specific behavior or decision the clinician is making.
- Note the resistance and ask, “Is this making you uncomfortable?” Or say, “I sense some defensiveness. We are looking at the data to focus on how we can more effectively take care of our patients.”
- Remind the physicians that the data are a tool to facilitate discovery.
- Reveal data at the same time to all practitioners so that they are reacting to it together.
- Address physicians’ concerns about the data (see Table 2):
Table 2. Addressing Physicians’ Concerns about the Data

<table>
<thead>
<tr>
<th>Concern</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data are inaccurate.</td>
<td>How can we make the data better? Be prepared to talk about the source of the data and how it was collected or manipulated.</td>
</tr>
<tr>
<td>These data aren’t real.</td>
<td>Share unblinded data with practitioner approval to stimulate sharing of best practices, but do not share data publicly outside of the meeting without agreement from the involved practitioners.</td>
</tr>
<tr>
<td>The data might be inaccurate or make them look bad.</td>
<td>These data are not shared outside of the group and are presented for the purpose of discovery, learning, and continuous improvement. We won’t use the data for incentives until we are confident of their accuracy and validity, and until you have time to respond to the data.</td>
</tr>
</tbody>
</table>

Strike a balance between standardization and flexibility.

Avoid spending time on specific cases that don’t fit the appropriateness criteria. Focus instead on the percentage of all cases that receive the service in question. For example, a practitioner might bring up a case where it was felt that spinal injections were believed to be the most appropriate treatment. The fact that 60% of this practitioner’s patients receive these injections, far more than most referring PCPs, should be the focus of the conversation. Focus on consistent patterns that suggest overuse rather than discuss uncommon cases for which the service was appropriate.

► Data are never perfect, but it is important that attribution at the provider level is as robust as possible and that definitions are shared.

► Physicians may ask for data to be manipulated in a certain way. Acknowledge then explore the request. If the request proves to be too time-consuming, share what would be involved to get the answer, and ask if the data are good enough to continue the conversation.

► Explain that the recommendations are not intended to fit all patients but should fit most. There are always appropriate clinical exceptions—patients who require the service in question; that is why the clinician is so important. The target is not 100% adherence to the recommendations.

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Case Study
—— Christine Castano, MD, medical director of utilization management, HealthCare Partners Medical Group

At HealthCare Partners we have a long tradition of sharing performance metrics. For example, we conduct quarterly patient satisfaction surveys, and every provider’s results are presented for all to see. This approach can work well with some groups to drive variation reduction, but in other specialty groups, neither the data nor the culture will support this kind of work.

We use Optum’s ETG (Episode of Treatment Group) tool to support our variation reduction efforts. This tool combines related services for a given diagnosis then assigns the total cost to an attributed managing physician. All of the services a patient got for her rheumatoid arthritis, for example, are included: she was on medications, went to the physical therapist, had labs done, had so many office visits, and needed a cane and a power wheelchair. You start to get a better picture of overall costs at the patient level for an episode of care.

Transparency
Rheumatology was the first group we worked with. A doctor emailed me: “We’ve noticed that rheumatologists that came from one section of the company see patients more frequently than the ones that come from the other section. Is this something we can use that tool to sort out?”

Using the ETG tool, we discovered that the main driver of cost for rheumatology was not the number of visits but the prescription of biologics. We got the rheumatologists together in a room to discuss the findings. We generated bar graphs so everyone could see the average cost for a rheumatoid arthritis patient for each of the doctors. We shared unblinded data. Although most of the doctors had never met one another before, they were excited to be in a room together and very interested in seeing the data.

One of the older doctors, who had practiced the majority of his career before biologics were invented, was pleased to be on the low-cost end of curve. Well-known and well-respected, he was a living example of getting great outcomes without high costs.

Incomplete data and group dynamics
Our work with the obstetrician/gynecologist group has evolved more slowly. There are some inherent challenges in working with ob/gyn groups: Someone needs to stay...
available for deliveries, so all members of a practice cannot attend meetings together. This creates a lack of cohesion within the group. Some of our physicians practice in very small groups, and others are in larger coalitions, so there are different alliances and practice patterns among them. Plus the data are challenging, since they are based on claims: The management of abnormal bleeding is vastly different in a 22-year-old and a 68-year-old, yet the data can be difficult to separate, since they may all be based on the same set of ICD-9 codes.

For this specialty, we elected to present blinded data to the group, while allowing individual physicians to locate themselves on the spreadsheet. Driving toward a common practice pattern has been more difficult in this specialty than in others. One reason is new advances in surgical techniques. There may be better techniques that some providers have not been trained to do. Conversely, some providers may have invested in training for techniques without strong evidence supporting their use. As a system, we do not feel this practice is in keeping with high-value patient care.

One solution is to have those providers who are trained in new techniques act as the local go-to provider for that procedure. Patients, however, may not wish to see a provider who is not their usual physician. There are also issues that can develop in the practice group around compensation and productivity as providers diverge in their abilities. At the same time, the go-to doctor for a particular procedure will appear in data analyses to be overusing that procedure if the intra-practice referral patterns are not taken into account. These are some of the challenges that a group must face as it tries to bring greater value to the care provided to their patients. How do you address each provider’s question of “what’s in it for me?”

