<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Leads</th>
<th>Meeting Materials</th>
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<tbody>
<tr>
<td>9 am</td>
<td>Welcome and Introductions</td>
<td>Anne Price, Covered California</td>
<td>• Participant List</td>
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| 9:15 AM| Agenda Review                                                        | Lance Lang, M.D., Covered California  
Jill Yegian, Ph.D., IHA                                                  | • Workgroup Charter  
• Idea Generation Matrix (October 2015)  
• October 2015 Meeting Summary |
| 9:25 AM| Results of the “Doing What Works” Project                          | Marjorie Ginsburg, Center for Healthcare Decisions                    | • Project Summary                                                                 |
| 10:05 AM| Consumer-Facing Resources on Overuse                                 | Beccah Rothschild, Consumer Reports                                   | • Low back pain: Low-Base pain Rack Card and Imaging tests for LBP two-page brochure  
• Opioids: Medicines to relieve chronic pain and Treating Headaches with Pain Relievers  
• C-Section: Ten Things to Reject in the Delivery Room and Why Scheduling Early Delivery is Not a Good Idea |
| 10:45 AM| Topic 1: Cesarean Section for Low-Risk First-Time Births            | Lance Lang, M.D., Covered California  
Stephanie Teleki, Ph.D., CHCF                                        | • Pathways for the SWGRO on C-Section  
• Working Toward Happier Birthdays (HA Blog)  
• Letter to non-submitting hospitals  
• Excerpt from Draft Covered CA 2017 contract  
• Summary of Key Activities to Reduce Unnecessary C-sections in California (CHCF) |
| 12:00 PM| Lunch                                                                |                                                                      |                                                                                  |
| 12:30 PM| Topic 2: Imaging for Low-Risk Back Pain                             | Kathy Donneson, Ph.D., CalPERS  
Richard Sun, M.D., CalPERS  
Update on progress:  
• Parag Agnihotri, M.D., SRS  
• Jennifer Sayles, M.D., UCLA | • Discussion Document on Approaches to LBP Imaging  
• Medicare requirements re CDS (2017)  
• LBP Imaging: CA Data for 2014 and Related Activities |
| 1:45 PM| Topic 3: Opioid Dependence                                           | Neal Kohatsu, M.D., DHCS  
Kelly Pfeifer, M.D., CHCF  
Reactors:  
• Salina Wong, PharmD,BSCA  
• Joel Hyatt, M.D., Kaiser/LA collaborative | • Call to Action on Opioids  
• Stemming The Tide of Prescription Opioid Overuse, Misuse, and Abuse (HA Blog)  
• Approaches to End the Opioid Crisis (CHCF)  
• Don’t Let Zeal for Stopping Opioid Epidemic Create a New Class of Refugees (CHCF blog)  
• Kaiser Permanente Opioid Safety Framework  
• Physicians for Responsible Opioids Prescribing (video) |
| 3:00 PM| Next Steps and Action Items                                         | Lance Lang, M.D., Covered California  
Jill Yegian, Ph.D., IHA                                                 |                                                                                  |
| 3:30 PM| Adjourn                                                              |                                                                      |                                                                                  |
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 disproportionately 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.
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<thead>
<tr>
<th>Communications/ Dissemination - Plan, Provider, Policymaker</th>
<th>Cesarean Section for Low-Risk, First-TimeBirths</th>
<th>Imaging for Low Back Pain without Red Flags</th>
<th>Opioid Dependence</th>
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<td>• Push for more Choosing Wisely® recommendations from relevant societies around limiting the start of opioids.</td>
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<td>• Public recognition/awards for performance</td>
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<td>• Recommend that all major purchasers in California not pay more for C-sections than for vaginal births.</td>
<td>• Coverage of evidence based alternatives for low back pain (e.g. yoga)</td>
<td>Evaluate programs on opiate management with health plans</td>
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<td>• No payment for elective delivery &lt; 39 weeks as a start.</td>
<td>• Require some type of clinical decision support be delivered for advanced diagnostics</td>
<td>• Greater prescribing/formulary controls, prior authorization</td>
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<td>• CalPERS works with its health plans to develop a patient safety program with providers to reduce C-section, and plans put fees at risk to meet this performance measure. Could Cov CA and DHCS adopt?</td>
<td>• Reference pricing for LBP imaging? Doesn’t get to overuse issue (targets variation in price rather than whether it should occur in the first place)</td>
<td>• Peer-to-peer counseling from PBMs—some docs don’t know their patients are on high-dose opioids</td>
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<td>Provider Interventions/Training</td>
<td>Communications/Dissemination – Member, Consumer-Facing</td>
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| - Facilitate guided pre-term C-section discussion to prevent induced labor consent discussion  
- Education of both medical school and residency level  
- Reduce fear of malpractice -- disseminate updated ACOG guidelines  
- To address physician convenience issue, provide support for women in labor through midwives, “laborists” and/or shifting expectations about how long labor takes  
- Encourage provider participation in CMQCC Toolkit implementation  | - Develop a social media campaign in the regions with the highest C-section rates.  
- Consumer Reports -- Create a “5 questions” version of the Choosing Wisely questions that is specific to C-section  
- Make member information/education available on purchaser, plan, provider websites (can link to CR resources) – e.g., PERS has a PPO newsletter  |
| - Encourage capitated groups to offer the effective treatments (e.g. yoga, with savings).  
- Engage specialists  
- Actionable report with clinical recommendations on what patient can do  
- Promote clinical practice guidelines with identification of red flags driving imaging  
- Create an algorithm that providers can use to decrease LBP imaging that supports Choosing Wisely ® with benchmarks  | - Enhanced consumer education to understand the value of conservative approach to LBP  
- Engage consumers in risks and benefits of imaging  |
| - Primary care toolkit endorsement/support  
- Standardize prescriber toolkits.  
- Dental counter-detailing against pharma’s detailing  
- Opioid risk assessment as a way to assess potential for abuse  
- Guidelines for opioid prescribing  
- Psychotherapist integration  
- 90 day trigger – use clinical decision support to flag patients at 60 days; still on opioids at 90 days, very difficult to stop  
- Require docs to check CURES database before prescribing  | - Promote public messaging around safety and opiate use  
- Increase patient education to be an informed patient with respect to opioids |
Statewide Workgroup on Reducing the Overuse of Ineffective or Unnecessary Medical Care
Co-Chairs: Covered California, CalPERS, DHCS
Meeting #2 – Meeting Summary
Thursday, October 29, 2015, Inland Empire Health Plan

The agenda, materials, and slide decks presented at the October meeting are available at:

Workgroup Purpose and Scope
Initiators: Anne Price, Covered California; Jill Yegian, IHA

