Statewide Workgroup on Reducing Overuse
Co-chairs: Covered California, CalPERS, DHCS
Meeting #3 – Meeting Summary
Monday, February 29, 2016, Covered California

The complete meeting packet, including agenda, is available at http://www.iha.org/our-work/insights/statewide-workgroup-on-reducing-overuse

High-level Summary: The Workgroup heard from Marge Ginsburg of the Center for Health Care Decisions regarding findings of the Doing What Works project, deliberative discussions with California consumers on overuse; full results will be released in an upcoming report. Next, Beccah Rothschild of Consumer Reports presented on consumer-facing materials to inform decision-making, with a focus on the national Choosing Wisely initiative and the three Workgroup focus areas of C-section for low-risk first time birth, imaging for low-risk back pain, and opioid overuse. Significant interest was expressed in both topics. The remainder of the day focused on the three priority topics. After substantive discussions of each topic, the Workgroup reached broad agreement to pursue several activities. Creation and dissemination of member-facing materials was identified as a priority across all three topics. Two additional priorities emerged for each of the three topics, as displayed in the table below.

	Cross Topic Focus	Topic Specific Priority #1	Topic Specific Priority #2
TOPIC 1: CESAREAN SECTION FOR LOW-RISK FIRST-TIME BIRTHS	Member-facing materials	Recognition/awards for reporting, high-performing hospitals	Payment principles (contracting language focus)
TOPIC 2: IMAGING FOR LOW-RISK BACK PAIN		Provider Tools	Clinical Decision Support
TOPIC 3: OPIOID OVERUSE		Provider Tools	Payer/plan interventions

Next steps: The California HealthCare Foundation is interested in continuing to support the Workgroup; based on the commitment of the Co-Chair organizations and the Workgroup participants, IHA plans to submit a proposal for funding. A scheduling poll will be sent out for the next meeting, which will be held over the summer. Before the next meeting, the project team may schedule a webinar or reach out to individual members to obtain guidance from the Workgroup on specific issues or questions. Below are additional details on the key discussion points that surfaced during each agenda session.

Welcome and Introductions/Agenda Review
Initiators: Anne Price, Covered CA; Lance Lang, MD, Covered CA; Jill Yegian, PhD, IHA

Anne Price welcomed the workgroup and thanked them for attending the third in-person meeting. She informed the group that she will be stepping down as chair and Lance Lang will be taking her place as the new chair. Jill Yegian recapped progress to date. The first meeting, in June 2015, focused on the broad topic of overuse. The second meeting, in October 2015,focused on laying the groundwork for the three topic areas selected by the Workgroup during webinar meetings in August: C-section for low risk first-time birth, imaging for low-risk low back pain, and opioid overuse. This meeting, the third one of the Workgroup, is focused on creating a 2016 action plan for each of the areas.

RESULTS OF THE "DOING WHAT WORKS" PROJECT
Initiators: *Marge Ginsburg, CHCD*

Marge Ginsburg presented the results of the *Doing What Works (DWW)* project, created to identify the perspectives on insured Californians on ways to reduce the use of medical services that are harmful and/or wasteful. CHCD held 10 half-day sessions of 9-12 people each, reaching a total of 117 people. Five groups were with Medi-Cal members (two in Spanish), four with CoveredCA members, and one with CalPERS members. Participants were presented with our case scenarios: use of antibiotics for adult bronchitis; C-Section with normal pregnancies; use of MRI scans for low back pain; use of costly cancer drugs. Options for the participants to consider were

- Physician-facing: **greater oversight**
- Physician-facing: **compensation related**
- Patient- facing: **incentives or disincentives**
- No action: Continue to **leave it to doctor/patient**

In her presentation, Marge discussed the results of the initiative and potential next steps for workgroup members to consider. Several high-level principles emerged from the project:

1. Physicians should be held responsible
2. Actions should be effective, efficient and credible
3. Not wasting resources is a valid reason for reducing unnecessary care
4. Respect for **patient choice** must be balanced by ethical practices
5. Patients have responsibility to be better informed

The full report on the project results is expected in Spring 2016.

CONSUMER-FACING RESOURCES ON OVERUSE
Initiators: Beccah Rothschild, MPA, Consumer Reports

Beccah Rothschild presented on the work of Consumer Reports related to overuse, which includes a partnership with the national Choosing Wisely initiative as well as an array of independent efforts that intersect with the topic areas selected by the Workgroup (C-section, low-back imaging, and opioids). There was strong support for the Workgroup to focus on development and dissemination member-facing information to support both consumer decision-making and provider-patient communication.