**Data as a starting point**

Our ultimate goal is to establish a culture of transparent sharing of accurate data that will drive providers toward agreed-upon best practices.

We preview the data and present the information with the understanding that the doctors will know the local circumstances, and that they may notice things that are out of whack that point to data errors. We always expect surprises and have trained ourselves to not react defensively.

We let the data speak for themselves, and allow the group to have a discussion about the data. Sometimes we will offer guiding comments, such as, “I’m a PCP, and I don’t know about this particular issue. Let’s say in the course of a couple months, I have three young women with swollen joints, and it looks like RA. I send one to you, one to you, and one to you, and each patient comes back to me with a different treatment plan. Can you please explain to me why?” Often doctors don’t realize that they are each doing different things. When you put it this way, no one is singled out, and you are recognizing that each doctor is using their best judgment.

Even if the meeting doesn’t end in a consensus, individual doctors often end up making changes on their own. When a doctor realizes that their clinical decisions are different than their peers’, they might go home and think, *Maybe I should do this differently.*

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**Measure Value**

Value is the balance between quality and affordability. To measure value, plan to track both from the outset. Increasing quality means improving access to care, improving clinical outcomes, making sure the most appropriate care is delivered, and improving the patient’s experience of care. To increase affordability — or reduce costs — organizations need to eliminate unnecessary patient and payer expenses. Reducing unwarranted variation in practice — decreasing underuse and overuse of services — can improve both the quality and cost elements of care. In other words, variation reduction will increase the value of care to the patient.

**Define Value for Your Organization**

- **Identify the quality and cost elements** that will be measured for each project.
- **Define the scope of analysis.** What question are you trying to address? Is it best to evaluate value for a single variation project at a time, or does the organization have the capacity to measure value for multiple projects simultaneously?
- **Establish parameters.** Set a timeframe for the data being analyzed, and define a comparison group either prospectively or retrospectively.
Define the value proposition (e.g., better outcomes, lower cost, or both). If cost is the main focus, make sure that there are quality measures attached to assure that cost is not being reduced at the expense of quality. Define outcomes or appropriate behaviors that support the value proposition.

Share projects with both staff and patients. Transparency helps engage staff and patients as partners in the process.

Address Misperceptions

Be prepared for the initial perception that work on clinical variation reduction is lost revenue.

Increasing affordability may result in some revenue loss early on in variation reduction work, especially for fee-for-service patients, but in the intermediate term, the cost per case should go down. Lowering costs will also gain the attention of payers and potentially increase your market share. For example, payers prefer to refer patients to organizations that can demonstrate that they provide high-value services.

Define value for each component of your organization, show how your team will evaluate the value of services to the patient, demonstrate a plan to quantify value, and share your results.

Blend cost and quality measures to determine a return on investment.

When return on investment (ROI) needs to be defined in terms of both value and dollars, it can be hard to measure. However, organizations can blend the quality portion of value measurements and cost calculations to make a single value measurement that is useful to the organization.

First, define value by setting the quality and cost components that will be measured.

Second, consider how traditional ROI calculations might be incorporated into the development of cost measures.

Third, measure value creation and report the data from a blended perspective.

Tailor Discussions to Your Audience

How you talk about creating value may be different depending on your target audience (see Table 3):

<table>
<thead>
<tr>
<th>Audience</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinicians</td>
<td>Doctors, physician assistants, nurse practitioners, and other clinicians will understand clinical quality improvement measurements. When it comes to defining value projects, you may need to spend time introducing the concept of appropriate reduction of cost to the patient and the elimination of waste in the medical system.</td>
</tr>
<tr>
<td>Data analysts</td>
<td>While analytics professionals spend much of their time working with clinical performance data, they are not clinicians and may not have a full understanding of clinical terms and codes. Data analysts should work closely with clinicians and should be trained in quality improvement methods.</td>
</tr>
<tr>
<td>Managed care staff</td>
<td>Any clinical overuse project can easily be used to create value measures, since objective outcomes and the resultant costs can be measured directly. Managed care departments tend to support value creation projects, as their goals and those of the project are frequently aligned.</td>
</tr>
<tr>
<td>Finance staff</td>
<td>An organization’s financial professionals focus primarily on the cost side of the equation. They may not see the importance of linking cost to quality measurement. Demonstrating the risk of reducing cost at the expense of quality should be stressed with finance department personnel. A challenge is the realization that creating value means initially investing in practice redesign, which may temporarily reduce revenues. Justifying this approach involves working with the finance department to create an overall business plan including a prediction of the project’s return on investment.</td>
</tr>
</tbody>
</table>
An organization’s geriatrics team was concerned about patients who were discharged from skilled nursing facilities (SNFs). Their data showed notable variation in the percentage of recently discharged patients who had timely primary care follow-up appointments. The geriatrics team decided to reduce this variation by starting a transitional care phone call program.

Measureable quality elements included:
- How often a transitional care phone call from the geriatric specialist occurred to help the patient coordinate follow-up care with a PCP.
- How many SNF patients were seen by a PCP within one week of discharge.
- Rate of emergency department (ED) visits and hospital readmissions among patients recently discharged from a SNF.