Anne Price welcomed the workgroup and thanked them for attending the second in-person meeting.
After introductions, Jill Yegian reviewed the Workgroup’s charter, presented on the progress to date of
the Workgroup since its inaugural meeting in June – including selection of three areas of focus for
reducing overuse: C-section for low-risk, first-time birth, low-back imaging without red flags, and opioid
dependence. She also shared the results of the member survey on promising intervention pathways,
and highlighted key areas of potential Workgroup activity – both collective and individual – including
creating a vision, partnering with national efforts such as Choosing Wisely, coordinated communication
efforts, and development of tools to support engagement (e.g. “action guides”). The group discussed
key areas of potential activity for purchasers, plans, providers, and consumers:

- **Purchasers**
  - influence plans (and providers) through contract requirements
  - educate consumers through member channels
  - influence consumers through benefit design

- **Plans**
  - influence providers through contracts (requirements or reimbursement)
  - share data with providers to support clinical decision-making
  - educate consumers through member channels

- **Providers**
  - influence clinician behavior through information, incentives
  - educate patients (and families) seeking inappropriate care

- **Consumers**
  - ask questions! Do I really need this? What are the risks? What if I do nothing?

Jill highlighted two key questions for the Workgroup members to keep in mind throughout the day:
1. What are the most promising intervention pathways for this test/treatment?
2. What role can the Workgroup play?

She asked participants to be prepared to contribute at least one idea for each of the three focus areas
(C-section, low-back imaging, and opioids) on 1) what the Workgroup could do together and 2) what
their own organization could do to reduce overuse.

**Topic 1: Cesarean Section for Low-Risk First-Time Births**
Initiators: Lance Lang, MD, Covered California; Stephanie Teleki, PhD, CHCF

Lance Lang kicked off the session with a brief description on the topic of Cesarean section for low-risk
births and the current work providers are doing to drive down the C-section rate. Lance introduced
Stephanie Teleki from the California HealthCare Foundation, who presented on the opportunities for collaboration on reducing C-section deliveries.

**Key Discussion Points:**

- Childbirth is the number one reason for hospitalization in the U.S.
- The costs for childbirth range from $15-20K/birth.
- California has over 500,000 births each year – 1/8 of all births in the U.S.; half are paid by Medi-Cal.
- C-section birth rates in both the U.S. and California are up by 50%.
- C-sections can cause harm to the baby that includes impaired neonatal respiratory function (NICU admits) and to the mother including increased rates of post-partum infection and depression complications.
- C-section births cost, on average, $5,000 more comparison with vaginal births.
- For plans: For every million members, reducing the C-section rate by one percentage point yields $200,000-300,000 in savings.
- Only 40% of California hospitals meet the national target (23.9%)
- CMQCC’s data center has the ability to track current hospital C-section rate, provide benchmarks, and drill down to MD and patient levels.
- Medi-Cal payment – a key factor, since Medi-Cal pays for 50% of births
  - In managed care, Medi-Cal has pushed a global rate (same for vaginal and C-section birth) to the health plans, and the plans are now pushing that rate to their contracted hospitals as the contracts are renegotiated.
  - Many women eligible for “pregnancy-only” Medi-Cal rather than full-scope, and their care is paid for on a FFS basis. Physician fees are same for C-section vs. vaginal but the hospital fee is still differentiated. Difficult to equalize those fees on the FFS side due to the many funding streams, complex financing.
- Malpractice – there were different perspectives on whether liability is a significant driver of C-section rates. One participant related first-hand experience with bad experiences of a few physicians being sued resulting in increased C-sections for the medical group. The high rate for the group isn’t due to convenience (they have hospitalists) or incentives (which are aligned) but rather concern about malpractice.
- Potential collaboration for the workgroup to consider in adopting/advocating include:
  - Urging provider level participation in CMQCC’s data center
  - Consumer level: providing educational tools to patients
  - Health Plan: Potential consideration of a value-based payment
  - Purchaser: Development of maternity care measures

**Ideas for the Workgroup to Pursue -- Cesarean Section for Low-Risk, First-Time Births**

After the discussion, participants contributed at least one idea regarding what the Workgroup could do to reduce C-section rates. A summary is below.

Partnering

- Consumer Reports -- Create a “5 questions” version of the Choosing Wisely questions that is specific to C-section
- Advocate ACOG to create a more specific Choosing Wisely® recommendation on this topic (mentioned by several members)
• Encourage and entice hospitals performing deliveries to participate and engage CMQCC, e.g. co-brand communications to hospital CEOs and CMOs encouraging CMQCC participation (multiple votes along these lines)
• ACOG and CAPG have a partnership for a speaker series
• Present topic at CAPG-CHA roundtable for increasing stakeholder engagement

Communications/Dissemination -- Consumer
• Develop a social media campaign in the regions with the highest C-section rates.
• Need to link with California organizations that serve labor and general public (SEIU, etc.) to communicate about decreasing C-sections.
• Continue to partner and diffuse educational efforts like disseminating tools to our members.
• Consumer education available on Covered California website – link to CR guides for “moms to be”
• Create coordinated effort for Workgroup to share/disseminate resources, information across the state.
• Develop deeper and broader consumer content
• Targeted communications to members
• Use organization website to reach others.

Data/Transparency/Public Reporting
• Share data with hospitals and plans and then publish comparable data – peer comparison is a significant driver for behavior change.
• Members should publicize NTSV C-section rate within their organizations highlighting the HP 2020 “23.9%” target.
• Publish NTSV rates by hospital and physician
• Increasing obesity rate needs to be addressed.

Payment/Purchaser Interventions
• Recommend that all major purchasers in California not pay more for C-sections than for vaginal births.
• No payment for elective delivery < 39 weeks as a start.
• CalPERS works with its health plans to develop a patient safety program with providers to reduce C-section. Plans put fees at risk to meet this performance measure.
• Encourage plans to standardize delivery payments to physicians and hospitals – one delivery payment; do not contract more for c-section.
• Equalize payment to hospital
• Align national care performance measures in core measurements, especially as they relate to payment reform.

Provider Interventions/Training
• Facilitate guided pre-term C-section discussion to prevent induced labor consent discussion
- Education of both medical school and residency level
- Resident training
- Reduce fear of malpractice -- disseminate updated ACOG guidelines
- To address physician convenience issue, provide support for women in labor through midwives, "laborists" and/or shifting expectations about how long labor takes

**Topic 2: Imaging for Low Back Pain Without Red Flags**

**Initiators:** Doug McKeever, CalPERS; Jennifer Sayles, MD, LAC-DHS; Parag Agnihotri, MD, Sharp Rees-Stealy; Sarah Maltby, MBBS, Stanford CERC

Doug McKeever remarked on the importance of musculoskeletal services as a cost driver for CalPERS, and the value of focusing on this topic for both PERS and its employees. He noted that PERS is also interested in pricing, as a next step in this area -- that is, if imaging for low back pain is necessary, how should it be priced? He committed support from PERS, including data, to help shape the pathway forward. Kathy Donneson from CalPERS commented on the model CalPERS has adopted to support population health. After framing comments, the group heard from three presenters: Drs. Jennifer Sayles, Parag Agnihotri, and Sarah Maltby. Dr. Sayles and Dr. Agnihotri are both grantees participating in ABIM Foundation’s Choosing Wisely ® initiative, and are targeting reducing imaging for nonspecific low back pain. Dr. Maltby presented via telephone.