Key Discussion Points:

- Branding is critical for reaching consumers – information must come from a recognized and trusted source. Consumers Reports is very well known in some market segments (older, more affluent) and less known in others. CR working hard on reaching a broader and more diverse group of consumers.
- Essential to reach members at a decision-making window, such as the point of care; without a specific need, they won't spend the time
- Literacy level is key for reaching target audience – 6th grade or lower
- Ideas for reaching members:
    - Wikipedia -- Consumer Reports has a staff person responsible for Wikipedia postings
    - Social media for reaching millennials – LinkedIn, Facebook, Instagram
    - WebMD as the most popular online source
    - Purchasers can include the Consumer Reports "5 questions" wallet cards (developed for the Choosing Wisely campaign) with open enrollment materials or other mailings
    - Pharmacies, clinic waiting rooms, social service departments – go where the consumers/patients go
    - Newsletters, online or mailed, from purchasers, plans, and providers
    - Patient portals hosted by plans, providers
- Ideas for reaching providers with resources intended to support discussions with patients:
    - Telehealth vendors, such as MD Live, Teledoc
    - EMR vendors, e.g. EPIC, Athena – incorporate into clinical decision support, or embed in to EMR as a link or PDF so that clinician has access to information/materials in real time

TOPIC 1: CESAREAN SECTION FOR LOW-RISK FIRST-TIME BIRTHS
Initiators: Lance Lang, MD, Covered California; Stephanie Teleki, PhD, CHCF

Dr. Lance Lang kicked off the session, highlighting a joint letter (in the meeting materials) from Covered California, CalPERS, the Department of Health Care Services, the Department of Public Health, and the California Health and Human Services Agency to "non submitting hospitals" (those hospitals not currently submitting maternity and C-section data to CMQCC) that strongly encourages data submission and identifies several specific action items and resources. Lance also briefly mentioned Covered California's draft 2017 contract that sets an expectation that health plan partners will reduce the C-section rate for members and related activities underway around the state. Jill Yegian invited discussion of the three proposed directions for the Workgroup to pursue related to C-section: recognition/awards for reporting, high-performing hospitals; member-facing materials, and payment principles.

<u>Key Discussion Points</u>:

- Standardizing contract language across purchasers related to reimbursement for C-sections would send a consistent message, and draft language from the Covered California contract could be a starting place.
- Contract language should include flexibility on payment methodology – intent is to stop providing financial incentives for unnecessary C-section, not to require a specific approach such as bundled payment.

- Important to retain a focus on Medi-Cal, given that the program pays for half of the births in the state. Challenging payment landscape, with many categories of membership and different rules and revenue streams (e.g. managed care members, undocumented women obtaining pregnancy/delivery care on a FFS basis). Contract language from PERS and Covered California can be helpful starting place.
- Signaling can be useful even before contract language goes into effect. If DHCS could indicate intent to address C-section reimbursement during the next round of contract negotiations, plans and providers would begin to respond even before that occurred.
- Many factors contribute to high C-section rates, including obesity in the patient population and the liability costs (threat of malpractice). Important to engage on multiple fronts.
- Payment is only one of many levers to influence C-section rates. Providers may not understand what is driving C-section rates and how to reduce unnecessary C-sections. Key that any effort includes comparative performance data and working collaboratively with providers, not just changing payment.
- Data transparency is a key component of effort to reduce C-section rates. Hospital data is available from CMQCC and will be featured in regional hospital association meetings starting next month. Physician performance data is not available; IHA is working with CMQCC to test C-section measures at the physician group level as part of Value Based P4P.
- Consumer-facing materials about C-sections created by Consumer Reports and co-branded with CMQCC could be credible to both consumers and providers, and would be worthwhile to pursue

When a vote was taken, all three of the approaches highlighted in the discussion document received strong majorities: recognition/awards for reporting, high-performing hospitals; member-facing materials; and payment principles

TOPIC 2: IMAGING FOR LOW-RISK BACK PAIN
Initiators: Kathy Donneson, PhD, CalPERS; Richard Sun, MD, CalPERS

Kathy Donneson and Richard Sun introduced the discussion of imaging for low-risk low back pain, referring to the discussion document highlighting proposed directions for the Workgroup to pursue: clinical decision support, measures and targets, and member-facing materials. Before turning to discussion, Drs. Parag Agnihotri from Sharp Rees-Stealy and Jennifer Sayles from LAC-DHS provided a brief update on efforts underway related to imaging for low back pain in their respective organizations, following up on their October 2015 presentations to the Workgroup.