Cost measures included:
- Cost of the transitional care phone call by the geriatrician (added cost).
- Cost of the follow-up appointment with the PCP (expected cost).
- Cost of any repeat ED visits or hospital readmissions within one month of discharge (preventable cost).

This clinical variation reduction project incorporated traditional ROI thinking. If the geriatricians are paid additional fees for making the transitional care phone call, this cost would be passed to the patient, reducing the value of the service to the patient. If this additional cost increases the rate of patient follow-up with the PCP, however, the improved quality would increase the value of the service provided. Finally, if the transitional care phone call prevented high-cost repeat ED visits and hospitalizations, the overall cost to the patient would decrease significantly, thereby increasing the value of the service to the patient and increasing ROI.

In this case, cost and quality need to be measured to show that the process of transitioning patients from a SNF to their home is creating more value to the patient overall even though there is a predictable increase in up-front operational costs. A small cost investment for the transitional phone call, approximately $200, could result in an ROI savings of $25,000 per patient per hospitalization prevented. Determining the decrease in readmissions to the hospital or ED, both of which are cost and quality measures, is a necessary component of the ROI calculation. For patients who belong to a capitated or HMO insurance plan, the ROI would be clear to finance professionals, and the quality improvement aspects of better follow-up and transitional care would be clear to clinicians.

**Case Study**
— Veko Vahamaki, DO, medical director for diagnostic coding, Palo Alto Medical Foundation

I use the equation \( \text{value} = \frac{\text{quality}}{\text{cost}} \). Quality is the more complicated variable because it can be divided into all sorts of things. There are objective quality measures, like how many units of blood were lost, and subjective measures, like patient pain levels. There are also challenging quality elements such as patient satisfaction, medical record quality, access to care, and appropriateness of services. Each of these can have their own particular unit of measurement, complicating data analytics. Fortunately, cost is easy to measure. The unit is universal, and regardless of the currency, you can convert it.

The innovative concept that clinical variation reduction efforts help to emphasize is measuring total value — not cost or quality alone.

In the beginning, it may easier to think in terms of “tiers.”

**Tier 1: Only one variable**
Tier 1 projects measure only one variable in the value equation. For example, you could measure cost and assume that quality stays the same, based on what experts are telling you. Alternatively, you could measure a quality variable and assume that cost is constant. I
consider this a weak value creation project, because you are measuring only half of the equation, depending on expert opinion to make an assumption that the other half is constant.

Early on, we conducted a Tier 1 project to improve the quality of our electronic health record. I got a group of people together from family medicine, internal medicine, endocrinology, and bariatric surgery who were interested in weight loss. They said that first, we should increase the number of obesity codes on the medical record. Few charts showed that patients were obese even though height and weight measurements were evidence that patients were obese. The first step to treat these patients was to identify that they were obese. We identified BMI based on vital signs and asked primary care doctors to add those data to the medical record. Sure enough, the number of obesity codes on the charts went up by thousands. The quality of the medical record was improved with not much added cost as result of the project. In this case, value was measured by demonstrating an increase in quality and assuming that cost was held constant.

**Tier 2: Cost and quality measures together**

Tier 2 projects measure both cost and quality at the same time. I consider this a “standard” value creation project, because it measures at least one of each variable.

We conducted a Tier 2 project with our oncologists who were looking at the use of Colony-Stimulating Factor (CSF) drugs with breast cancer patients. These drugs, which are used to increase white blood cells to protect patients against infections and fevers, cost thousands of dollars per dose. A national study, however, showed that CSF drugs don’t improve patient outcomes. Our oncologists looked at their data and found that some were using the CSF treatment and some were not. The variation reduction team also showed cost data to the oncologists. They noted that those specialists that were not using the CSF treatment had significantly lower costs overall. The group decided to create a clinical standard and discontinued use of CSF drugs in a specific group of cancer patients. We measured the incidence of infection and fever, and it was on par with the national level. In one year, the total amount of charges to the patient was $3 million less. Amazingly, a few months after they enacted this breast cancer standard, costs in lung cancer went down too. We realized the oncologists had spread their CSF clinical standard to a different cancer. Now they were applying principles of variation reduction on their own. They were rapidly driving down costs, and at the same time measuring quality outcomes variables so they’d know that they were not hurting patients. Value was again measured by studying both quality and cost data.

**Tier 3: Multiple variables**

Tier 3 projects are the holy grail of value measurement. I consider this tier “strong” evidence of value creation. These involve multiple variables on both sides of the equation — you might measure 3-5 quality elements and 3-5 cost elements.

What happens is that a Tier 1 project eventually becomes a Tier 2 project as a variable is added, and then multiple Tier 2 projects become a Tier 3 project if they are related to the same medical condition or service. Those are system-level projects that sometimes involve multiple specialties and complex data. You may also be dealing with subjective (opinion-based) and objective (clinical) data together, and it can get complicated.

Ultimately, however, if the Tier 1 and Tier 2 variation reduction projects are well designed, the larger Tier 3 projects can be used to measure total value of care for even the most complex medical services.