**Jennifer Sayles -- Key Discussion Points:**
- Currently no systemic approach to ensuring appropriate and evidence based use of imaging resources.
- One way LA County Department of Health Services (LAC-DHS) is approaching high value imaging is through the use of a clinical decision support (CDS) tool integrated into their EHR providing real time recommendations that match their clinical practice guidelines and resources.
- Medicare will require CDS for reimbursement of advance imaging starting in 2017.
- The decision support tools were piloted at two facilities in June 2015 and had an intended goal of demonstrating a 10% reduction in inappropriate diagnostic imaging orders after six months of implementation.
- For the period of February 2015-June 2015 LAC-DHS received a total of 33,965 diagnostic imaging orders across the piloted sites, one-third of which received guidance via clinical decision support. LAC-DHS found:
  - 17% reduction in inappropriate diagnostic imaging --7% above their initial goal.
  - over the 6 month pilot period for sites, 14% of orders for LBP MRIs were inappropriate: no red flags were present and the CDS recommended no imaging, but the MRI was still ordered.
  - Opportunity for savings of $902,000 for LBP imaging alone in a year if 12% reducing in appropriate imaging is spread throughout system.

**Parag Agnihotri -- Key Discussion Points:**
- Sharp Rees-Stealy (SRS) Medical Group is a project partner under the leadership of IHA, one of seven organizations participating in efforts to reduce inappropriate care through a grant with the American Board of Internal Medicine Foundation. SRS is focused on demonstrating a reduction in inappropriate care for the following test and treatments: antibiotic usage, preoperative stress testing, and imaging for low back pain.
- Sharp Rees-Stealy is working to align stakeholders internally toward reducing overuse.
Provider and staff educational resources such as those provided by Choosing Wisely® written by Consumer Reports are important in teaching clinicians how to administer appropriate care for patients. In addition to provider resources, Choosing Wisely® has also provided consumer engagement materials for patients to make for a shared decision making process.

Currently, SRS is finding that back specialists are ordering high numbers of LBP images for patients in comparison to primary care physicians indicating that engagement efforts should be made for all clinicians – not just PCPs -- in order to see improvement.

Sarah Maltby -- Key Discussion Points:

1. 1 in 10 healthcare dollars is spent on spine pain in the U.S.
2. The current care flow for patients faced with back pain is a maze of options with no clear signposts. Care is fragmented and outcomes highly variable.
3. Stanford CERC’s team is focusing on a new model of care for patients experiencing spine pain called the ICE Model.
   - I: Early Identification of patients: a brief validated risk assessment tool triages patients into 2 groups -- those at low risk and those at high risk of developing chronic back pain. The 90% of people who will improve within 6 weeks are directed to the low risk pathway and will receive education in prognosis and cause of spine pain and in self care management by a skilled physical therapist.
   - C: For the 10% of patients identified as being at high risk of chronic pain: High touch coordinated care is provided by a dedicated spine team
     - The spine clinician acts as the quarterback, with navigation aided by a back coach and overseen by medical director
   - E: Both patient and provider are engaged by enhanced decision support throughout the model.
     - For patients: shared decision making support and primers to help navigate evidence based preference sensitive referrals
     - For doctors: decision supports embedded in spine service for prescriptions/imaging and onward referral
4. Team has forecast that they will achieve a conservative 25% savings.

Ideas for the Workgroup to Pursue – Imaging for Low-Back Pain without Red Flags

After the discussion, participants contributed at least one idea regarding what the Workgroup could do to reduce low-back imaging.

Partnering

- This group can address HASC area hospitals in the Most Appropriate Care (MAC) Initiative about levers (e.g. clinical decision support), especially for patients presenting to ED with LB pain, and alternatives to imaging.
- Work w/ CMS Region IX RIM group to broadly communicate the Choosing Wisely® imaging for LBP campaign (i.e. webinar, symposium, etc.).

Communications/Dissemination -- Consumer

- Enhanced consumer education to understand the value of conservative approach to LBP
- Engage consumers in risk and benefits of imaging.
Data/Transparency/Public Reporting

- Set target based on analysis of variation in rates/1000 (need better measure)
- Establish the measurement and benchmarking model to create transparency and physician and practice level similar to what happened for c-section.
- Establish statewide benchmarks; rates in different populations; definitions.

Payment/Purchaser Interventions

- Coverage of alternative evidence based alternatives for low back pain (e.g. yoga)
- Require some type of clinical decision support be delivered for advanced diagnostics
- Reference pricing for LBP imaging? Doesn’t get to overuse issue (targets variation in price rather than whether it should occur in the first place)
- Push health plans to resume prior authorization if there is no red flag.

Provider Interventions/Training

- Encourage capitated groups to offer effective treatments (e.g. yoga).
- Engage all specialists.
- Actionable report with clinical recommendations on what patient can do.
- Promote clinical practice guidelines with identification of red flags driving imaging.
- Create an algorithm that providers can use to decrease LBP imaging that supports Choosing Wisely® with benchmarks.
- Educate clinicians what they can do to assist patients with lower back pain alongside clinical decision support of when not to do MRI’s.
- Data sharing at the primary and specialty physician level (comparative data/feedback)

Topic 3: Opioid Dependence
Initiators: Neal Kohatsu, MD, DHCS; Kelly Pfeifer, MD, CHCF

Neal Kohatsu made opening remarks about the increase in opioid use and the current costs DHCS is seeing through the rise in prescription drugs and the potentially harmful effects -- at times fatal -- seen among patients. He proposed that an important measure for success in this area is reduced mortality. Neal then introduced Dr. Kelly Pfeifer from CHCF to provide an overview of the issue of opioids dependence and pathways to create change.

Key Discussion Points:

- Over a ten year period (2001-2012) the sale of opioids has gone up by 100%. California’s rural north has the highest prescribing rates. Counties with no narcotic treatment programs tend to have high death rates.
- Severe dopamine depletion is a chronic brain disease caused by long-term licit or illicit opioid use that can be temporary or permanent, leading to making poor judgement calls and potentially resulting in overdose, suicide.
• Long-term opioids can worsen the pain and increase disability. Slow tapers to lower doses can decrease pain, improve function and decrease mortality.