<u>Update on Progress</u>

Parag Agnihotri, MD, Sharp Rees Stealy
- Emphasized the importance of clinical decision support in the SRS effort to reduce overuse of low back imaging
- Highlighted the importance of including specialists as well as primary care physicians
- Noted that, in spite of concerns that clinicians may respond to efforts to reduce overuse of low back imaging by upcoding (result in exclusion from the measure), SRS has not observed upcoding
- Mentioned that SRS offers yoga and has a small number of takers

Jennifer Sayles, MD, L A County DHS

- The entire LA system now has clinical decision support embedded in the EMR, which has resulted in great data. As described in detail in the October presentation, over first 9 months the new system has resulted in approximately 12-15% decrease in imaging.
- Important to have real time feedback for providers including facility specific and provider specific reporting as well as understanding how to engage patients. Conducting a survey of patients to better understand how they are thinking; also working on member-facing materials tailored to safety net population
- NQF measure on low back imaging is not capturing meaningful information in this specific population due to 28 day timeframe – relatively few patients see a provider within the 28 day window identified in the measure, so results less relevant.

Key Discussion Points:

- Important to focus on what should be done and not just what should NOT be done – for both clinicians and for patients. If imaging is not appropriate, providers need a robust set of modalities use with and suggest to patients
    - Virginia Mason and Stanford CERC are good resources on clinical pathways
    - Low back pain and opioids are interlinked. Reducing opioids leads to more imaging. If we are taking pain medication away, need to have alternatives to offer patients.
    - Kaiser has created low back clinics, and refers patients with low back pain
    - What should the clinician actually say to the patient? Scripting could help providers with patient discussions; Consumers Reports is working on scripting with providers in Minnesota
    - Human contact, listening, "touches" can substitute for imaging/technology but time is a constraint
- Clinical pathways for acute back pain are different from those for chronic back pain – need to develop distinct algorithms to guide providers in their work with patients in each group
- Clinical decision support for Choosing Wisely recommendations is complex – bring the large EMR systems to the table; analogy to eprescribing

When a vote was taken, there was majority support for member-facing materials, developing provider tools, and promoting clinical decision support. There was less support for working on improving the HEDIS measure.

TOPIC 3: OPIOID OVERUSE

Initiators: Neal Kohatsu, MD, DHCS; Kelly Pfeifer, MD, CHCF

Neal Kohatsu and Kelly Pfeifer introduced the discussion of opioid overuse, referring to the discussion document highlighting proposed directions for the Workgroup to pursue: provider tools related to safer prescribing practices, payer and health plan interventions (e.g. formulary controls), community coalitions, a united policy agenda, and member-facing materials. The Workgroup also heard from Dr. Salina Wong of Blue Shield of California and Dr. Joel Hyatt of Kaiser Permanente on initiatives to reduce opioid overuse (see one-page handout from each of them in the packet). Blue Shield of California and Kaiser have both created extensive programs targeting opioid overuse, with significant success.

Key Discussion Points:

- As of July 1, all providers/pharmacists need to be registered with CURES, but not required to USE it
- Potential role for the Workgroup, or for a separate subgroup of interested members, related to policy issues
    - Endorsing forthcoming CDC guidelines
    - Regulations related to CURES – who should use it, for which patients, and whether/how data from CURES should be made available to groups and plans
    - Several opioid bills under consideration in state legislature
- Important distinction between "pill mill" docs and physicians prescribing opioids as part of caring for patients with acute issues such as orthopedic surgery – different issues, different solutions
- Need to change message to patients. Often times they need to live with pain, and providers need to instill that message. Member facing materials to get people to understand that could be important
    - Major cultural change from "pain is the 5th vital sign" that developed expectation of always treating, eliminating pain
    - Provider materials also needed to support this work
- Setting target for group about opioid reduction is premature; this could be discussion for next meeting

When a vote was taken, there was majority support for developing member-facing materials; provider tools to support safer prescribing and alternative modalities; and payer/plan interventions. There was significant interest in pursuing policy options, and Kelly Pfeifer plans to convene teleconference with interested individuals. Community coalitions received the fewest votes, with the clarification from several members that coalition work is essential but is underway and does not need Workgroup support at this stage.

NEXT STEPS AND ACTION ITEMS

Jill Yegian summarized the key action items identified for each topic area, and asked the Workgroup for guidance on whether overarching communication strategies should also be pursued for 2016, such as conference presentations and cross-topic content development. There was agreement that those activities should wait until progress has been made, and the Workgroup has specific accomplishments to point to for the three topics; this was seen as a 2017 activity.