**Variation reduction is more than quality improvement**

How is variation reduction different from quality improvement? Quality improvement often ignores cost. Variation reduction creates value. When you tell most quality departments that diabetes patients need a test, they may follow through with no accountability of cost. That medical director can use resources at any cost within the given budget to achieve that quality measure. For variation reduction, cost is just as important as improved quality. That’s value. We’re measuring both so we can tell the patient, “I can prove to you that we improved quality without driving up cost.”
Appendix A: Contributing Participants

DaVita HealthCare Partners
DaVita and HealthCare Partners joined forces to form DaVita HealthCare Partners. DaVita has 1,912 outpatient dialysis centers in 43 states, serving approximately 150,000 patients, and 24 centers in five countries outside of the US that serve approximately 1,000 patients. HealthCare Partners, a division of DaVita HealthCare Partners, serves 745,000 managed care patients across California, Florida, Nevada, and New Mexico, and is the largest operator of medical groups and physician networks in the country.

HealthCare Partners has initiated variation reduction work in both primary and specialty care. They have found that conversations among specialists, which rarely occurred before these variation reduction project meetings, were an additional benefit of the work. HealthCare Partners is now including employed and contracted specialists in these specialty meetings as well.

Humboldt–Del Norte IPA and Foundation for Medical Care
Humboldt–Del Norte IPA and Foundation for Medical Care provides administrative, medical management, and care coordination services for health plans and local self-funded employers. The foundation is part of the California Foundation for Medical Care. Together, they serve approximately 15,000 patients in Humboldt County.

The IPA/foundation is currently engaged in a long-evolving effort to address variations in care. It faces the challenge of small practice sizes and partial access to practice data. Their current approach to variation reduction includes reducing the number of measures followed, limiting work to include only those practices that use electronic health records, and exploring different sources of data such as PPO claims and Medi-Cal Managed Care.

Palo Alto Medical Foundation
Palo Alto Medical Foundation, part of the Sutter Health network, is a nonprofit HMO serving more than 800,000 patients. Its 1,200 physicians and 4,300 employees are at 40 locations across Alameda, San Mateo, Santa Clara, and Santa Cruz Counties.

Palo Alto Medical Foundation has been addressing variations of care since the early 2000s. Today, variation reduction is one of two major cost-reduction strategies for the medical group. The approach is bottom-up, with departments deciding what variations need to be addressed. Eighty-five variation reduction projects are projected to result in $56 million in savings to the patient over five years. Five physician champions, a full-time analyst, a medical director, and a half-time project director are supporting the implementation of standards that are reducing variations in care and cost.

Sutter Health
Sutter Health, a nonprofit HMO, is a network of physician organizations, nonprofit hospitals, outpatient centers, home health, and other medical services that care for 3 million patients in more than 100 Northern California cities and towns.

Variation reduction is a robust initiative across Sutter Health that was started in the Palo Alto Medical Foundation in the late 2000s. Soon after, variation reduction was initiated across Sutter using episode grouping and analysis. Today, over 400 projects have been implemented across the continuum of care, and that number is increasing on a weekly basis.

Sutter has standardized the work flow and deployment model so that data analytics are done across the organization. Progress has been made leveraging data directly from EPIC both on the ambulatory and the inpatient settings, and therefore variation can be explored within the local region as well as across the organization. This also helps projects spread across the organization. While data are important, the key to success is discussion with providers. Sutter has trained facilitators that support variation reduction, and these skilled facilitators are one of the reasons so many clinicians eagerly request support from the variation reduction team. Sutter continues to preserve a bottom-up approach, and clinicians across almost all specialties are actively participating in variation reduction work. Variation reduction has not only improved the delivery of care, but it has also decreased costs and increased collaboration among providers.
UCLA Health System

UCLA Health System provides services to most major HMOs and patients enrolled in PPOs. With more than 2,000 physicians, UCLA serves more than 300,000 people at four hospitals and at primary care and specialty offices throughout the Los Angeles region.

UCLA Health System started addressing variations in care in 2013. Their variation reduction team engages specialists at the department level to define outcome measures for procedures and conditions, and to identify the path to achieving those measures. UCLA is quickly scaling up its efforts throughout the system.
Appendix B

Resources and Tools


“Beyond the Efficiency Index: Finding a Better Way to Reduce Overuse and Increase Efficiency in Physician Care,” by Robert A. Greene, Howard Beckman, and Thomas Mahoney. content.healthaffairs.org/content/27/4/w250.full


A Clearer View: Humboldt Steps Out of the Fog of Medical Variation, by Russ Mitchell www.chcf.org/publications/2013/05/humboldt-story

All Over the Map: Elective Procedure Rates in California Vary Widely, by Shannon Brownlee and Vanessa Hurley of the New America Foundation Health Policy Program www.chcf.org/publications/2013/05/medical-variation-map

Clinical Variation Reduction Champion’s Training Guide, by Veko Vahamaki*

Variation Reduction Success Stories, by Sutter Medical Network*

*Please send requests for electronic copies of these publications to cin@chcf.org with “CIN Variation Reduction Resource Request” in the subject line.
5 QUESTIONS to Ask Your Doctor Before You Get Any Test, Treatment, or Procedure

1. **Do I really need this test or procedure?** Medical tests help you and your doctor or other health care provider decide how to treat a problem. And medical procedures help to actually treat it.

2. **What are the risks?** Will there be side effects? What are the chances of getting results that aren’t accurate? Could that lead to more testing or another procedure?