• **Need a three-pronged effort:**
  - **Safe Prescribing**
    - Avoid new starts, taper chronic users to safer doses where possible
  - **Medication-Assisted Treatment**
    - Help opioid “refugees” – treat those who are dependent
  - **Naloxone**
    - Useful in preventing deaths and saving lives

• A few California organizations are leading the way in tackling the issue of overuse including, e.g. Partnership Health Plan reduced number of opioid prescriptions dramatically through ECHO, authorized policies and local coalition

• Potential next steps for the workgroup to consider:
  - Vision and Call to Action: 20/20/2000 Campaign – drop prescriptions and deaths by 20%, save 2000 lives by 2020
  - Communication campaign of notable successes, dissemination of resources
  - Producing or endorsing action guides for policy/purchaser, health plan, provider/group, consumer/patient/families

**Ideas for the Workgroup to Pursue – Opioid Dependence**

After the discussion, participants contributed at least one idea regarding what the Workgroup could do to reduce low-back imaging. There was strong support from multiple Workgroup members for focusing on “no new starts” across multiple disciplines, all prescribing providers, and multiple settings.

**Partnering**

- Push for more *Choosing Wisely* ® recommendations from relevant societies around limiting the start of opioids.
- Support materials and messaging to county-wide collaborative.
- Support/fund materials distribution for existing county collaborative like the IE safe ED prescribing task force on which I sit to get the resources into the EDs to help decrease initial dosing (new starts).

**Communications/Dissemination -- Consumer**

- Promote public messaging around safety and opiate use.
- Increase patient education to be an informed patient with respect to opioids.
- Success stories – how did they do it? Partnership Health Plan, Kaiser (CHCF doing an issue brief on best practices)

**Data/Transparency/Public Reporting**

- Tackle patient satisfaction ratings concern – denying patients opioids (e.g. in emergency room) results in patients “dinging” physicians on satisfaction surveys.

**Payment/Purchaser Interventions**
- Evaluate programs on opiate management with health plans.
- Plans → firm quantity limits and morphine equivalent limits on opiates (e.g. limited dose, zero refills)
- DHCS should encourage or mandate safe prescribing policies.
- New start focus- better pharma pain-management without interrupts to palliative care.
- Greater prescribing/formulary controls, prior authorization
- Peer-to-peer counseling from PBMs – some docs don’t know their patients are on high-dose opioids

**Provider Interventions/Training**

- Primary care toolkit endorsement/support.
- Dental counter-detailing against pharma’s.
- Opioid risk assessment as a way to assess potential for abuse.
- Guidelines for opioid prescribing.
- Psychotherapist integration
- 90 day trigger – use clinical decision support to flag patients at 60 days because if they are still on opioids at 90 days it will be very difficult to stop
- Standardize prescriber toolkits.

**Next Steps: Where do we go from here?**
Initiators: Jill Yegian, IHA; Anne Price, Covered CA

The discussion focused on developing a “roadmap” for each of the three focus areas. Efforts on C-section are farthest along, and could provide a useful model for organizing multi-pronged efforts in the other areas (see graphic below). Specific next steps are to:

1. Summarize the ideas suggested by Workgroup members in each of the three areas, and work with Co-Chairs and other members to prioritize among those ideas
2. Develop a plan to obtain baseline data, set targets, and evaluate and track progress. Sources for each area include CMQCC for hospital C-section rate, CURES 2.0 for opioids, and CalPERS for low back imaging.
3. Pursue a Workgroup “brand” and communications strategy to leverage the influence of the organizations involved
4. Convene the third meeting of the Workgroup in February, and discuss specific activities in each area for collective Workgroup effort.

Jill and Anne thanked the members of the Workgroup for attending, and IEHP for hosting, and adjourned the meeting.
Doing What Works: engaging the public as policy-makers

Note: the results of DWW will be presented at the Workgroup meeting 2/29/16

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 ineffective, harmful and/or wasteful. This project was developed to inform the work of both the Statewide Work Group on Reducing Overuse as well as IHA’s ABIM/RWJF project Decreasing Inappropriate Care in California in Partnership with Choosing Wisely. DWW objectives:

- Engage lower-to-middle income Medi-Cal, CoveredCA and CalPERS members in deliberative group discussions on the topic of reducing overuse.
- Identify the approaches that are the most acceptable for reducing overuse of unnecessary care.
- Establish a precedent of civic participation in California healthcare policy.
- Contribute to state and national understanding of how the public views the role of medical evidence in treatment or coverage decisions.

DWW Project Description
Unlike typical focus groups, DWW deliberative discussions ask participants to:

- Help solve a problem, not just comment on it.
- Consider the impact on everyone with insurance, not only themselves or their family.
- Act as social decision-makers providing input to policy decisions.

There were 117 participants in 10 deliberative sessions, each 4½ hours long, in multiple regions of the state. Two of the sessions were conducted in Spanish. Each session centered on four case scenarios:

1. Overuse of antibiotics for adult bronchitis
2. Overuse of C-sections with normal pregnancies
3. Overuse of MRIs for acute low back pain
4. Using costly, minimally-effective drugs

Pre and post-survey questions gauged the impact of the discussion on their perspectives.

Advisory Committee
Advisory committee members provided input to all aspects of project design:

- 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
- Elizabeth Landsberg, JD, Director of Policy Advocacy, Western Center on Law & Poverty
- Marion Leff, MD, family practice physician
- Susan Perez, Ph.D, MPH, Postdoctoral Fellow, UC Davis Medical Center
- Beccah Rothschild, MPA, Senior Outreach Leader, Health Impact Team, Consumer Reports
- Crystal Tarver, Medi-Cal member
- Glennah Trochet, MD, retired family practice physician/county health officer

Project support
DWW is funded by the California HealthCare Foundation and Kaiser Permanente National Community Benefit Fund.
Does your lower back hurt?
You probably don’t need an MRI, CT scan, or X-ray.

Here’s why:

• They won’t help you feel better any faster.
• They have risks, including exposure to radiation.
• They aren’t cheap.

What can you do to feel better? Five easy ideas are on the other side.
Most people can get over lower-back pain in a few weeks by trying these steps:

1. Stay active and walk.
2. Use heat.
3. Take non-prescription pain relievers like Tylenol, Advil, or Aleve.
4. Sleep on your side or your back, with a pillow between or under your knees.
5. Ask your doctor about acupuncture, massage, yoga, or physical therapy.

There are still times when you might need an imaging test. Talk to your doctor about your symptoms to find out if you need imaging tests – or if you can wait to see if you just get better with time.

Learn more at www.ConsumerHealthChoices.org/BackPain

This information is to use when talking with your healthcare provider. It is not a substitute for medical advice and treatment. Use this information at your own risk.