3. **Are there simpler, safer options?** Sometimes all you need to do is make lifestyle changes, such as eating healthier foods or exercising more.

4. **What happens if I don’t do anything?** Ask if your condition might get worse — or better — if you don’t have the test or procedure right away.

5. **How much does it cost?** Ask if there are less-expensive tests, treatments or procedures, what your insurance may cover, and about generic drugs instead of brand-name drugs.

**Use the 5 questions to talk to your doctor about which tests, treatments, and procedures you need — and which you don't need.**

Some medical tests, treatments, and procedures provide little benefit. And in some cases, they may even cause harm.

Talk to your doctor to make sure you end up with the right amount of care — not too much and not too little.

FOR MORE INFORMATION

Use your smartphone to access all of the lists of tests and procedures for you and your physicians to question as part of the Choosing Wisely® campaign.

http://consumerhealthchoices.org/campaigns/choosing-wisely/
There is broad agreement that there is substantial waste in the health care system. The IOM Report Best Care at Lower Cost estimated the cost of unnecessary services at $210 B annually (Table S-1), and articles in the mainstream media have increasingly highlighted overuse of procedures such as spinal fusion and stents; see the reference list for examples (including hyperlinks). The recent New Yorker article by Atul Gawande, Overkill, emphasized the pervasiveness of the problem, and the implications of overuse for patient care and costs.

The first step in addressing overuse is to identify high-priority opportunities. The ABIM Foundation’s Choosing Wisely® initiative, in partnership with specialty societies, has produced extensive lists of overused test and treatments. Narrowing the focus requires criteria for prioritizing among the many opportunities. A recent report by Bailit and colleagues presents examples of criteria that could be used for prioritizing among the opportunities:

- Relative risk to patient safety
- Frequency and cost of problem
- Data completeness and ability to report the extent of the problem
- Practice variation within the state
- Literature on the extent of overuse
- Whether there are established, tested, and available evidence-based clinical pathways

**What have other states targeted in implementing Choosing Wisely recommendations?**

A number of state collaboratives were awarded grants by the ABIM Foundation in 2013 to spread the Choosing Wisely initiative by targeting reduction of services identified on the specialty society lists. An overview of those efforts and the services they targeted is below.

<table>
<thead>
<tr>
<th>Lead Organization</th>
<th>Tests/Treatments of Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better Health Greater Cleveland</td>
<td>• Cardiac Testing&lt;br&gt;• Imaging for acute low back pain&lt;br&gt;• Antibiotics or imaging for sinusitis&lt;br&gt;• Imaging for headaches&lt;br&gt;• Screening for cervical cancer</td>
</tr>
<tr>
<td>HealthInsight Utah</td>
<td>• Improving value of healthcare delivery</td>
</tr>
<tr>
<td>Institute for Clinical Systems Improvement/Minnesota Health Action Group</td>
<td>• Unwarranted medical procedures</td>
</tr>
</tbody>
</table>
| Iowa Healthcare Collaborative | - Don’t obtain imaging studies in patients with non-specific low back pain; and don’t do imaging for low back pain within the first six weeks, unless red flags are present.  
- Don’t do imaging for uncomplicated headache.  
- In the evaluation of simple syncope and a normal neurological examination, don’t obtain brain imaging studies (CT or MRI).  
- Avoid use of computed tomography (CT) scans in the immediate evaluation of minor head injuries.  
- Don’t order sinus CT or indiscriminately prescribe antibiotics for uncomplicated acute rhinosinusitis. |
| Maine Quality Counts | - Education on best practices in partnership with patients |
| Massachusetts Health Quality Partners | - Imaging for lower back pain  
- Imaging for uncomplicated headache  
- Early induction in childbirth  
- Colorectal cancer screening  
- Antibiotic overuse for:  
  - Pediatric URI  
  - Adult Sinusitis  
  - Urinary tract infections  
  - Cancer treatment at end of life |
| Michigan Health Information Alliance | Didn’t specify |
| Washington Health Alliance | - Imaging for uncomplicated headaches  
- Antibiotics for sinus infections  
- CT scans for sinus infections  
- Imaging for uncomplicated low back pain  
- Imaging for simple syncope (fainting)  
- CT scans for appendices  
- Too frequent Pap tests  
- Pap tests for patients with a previous hysterectomy  
- Pap tests for young women under 21 years old  
- Follow-up testing for adnexal (ovarian) cysts  
- Spirometry testing for asthma |
| Wisconsin Collaborative for Healthcare Quality | - Create and design decision support tools within EHR systems to improve access to CW recommendations |

**What do we know about overuse in California?**

Efforts to reduce overuse in California begins with data and benchmarks to inform decisions about where to focus efforts. Each purchaser, health plan, and provider system has access to data that can support identification of overused tests and procedures. At a statewide level, the California HealthCare Foundation has been a leader in the state with respect to focusing attention on variation reduction, producing an interactive online map (“All Over The Map”) and series of publications highlighting variation in rates of elective procedures across the state. The most recent information includes rates for
ten “preference sensitive” procedures at two points in time, as described in the table below. For most procedures, there is no “right” rate or specific target.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Rate Per 1000 Population, California</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2005-2008</td>
</tr>
<tr>
<td>Angiography</td>
<td>5.9</td>
</tr>
<tr>
<td>PCI</td>
<td>1.4</td>
</tr>
<tr>
<td>CABG</td>
<td>.54</td>
</tr>
<tr>
<td>C-Section</td>
<td>168.2</td>
</tr>
<tr>
<td>Elective Inductions</td>
<td>76.6</td>
</tr>
<tr>
<td>VBAC</td>
<td>88.2</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>3.4</td>
</tr>
<tr>
<td>Total hip replacement</td>
<td>.8</td>
</tr>
<tr>
<td>Total knee replacement</td>
<td>1.6</td>
</tr>
<tr>
<td>Cholecystectomy</td>
<td>3.0</td>
</tr>
<tr>
<td>Carotid Endarterectomy</td>
<td>.3</td>
</tr>
</tbody>
</table>

CHCF’s initial reporting on variation across the state found very high rates of elective surgery in Humboldt, in some cases more than double the statewide average. In response, the community came together to address the issue through a series of Community Care Improvement projects led by the Humboldt Del Norte IPA. CHCF has documented the Humboldt effort in a publication (May 2013), A Clearer View: Humboldt Steps Out of the Fog of Medical Variation, and in an online multi-media narrative, Out of the Fog.

How do the elective procedures highlighted in “All Over the Map” intersect with Choosing Wisely?

Several of the procedures featured in “All Over the Map” have been identified by specialty societies as overused tests and treatments, and recommendations issued to reduce their utilization. The table below lists the recommendation(s) and specialty society for each of the procedures.

<table>
<thead>
<tr>
<th>Test/Treatment</th>
<th>Recommendation</th>
<th>Specialty Society</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angiography</td>
<td>Don’t perform stress cardiac imaging or coronary angiography in patients without cardiac symptoms unless high-risk markers are present</td>
<td>American Society of Nuclear Cardiology</td>
</tr>
<tr>
<td></td>
<td>Don’t image for suspected pulmonary embolism (PE) without moderate or high pre-test probability of PE</td>
<td>American College of Radiology</td>
</tr>
<tr>
<td></td>
<td>Don’t routinely order coronary computed tomography angiography for screening asymptomatic individuals</td>
<td>Society of Cardiovascular Computed Tomography</td>
</tr>
<tr>
<td></td>
<td>Don’t use coronary computed tomography angiography in high risk emergency department patients presenting with acute chest pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Avoid coronary angiography in post-coronary artery bypass graft (CABG) and post-PCI patients who are asymptomatic, or who have normal or mildly</td>
<td>Society for Cardiovascular Angiography and</td>
</tr>
<tr>
<td>Intervention</td>
<td>Interventions</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>abnormal stress tests and stable symptoms not limiting quality of life</td>
<td>Interventions</td>
<td></td>
</tr>
<tr>
<td>Avoid coronary angiography to assess risk in asymptomatic patients with no</td>
<td>Avoid coronary angiography to assess risk in asymptomatic patients with no</td>
<td></td>
</tr>
<tr>
<td>evidence of ischemia or other abnormalities on adequate non-invasive testing</td>
<td>evidence of ischemia or other abnormalities on adequate non-invasive testing</td>
<td></td>
</tr>
<tr>
<td>Avoid coronary angiography for risk assessment in patients with stable</td>
<td>Avoid coronary angiography for risk assessment in patients with stable</td>
<td></td>
</tr>
<tr>
<td>ischemic heart disease who are unwilling to undergo revascularization or who</td>
<td>ischemic heart disease who are unwilling to undergo revascularization or who</td>
<td></td>
</tr>
<tr>
<td>are not candidates for revascularization based on co-morbidities or individual</td>
<td>are not candidates for revascularization based on co-morbidities or individual</td>
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<tr>
<td>preferences</td>
<td>preferences</td>
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<tr>
<td>PCI</td>
<td>PCI</td>
<td></td>
</tr>
<tr>
<td>Avoid PCI in asymptomatic patients with stable ischemic heart disease</td>
<td>Avoid PCI in asymptomatic patients with stable ischemic heart disease</td>
<td></td>
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<tr>
<td>without the demonstration of ischemia on adequate stress testing or with</td>
<td>without the demonstration of ischemia on adequate stress testing or with</td>
<td></td>
</tr>
<tr>
<td>abnormal fractional flow reserve testing</td>
<td>abnormal fractional flow reserve testing</td>
<td></td>
</tr>
<tr>
<td>CABG</td>
<td>C-Section</td>
<td></td>
</tr>
<tr>
<td>Don’t initiate routine evaluation of carotid artery disease prior to cardiac</td>
<td>Don’t initiate routine evaluation of carotid artery disease prior to cardiac</td>
<td></td>
</tr>
<tr>
<td>surgery in the absence of symptoms or other high-risk criteria</td>
<td>surgery in the absence of symptoms or other high-risk criteria</td>
<td></td>
</tr>
<tr>
<td>C-Section</td>
<td>C-Section</td>
<td></td>
</tr>
<tr>
<td>Don’t schedule elective, non-medically indicated inductions of labor or</td>
<td>Don’t schedule elective, non-medically indicated inductions of labor or</td>
<td></td>
</tr>
<tr>
<td>Cesarean deliveries before 39 weeks, 0 days gestational age</td>
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<tr>
<td>Elective Inductions</td>
<td>Elective Inductions</td>
<td></td>
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<tr>
<td>Don’t schedule elective, non-medically indicated inductions of labor or</td>
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</tr>
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<td></td>
</tr>
<tr>
<td>C-Section</td>
<td>C-Section</td>
<td></td>
</tr>
<tr>
<td>Avoid elective, non-medically indicated inductions of labor between 39</td>
<td>Avoid elective, non-medically indicated inductions of labor between 39</td>
<td></td>
</tr>
<tr>
<td>weeks, 0 days and 41 weeks, 0 days unless the cervix is deemed favorable</td>
<td>weeks, 0 days and 41 weeks, 0 days unless the cervix is deemed favorable</td>
<td></td>
</tr>
<tr>
<td>VBAC</td>
<td>VBAC</td>
<td></td>
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<tr>
<td>Not found in the CW recommendations</td>
<td>Not found in the CW recommendations</td>
<td></td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>Hysterectomy</td>
<td></td>
</tr>
<tr>
<td>Not found in the CW recommendations</td>
<td>Not found in the CW recommendations</td>
<td></td>
</tr>
<tr>
<td>Joint Replacement (total hip, knee)</td>
<td>Joint Replacement (total hip, knee)</td>
<td></td>
</tr>
<tr>
<td>Not found in the CW recommendations</td>
<td>Not found in the CW recommendations</td>
<td></td>
</tr>
<tr>
<td>Cholecystectomy</td>
<td>Cholecystectomy</td>
<td></td>
</tr>
<tr>
<td>Not found in the CW recommendations</td>
<td>Not found in the CW recommendations</td>
<td></td>
</tr>
<tr>
<td>Carotid Endarterectomy</td>
<td>Carotid Endarterectomy</td>
<td></td>
</tr>
<tr>
<td>Don’t recommend carotid endarterectomy for asymptomatic carotid stenosis</td>
<td>Don’t recommend carotid endarterectomy for asymptomatic carotid stenosis</td>
<td></td>
</tr>
<tr>
<td>unless the complication rate is low (&lt;3%)</td>
<td>unless the complication rate is low (&lt;3%)</td>
<td></td>
</tr>
</tbody>
</table>