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Imaging tests for lower-back pain
You probably do not need an X-ray, CT scan, or MRI

X-rays, CT scans, and MRIs are called imaging tests because they take pictures, or images, of the inside of the body. You may think you need one of these tests to find out what is causing your back pain. But these tests usually do not help. Here’s why:

The tests do not help you feel better faster.
Most people with lower-back pain feel better in about a month, whether or not they have an imaging test.

People who get an imaging test for their back pain do not get better faster. And sometimes they feel worse than people who took over-the-counter pain medicine and followed simple steps, like walking, to help their pain.

Imaging tests can also lead to surgery and other treatments that you do not need. In one study, people who had an MRI were much more likely to have surgery than people who did not have an MRI. But the surgery did not help them get better any faster.

Imaging test have risks.
X-rays and CT scans use radiation. Radiation has harmful effects that can add up. It is best to avoid radiation when you can.
Imaging tests are expensive. The chart below shows the costs of imaging tests according to HealthcareBlueBook.com. Why waste money on tests when they do not help your pain? And if the tests lead to surgery, the costs can be much higher.

<table>
<thead>
<tr>
<th>Imaging Test</th>
<th>Price Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-rays of the lower back</td>
<td>$200 to $290</td>
</tr>
<tr>
<td>MRI of the lower back</td>
<td>$880 to $1,230</td>
</tr>
<tr>
<td>CT scan of the lower back</td>
<td>$1,080 to $1,520</td>
</tr>
</tbody>
</table>

When are imaging tests a good idea?
In some cases you may need an imaging test right away. Talk to your doctor if you have back pain with any of the following symptoms:
- Weight loss that you cannot explain
- Fever over 102° F
- Loss of control of your bowel or bladder
- Loss of feeling or strength in your legs
- Problems with your reflexes
- A history of cancer
These symptoms can be signs of nerve damage or a serious problem such as cancer or an infection in the spine.

If you do not have any of these symptoms, we recommend waiting a few weeks. Before you have a test, try the self-care steps in the blue box.

Advice from Consumer Reports
How to treat lower-back pain

Many people get over lower-back pain in a few weeks by following these self-care steps:

**Stay active.** Walking is a good way to ease lower-back pain. If you stay in bed, it can take longer to get better. If you stay in bed more than a day or two, you can get stiff, weak, and even depressed. Get up and move.

**Use heat.** Heat relaxes your muscles. Try a heating pad, electric blanket, warm bath, or shower.

**Take over-the-counter medicines.** To help relieve pain and reduce swelling, try pain relievers or drugs that reduce swelling (called anti-inflammatory drugs). Remember, generic medicines cost less than brand names, but work just as well.
- Generic acetaminophen (brand name Tylenol)
- Generic ibuprofen (brand name Advil)
- Generic naproxen (brand name Aleve)

**Sleep on your side or on your back.** Lie on your side with a pillow between your knees. Or lie on your back with one or more pillows under your knees.

**Talk to your doctor.** If your pain is very bad, ask about prescription pain medicines. If they do not help within a few days, talk with your doctor again. Ask if the pain might be caused by a serious health problem.

**Find out about other ways to treat back pain.** If you still have pain after a few weeks, you may want to ask your doctor about other treatments for lower-back pain. Treatments include:
- Physical therapy
- Chiropractic care
- Acupuncture
- Yoga
- Massage
- Cognitive-behavioral therapy
- Progressive muscle relaxation

Find out if your health insurance pays for any of these treatments.

**Surgery is a last choice.** Surgery usually does not help very much. It has risks, and it costs a lot. Think about surgery only if other treatments do not help your pain.
Medicines to relieve chronic pain
When you need opioids (narcotics)—and when you don’t

Opioids (narcotics) are common pain medicines. They can help if you have bad short-term pain—like pain after surgery for a broken bone. They can also help you manage pain if you have an illness like cancer.

But opioids are strong drugs. And usually they are not the best way to treat long-term pain, such as arthritis, low back pain, or frequent headaches. This kind of pain is called “chronic” pain. Before getting opioids for these problems, you should discuss other choices with your doctor. Here’s why:

Opioids are prescribed too often.
Chronic pain is one of the most common reasons people see the doctor. One in five of these patients gets a prescription for opioids.

Common opioids include:
• Hydrocodone (Vicodin and generic).
• Oxycodone (OxyContin, Percocet, and generic).
Short-term use of these medicines may help. But there is no proof that they work well over time.

Opioids have serious side effects and risks.
Over time, the body gets used to opioids and they stop working as well. To get the same relief, you need to take more and more. Higher doses can cause serious side effects:

• Nausea
• Vomiting
• Itching
• Constipation
• Not being able to urinate enough
• Breathing problems, which can be deadly
• Confusion and mental disturbance

Opioids can be very addictive. Up to one in four people who take opioids long-term become addicted. Worst of all, every day, 46 Americans die from an overdose of opioid painkillers. And hundreds more go to the emergency room.
Opioids can be expensive.
Some opioids, such as oxycodone, can cost over $1,000 each month. A good insurance plan may cover the drugs. But if you have bad side effects, you might still spend a lot.

Other pain treatments may work better and have fewer risks.
Pain medicine specialists say that usually you should try other treatments first:
• Over-the-counter medicines (see Advice column)
• Non-drug treatments:
  o Exercise
  o Physical therapy
  o Spinal manipulation
  o Massage therapy
  o Acupuncture
• Injections, such as steroids
• Other prescription drugs
  (ask about risks and side effects):
  o Non-steroidal anti-inflammatory drugs (NSAIDs)
  o Anti-seizure drugs

When should you consider taking opioids?
You have cancer with severe pain: Opioids may be the right choice if pain is a bigger concern than the possibility of addiction and the need to keep increasing the dose.

You have chronic pain that is not caused by cancer: Only use opioids when the pain is strongest. Your doctor should check you often.

If you need around-the-clock pain relief and other treatments are not helping enough: In this case, your doctor may consider an extended-release opioid like oxycodone, morphine, and the new drug Zohydro ER (a long-acting version of hydrocodone). Don’t use long-acting drugs simply because it’s easier to take fewer pills.

What should you do if your doctor prescribes opioids?
Talk to your doctor about the possible side effects and risks. Watch for side effects and signs of addiction. These include unusual moodiness or bursts of temper, cravings, and risk-taking.

Advice from Consumer Reports
Using over-the-counter pain relievers
Depending on your pain, an over-the-counter drug might be all you need. The drugs listed below are generally safe if they are used correctly and not too often:
• Acetaminophen (Tylenol and generic)
• Ibuprofen (Advil, Motrin IB, and generic)
• Naproxen (Aleve and generic)

The generic and store-brand versions of these drugs are cheaper than brand-name versions. And they are just as safe and effective.