What data on appropriate care/overuse, with benchmarks, are easily available for California?

As a starting place, the table below presents information on several measures, all but one of which are HEDIS measures, that are available for services that have been targeted for reduction through the Choosing Wisely initiative. For the measures shown below, commercial HMO data are available through IHA’s Pay for Performance program and Medi-Cal managed care data are available through DHCS. Data below are for Measurement Year 2013, reported in 2014.

For the avoidance of antibiotic treatment and the use of imaging studies for low back pain, lower is generally better; for the other measures, higher is better. In the commercial HMO market, there is
significant variation in all the measures. Only two measures were easily available for both commercial HMO and Medi-Cal; the use of imaging studies for low-back pain is similar, while the avoidance of antibiotics for bronchitis is quite a bit higher in commercial HMO than it is in Medi-Cal managed care.

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure name</th>
<th>Range Among Physician Organizations</th>
<th>Average %</th>
<th>National benchmark * %</th>
<th>Average %</th>
<th>National benchmark* %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis</td>
<td>9.21-96.08</td>
<td>45.01</td>
<td>26.63</td>
<td>29.96</td>
<td>26.67</td>
</tr>
<tr>
<td></td>
<td>Appropriate Testing for Children With Pharyngitis</td>
<td>7.23-97.01</td>
<td>82.34</td>
<td>88.3</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Evidence-Based Cervical Cancer Screening - Too Frequently: All Ages (24-65, 67+)</td>
<td>1.5-66.01</td>
<td>12.45</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Use of Imaging Studies for Low Back Pain</td>
<td>58.33-96.55</td>
<td>84.84</td>
<td>78.77</td>
<td>80.84</td>
<td>79.38</td>
</tr>
<tr>
<td></td>
<td>Low Risk (NTSV) C-Section</td>
<td>3.5-53.33</td>
<td>30.16</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Appropriate Treatment for Children with Upper Respiratory Infection</td>
<td>52.53-100</td>
<td>96.19</td>
<td>90.65</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*= 75th percentile of national HEDIS. PO= Physician Organization; commercial HMO average rate is at the PO-level, weighted by enrollment, and excludes POs with a denominator <30.

The table below maps the HEDIS measures shown above to the Choosing Wisely recommendations.

<table>
<thead>
<tr>
<th>Measure name</th>
<th>Recommendation</th>
<th>Society</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis</td>
<td>Antibiotics should not be used for apparent viral respiratory illnesses (sinusitis, pharyngitis, bronchitis)</td>
<td>Several specialty societies</td>
</tr>
<tr>
<td>Appropriate Testing for Children With Pharyngitis</td>
<td>Antibiotics should not be used for apparent viral respiratory illnesses (sinusitis, pharyngitis, bronchitis)</td>
<td>American Academy of Pediatrics</td>
</tr>
</tbody>
</table>
| Evidence-Based Cervical Cancer Screening - Too Frequently: All Ages (24-65, 67+) | Don’t screen women older than 65 years of age for cervical cancer who have had adequate prior screening and are not otherwise at high risk for cervical cancer  

Don’t perform Pap smears on women younger than 21 or who have had a hysterectomy for non-cancer disease  

Don’t perform routine annual cervical cytology screening (Pap tests) in women 30 – 65 years of age | American Academy of Family Physicians  

American College of Obstetricians and Gynecologists |
**Use of Imaging Studies for Low Back Pain**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t perform screening for cervical cancer in low-risk women aged 65 years or older and in women who have had a total hysterectomy for benign disease</td>
<td>American College of Preventive Medicine</td>
</tr>
<tr>
<td>Don’t do imaging for low back pain within the first six weeks, unless red flags are present</td>
<td>American Academy of Family Physicians</td>
</tr>
<tr>
<td>Don’t obtain imaging studies in patients with non-specific low back pain</td>
<td>American College of Physicians</td>
</tr>
<tr>
<td>Don’t obtain imaging (plain radiographs, magnetic resonance imaging, computed tomography [CT], or other advanced imaging) of the spine in patients with non-specific acute low back pain and without red flags</td>
<td>American Association of Neurological Surgeons and Congress of Neurological Surgeons</td>
</tr>
<tr>
<td>Don’t initially obtain X-rays for injured workers with acute non-specific low back pain</td>
<td>American College of Occupational and Environmental Medicine</td>
</tr>
<tr>
<td>Don’t recommend advanced imaging (e.g., MRI) of the spine within the first six weeks in patients with non-specific acute low back pain in the absence of red flags</td>
<td>North American Spine Society</td>
</tr>
<tr>
<td>Avoid lumbar spine imaging in the emergency department for adults with non-traumatic back pain unless the patient has severe or progressive neurologic deficits or is suspected of having a serious underlying condition (such as vertebral infection, cauda equine syndrome, or cancer with bony metastasis)</td>
<td>American College of Emergency Physicians</td>
</tr>
<tr>
<td>Avoid imaging studies (MRI, CT or X-rays) for acute low back pain without specific indications</td>
<td>American Society of Anesthesiologists – Pain Medicine</td>
</tr>
</tbody>
</table>

**C-Section**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t schedule elective, non-medically indicated inductions of labor or Cesarean deliveries before 39 weeks, 0 days gestational age</td>
<td>American Academy of Family Physicians</td>
</tr>
</tbody>
</table>

**Appropriate Treatment for Children with Upper Respiratory Infection**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antibiotics should not be used for apparent viral respiratory illnesses (sinusitis, pharyngitis, bronchitis)</td>
<td>American Academy of Pediatrics</td>
</tr>
<tr>
<td>Avoid prescribing antibiotics for upper respiratory infections</td>
<td>Infectious Diseases Society of America</td>
</tr>
</tbody>
</table>

**What approaches might be taken to reduce overuse?**

A 2014 report by Bailit Health Purchasing Strategies identifies several strategies that states can pursue in efforts to reduce overuse:
• Partner with other large purchasers in a multi-stakeholder workgroup – coordination will send consistent signals to the marketplace about the importance of reducing overuse and misuse, and allow providers and plans to focus on common goals.

• Measure and report plan and provider performance – there are few NQF-endorsed measures of overuse (primarily focused on inappropriate use of imaging and inappropriate use of antibiotics), so efforts may need to include identifying other relevant utilization measures.

• Hold plans and providers accountable for performance, with possible approaches to include (see p.6):
  o Require each managed care plan to stipulate that its subcontracted providers operationalize clinical guidelines adopted by the workgroup
  o Require a reduction in occurrence of overused or misused services or the attainment of a benchmark level of performance
  o Impose financial consequences for not achieving a reduction in overused or misused services

• Explicitly incorporate evidence criteria into policies, regulations, and statutes regarding coverage determinations
  o State purchasers should determine what actions they can take to introduce or clarify evidence-based criteria without legislative changes and potentially with limited regulatory changes
  o State purchasers should consider the need and timing for a more deliberative regulatory and legislative agenda and process related to limiting overuse and misuse based on evidence

• State employee health benefit purchasers should introduce value-based insurance design that encourages members to utilize high-value services, such as those implemented in Oregon and Colorado

In addition to the state strategies outlined in the Bailit report, it also may be worth considering how the Workgroup can support provider systems across the state in their efforts to reduce practice variation and address the problem of overuse/misuse. California chapters of specialty medical societies may be interested in partnering, much as the national specialty societies have partnered to provide recommendations on where to focus efforts to reduce overuse in collaboration with the Choosing Wisely initiative.

A final consideration may be whether there are opportunities to build upon related activities within the state that already have some momentum. For example, substantial work was performed by a wide array of stakeholders on the CalSIM effort. While ultimately not funded, the investment in designing the CalSIM initiative -- particularly the groundwork laid in the area of maternity care -- is worth assessing as a launch pad for the Workgroup’s efforts. Given the large number of births paid for by DHCS, CalPERS, and through Covered California; the relatively high C-section rate and variation in that rate across providers; the availability of performance measures; and the active engagement of the California Maternal Quality Collaborative in support of quality improvement, maternity may be a productive initial area of focus.
References