Follow these safety tips:
• Read labels carefully and take the recommended dose.
• Do not take acetaminophen if you drink a lot of alcohol, or if you have liver disease or are at risk for it.
• Do not mix similar drugs, such as ibuprofen and naproxen. Both of these drugs are NSAIDs.
• Do not take ibuprofen or naproxen or any other NSAID for more than 10 days without talking to your doctor. These drugs can cause stomach and intestinal bleeding. Long-term use can cause kidney damage.

Watch out for acetaminophen overdoses.
Consumer Reports recommends staying below 3,250 mg per day.
• Taking more can increase the risk of liver, brain, and kidney damage.
• It is easy to get too much acetaminophen. It is in more than 600 products, including pain relievers, cold and sinus drugs, seasickness pills, and sleep aids.
• Read labels and add up the totals if you take more than one drug containing acetaminophen.

This report is for you to use when talking with your health-care provider. It is not a substitute for medical advice and treatment. Use of this report is at your own risk.
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Treating frequent headaches with pain relievers

When you need them—and when you don’t

Many people suffer from frequent, severe headaches, including migraines. These headaches need careful treatment, with a focus on prevention. Talk to your doctor about ways to prevent and treat your headaches.

- Limit use of over-the-counter pain drugs. If you are taking them more than two days a week, cut back.
- Avoid using prescription drugs containing opioids or butalbital, except as a last resort.

It is easy to use too much pain medicine. This can make headaches worse and cause other medical problems. Here’s why:

**Over-the-counter pain medicines can have dangerous side effects.**

Aspirin, acetaminophen, and ibuprofen work well for headaches if you don’t use them often.

But if you take these drugs too often, you can get serious side effects. In rare cases, if you often take acetaminophen several days in a row, you can damage your liver. This can happen even if you take just a little over the recommended dose.

Rarely, these drugs can also cause kidney problems. Aspirin and ibuprofen can, at times, cause stomach bleeding.
Watch out for overuse headaches.
If you overuse pain medicines, they may no longer help as much. And you may also get headaches more often. This worsening of headaches is called “medication overuse headaches.” The following drugs are thought to most likely cause overuse headaches. They may also make you more sensitive to pain:

Prescription drugs:
- Drugs with butalbital (Fiorinal, Fioricet, Esgic and others)
- Opioid painkillers
  - hydrocodone (Vicodin and other brands and generics)
  - oxycodone (OxyContin, Percodan, Percocet and others)

Non-prescription drugs that contain caffeine (Excedrin Migraine)

Some pain drugs can cause addiction.
Drugs that contain opioids or butalbital can make you drowsy. Long-term use of these drugs can cause addiction or physical dependence, and overuse headaches.

Some people need headache treatment for years, or even decades. They should take addictive drugs only if safer treatments don’t work. If you do have to take addictive drugs, ask your doctor how to avoid overuse and addiction.

Lifestyle changes can help some people with severe headaches.
Often, you can prevent headaches or have them less often if you:
- Reduce stress, or learn to cope with it more effectively.
- Drink a minimum of alcohol.
- Get enough sleep.

If you still get headaches more than once a week, you can consider taking a daily preventive drug.

If you need pain relief during a bad migraine, drugs called triptans work well for most people. They usually have fewer side effects than other prescription drugs. Four of the seven FDA-approved triptans are available as generics, such as sumatriptan (Imitrex).

Tips to help you manage headache pain

Keep a record of each headache.
Note possible triggers—foods, beverages, sleep patterns, or other things that cause your headaches.

Reduce triggers.
For example, consider using tinted glasses to reduce the effects of bright light.

If menstruation routinely leads to migraines, ask your doctor if you could ward off headaches by taking ibuprofen (Advil, Motrin IB, and generic) regularly for a few days around your period.

Simple changes can sometimes prevent headaches:
- Cut back on alcohol.
- Control the effects of stress with bio-feedback, meditation, relaxation, or in other ways.
- Aim for 6 to 8 hours sleep each night. Go to bed and wake up around the same time. Don’t watch TV or use a computer in bed.
- If you snore, ask your doctor if you should be checked for sleep apnea.

If you need preventive drugs, start with safer choices. Choose drugs that have been proven to work.

Beta blockers are often the best first choice. They don’t cost much and they have long safety records. Examples include propranolol (Inderal and generic) and timolol (Blocadren and generic). Some side effects are fatigue and fainting, caused by low blood pressure.

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10 Things To Reject In the Delivery Room

Talk to your doctor about these 10 things that you may want to reject during your baby's delivery. They’ll help you – and your baby – get off to a healthier start.

1. **An early, elective delivery**
   Carrying your baby to at least 39 weeks has important health benefits. It will help your baby develop and grow, and help you avoid postpartum depression.

2. **Inducing labor without medical reason**
   If your labor is induced – or started – before you and your baby are ready, you are more likely to have a C-section and other complications, including more painful contractions.

3. **Continuous electronic monitoring**
   Unless your labor is induced, you had an epidural, or you are trying a VBAC, ask for your baby to be monitored at certain intervals instead of continuously. Continuous monitoring will keep you from moving around, may slow your labor, and may lead to a C-section or forceps delivery.

4. **A C-section for a low-risk, first birth**
   A C-section is major surgery for you and adds risks for your baby. If it’s not medically necessary, the safest way to deliver is vaginally.

5. **An automatic C-section for a second birth**
   Even if you had a C-section before, you don't automatically need to have one again. Most women who try to have a vaginal birth after C-section (VBAC) are successful.

6. **An early epidural**
   An epidural puts medicine in your back to block pain. But the longer you have it, the more medicine builds up in your body. Too much can make it hard to feel enough to push and can slow labor. If you have an epidural, talk to your doctor about using a lighter dose and not starting it early in your labor.

7. **Breaking your water**
   Sometimes doctors want to break your water. They do this to try to make contractions stronger and labor shorter. But, it usually doesn’t work and can cause complications.

8. **A routine episiotomy**
   This surgical cut makes the opening of your vagina bigger. It may be needed for forceps and vacuum deliveries, or if your baby is coming down too fast. But otherwise, it doesn’t help and can lead to a longer healing time.

9. **Sending your newborn to the nursery**
   Unless your newborn needs special attention, keep him or her with you. This will help with bonding.

10. **Waiting to breastfeed**
    Have your healthy, naked baby placed on your bare chest right after it's born. Your baby will be warmer and more likely to breastfeed.

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Sometimes there are medical reasons for a woman to deliver her baby before naturally going into labor. For example, if a week or more passes after the due date and the baby does not come, doctors may need to start, or induce, labor. Or if the woman or her baby is at risk, doctors may need to deliver the baby by Cesarean delivery, or C-section.

These types of deliveries can save lives. But to hurry a baby’s birth—just to make it convenient for you or your doctor—can increase the risk of serious problems for both you and your baby. Here’s why:

**Full term is better.**
A full-term pregnancy lasts at least 39 weeks. Of course, some babies naturally arrive sooner. And complications during pregnancy can make an early delivery the safest choice. But most babies need 39 weeks to develop fully. Induced or planned delivery before that time—without valid medical reason—is not in the best interest of the baby or the mother.

Between 1990 and 2007, there were fewer full-term births, and almost twice as many babies born at 37 and 38 weeks. One reason for this is that it became more common for women to be scheduled for a C-section or to have labor induced before their due date. Some hospitals have taken recent steps to reduce unnecessary early deliveries, but too many births are still being scheduled for convenience.

Carrying an infant the full 39 weeks has important health benefits for the baby and the mother. For example, during weeks 37 and 38, the baby’s lungs and brain are still developing. The baby’s body also gains fat during this time, which helps the baby keep a healthy body temperature.
Babies induced or delivered by C-section before 39 weeks are more likely to have problems breathing and feeding, have severe jaundice, and need intensive care after birth. They also have a higher chance of having cerebral palsy, which can affect movement, hearing, seeing, thinking, and learning. And, while the overall risk of infant death is low, it is higher for babies who are delivered before 39 weeks.

Women who carry their baby at least 39 weeks also have less postpartum depression. This may be because their infants are less likely to have problems than those born early.

**Let nature take its course.**

To prepare for birth, the cervix softens and thins. As this happens, the opening gets bigger, or dilates. But if your cervix has not changed, even if you’re in the 39th week of your pregnancy, you should not induce labor without a medical reason.

If your body is not ready, your delivery is less likely to go smoothly. For example, you are at increased risk of having a C-section, especially if you are giving birth for the first time. And your baby may be more likely to need intensive care after delivery.

Even when the cervix shows signs of being ready, there are reasons to allow labor to happen on its own. Natural labor is usually easier and shorter than induced labor. And you can usually spend the early part of your labor at home, moving around and staying as comfortable as you can.

By contrast, an induced labor takes place in the hospital. You will most likely be hooked up to medical equipment, including at least one intravenous (IV) line and an electronic fetal monitor. You will be given medicines to start your labor. You may not be able to eat or drink.

**When should you induce labor?**

Having a doctor start your labor is justified when there’s a medical reason, such as your water breaking and labor not starting. You may also need labor induced if you are a week or more past your due date.

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**Advice from Consumer Reports**

**What you can do to make your delivery easier**

The hustle and bustle of a hospital can feel overwhelming. Here are three ways to help yourself feel more in control and help your delivery go more smoothly:

- **Get support during your labor.** Women who receive continuous support during labor have shorter labors and need less medical help. You might get support from a family member, close friend, or trained birth assistant (a doula).

- **Plan what to do, and listen to yourself.** Plan several ways to cope with your labor, such as walking, rocking, and showering. When it is time to push, sit up straight or lay on your side instead of flat on your back. And trust your instincts about when to push. Research shows that allowing the woman to push in the way that feels right to her works better than having her push when someone else says to push.

- **Cuddle your newborn right away.** Healthy newborns who are placed naked on their mother’s chest right after birth stay warmer. They are also more likely to be breast-fed and to breast-feed longer than those who are taken away to be cleaned, measured, and dressed.

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Topic 1: Cesarean Section for Low-Risk First-Time Births
Meeting Materials
Pathways for the SWGRO on Reducing C-Sections in Low-Risk Births

The blog posting “Working Toward Happier Birthdays: An Effort in California to Lower C-Section Rates” by Stephanie Teleki that appeared in Health Affairs in November (in the materials packet) provides a great overview of this issue. Other background materials included in the packet, intended to provide context for the Statewide Workgroup on Reducing Overuse efforts to lower the rate of Cesarean section for first-time, low-risk birth in California, include:

- A joint letter 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
- An excerpt from Covered California's draft 2017 contract that sets an expectation that health plan partners will reduce the C-section rate for their members;
- A summary of related activities ongoing around the State

What can the Statewide Workgroup on Overuse Do?

Given the progress that has been made and the momentum gained on reducing C-section for low-risk, first-time birth, what can the Statewide Workgroup on Reducing Overuse do to contribute to effort? Three potential next steps are proposed for the Workgroup's consideration:

- Public recognition (or awards) for hospitals contributing data and/or meeting target
- Member-facing materials – create targeted, accessible materials and make them available to consumers and providers
- Payment principles – identify key levers available to purchasers and plans in the payment realm, and commit to adopting them for future contracts

Public Recognition/Awards for Hospitals

While much of the attention to incentives focuses on payment, non-financial rewards can be a very powerful motivator in changing provider behavior. Potential directions and discussion questions are outlined below.

Potential Directions:

- Recognition in provider directories for:
  - Data center participation (submitting data to CMQCC)
  - Participation in CMQCC’s quality improvement collaborative
  - Meeting the national target (23.9%)
- Annual awards for high-performing hospitals – options include:
  - Meeting the national target
  - Reaching other benchmarks
• Most improved

Questions for Workgroup:
1. How influential do you think recognition in provider directories would be for hospitals? How feasible?
2. How influential do you think an annual awards program for high-performers would be for hospitals? How feasible?
   a. Should an award come from the Statewide Workgroup on Reducing Overuse, from CMQCC, or from some other source?
   b. Would you be willing to endorse/sign on to an award program?

Member-Facing Materials
One factor contributing to high C-section rates is lack of awareness of the risks for both mom and baby. Educational materials can be helpful, if they are relevant, accessible, and specific. Purchasers and health plans can make materials available to members, and providers can make them available to clinicians working with patients. Potential directions and discussion questions are outlined below.

Potential Directions:
• Create evidence-based materials on C-section for low-risk first-time birth
  o Collaborative effort, co-branded by Consumer Reports (for consumer credibility) and CMQCC (provider credibility)
  o Tailor to appropriate literacy levels and diverse populations
• Make consumer-facing materials widely available
  o Post on purchaser, plan and provider websites
  o Make available to providers, others working with pregnant women to support discussions about delivery

Questions for Workgroup:
1. Would you be interested in/willing to post consumer-facing materials on your website?
2. Do you see a need/demand among providers for materials that can be given to consumers related to C-section?

Payment Principles
Reimbursement is clearly an important lever in addressing inappropriate and unnecessary Cesarean section, but it is also a blunt instrument and requires attention to feasibility and unintended consequences. Potential directions and discussion questions are outlined below.

Potential Directions:
• Align payment with desired outcomes for both hospitals and physicians
• Do not pay more for C-sections
  • Like Covered California, can leave open how payment is structure (e.g. blended, other), but key is to remove financial incentive for C-section
Network Participation Principles

- Set a deadline for achieving clinical target with intermediate milestones:
  - Data center participation (especially for smaller hospitals for which center participation fees to be instituted in 2017 may be a hardship)
  - Participation in the QI Collaborative to start in Spring 2016 (focused on hospitals that are above 23.9%; first recruitment wave to be in Southern California where birth and C-section rates are highest; second wave statewide)
  - Meeting the national target (23.9%)
    - Hospitals not meeting a specified target by X date would no longer be in the network for maternity services (unless in working with the Health Plan they can provide a rationale for continued participation in spite for higher rates and document ongoing efforts to improve, following the Covered California model)

Questions for Workgroup:
1. Would you be willing to commit to these payment and network participation principles, in concept?
2. What are the barriers to moving ahead based on these principles?
3. Are other purchasers moving to align with these principles?
Working Toward Happier Birthdays: An Effort In California To Lower C-Section Rates

Stephanie Teleki
November 2, 2015

Birth is universal, and because of this fact, it is also a big health care issue. Childbirth is the number-one reason for hospitalization in the United States. The stakes are high, both healthwise and costwise. It is the only instance that begins with one patient and ends with at least two. And at about $15,000-$20,000 per birth \(^1\), it is an expensive proposition. Additionally and importantly, birth is a compelling Medicaid issue \(^2\), because nationwide, Medicaid pays for half of births.

Within the topic of maternity care, cesarean section ("C-section") figures prominently, especially in the United States, where the rate is one of the highest among industrialized
nations [3]. The US C-section rate has risen by 50 percent over the past fifteen years, according to the California Maternal Quality Care Collaborative (CMQCC) [4]. (The CMQCC is "a multi-stakeholder group that drives improvement in maternal and infant outcomes through rapid-cycle data analytics and collaborative action," according to its website.) Now, one-third of all babies born in this country enter the world via surgery [5]—a significant departure from the federal Healthy People 2020 goal [6] of 23.9 percent for low-risk mothers.

So what?

Why should we care about C-section overuse? Overuse matters because, while C-sections are critical and often life-saving in limited circumstances, they bring serious risks for both mothers and babies [5].

For the baby, C-sections are associated with higher rates of infection, respiratory complications, and neonatal intensive care unit stays.

For mothers, C-sections often mean higher rates of hemorrhage, transfusions, infection, blood clots, and postpartum depression. Mothers having undergone a C-section also have a longer recovery and will almost always (a greater than 90 percent chance) have a repeat C-section in subsequent births—leading to higher risks of major complications (for example, hysterectomy, uterine rupture). Also, to the detriment of both mother and baby, breastfeeding rates are lower following C-sections.

On the cost side, C-sections are on average $5,000 more than vaginal births, not including associated costs (for example, hospital readmissions, home care, subsequent C-sections), according to the CMQCC [4]. When one considers overall US health care spending, that may not seem like much. But with tight Medicaid budgets, and about 4 million total US births annually, it adds up. The bottom line: C-sections are an important tool—but one that should be used sparingly.

Moving toward a solution in California

In California, where 500,000 babies are born each year—one-eighth of all US births—an effort is afoot to lower the C-section rate. Focusing on first-time, low-risk mothers (another way of saying "low-risk" is "NTSV" or nulliparous, term, singleton vertex), many stakeholders across the state are recognizing the importance of this issue and are starting to take action. These stakeholders are spurred on by the fact that there is striking, unwarranted variation in the C-section rates of low-risk mothers. These vary from 12 to 70 percent across California's 251 hospitals providing maternity care. This variation [7] means that a woman's method of birth can be very different simply because of the
hospital at which she delivers (that is, for no evidence-based reason at all).

**Figure 1. First Time, Low-Risk C-Section Variation In California Hospitals**

![Graph showing variation in low-risk C-section rates across California hospitals.](image)

*Source: California Maternal Quality Care Collaborative (CMQCC), 2014.*

Although troubling, this variation also signals an opportunity: while 60 percent of California hospitals need to improve to hit the national target, 40 percent of hospitals already meet the goal—showing that achieving that goal is possible. Additionally, a recent successful pilot in three Southern California hospitals[9] led by Pacific Business Group on Health (PBGH)[10] underscores cause for hope. These hospitals lowered their low-risk C-section rates by about 20 percent in six months and, notably, *have maintained their lower rates since.*

How was this reduction accomplished? It took pulling several key levers (depicted below). Through the innovative, low-burden, low-cost Maternal Data Center[11] run by the CMQCC, these hospitals were able to obtain their hospital rate and also “drill down” in the data to get physician and patient information, which is very helpful in understanding the drivers of the overall hospital rate. The CMQCC also showed providers how to change (achieve “quality improvement”).

Purchasers—such as Disney—signaled dissatisfaction with their employees’ high C-section rates. The contract requirements and payment methods that followed suit aimed to put in place one “blended” payment for a delivery of either type versus paying more for
C-sections, which is now often the case.

Likewise, patients helped the cause: negative social media about high C-section rates at one hospital got the attention of administrators.

In the background, public policy was hinting at change: legislation[^12] was being considered to allow midwives—whose goal is supporting normal birth—to practice at the top of their license.

**Figure 2: Levers To Lower The C-Section Rate**

![Diagram showing the levers to lower the C-section rate](image)

[^13]: California HealthCare Foundation (CHCF)

What happened in these pilots serves as a good model. Not all of the levers have to be pulled, but several are certainly needed. And the more levers pulled, the more accelerated and sustained the change can be.

**Building on Success**

As part of its emphasis on high-value care, California HealthCare Foundation (CHCF)[^14], a nonprofit philanthropy based in Oakland, has launched an initiative to lower the state's C-section rate for low-risk women to 23.9 percent in five years. CHCF is funding projects to pull as many levers as possible, as simultaneously as possible, to bring about change—building on statewide momentum by working with many engaged partners such
as, but not limited to, CMQCC, PBGH, \textsuperscript{[15]} California Department of Health Care Services (DHCS/Medi-Cal), Covered California (state exchange), Integrated Healthcare Association, California Public Employees Retirement System (CalPERS), the Hospital Quality Institute of the California Hospital Association, and both state and national specialty provider societies. Notably, the Statewide Workgroup on Reducing Overuse \textsuperscript{[16]}—a multistakeholder group (led by CalPERS, DHCS, and Covered California) that purchases and/or manages care for 15 million Californians—recently selected C-section reduction as one of its three goals.

Building on CHCF's early investment in the Maternal Data Center, CHCF is providing continued support for this critical transparency lever, as well as for development of a C-section toolkit for providers and a statewide quality improvement initiative to implement the toolkit in at least sixty hospitals. CHCF also anticipates funding projects to engage patients and support payers.

It is possible to lower the C-section rate. And knowing what we know about the health risks and costs, we have an imperative to eliminate overuse. With strategically placed funding, CHCF aims to contribute to “moving the dial.” We hope to be reporting success in a few years, thus giving California more reasons to celebrate its 500,000 annual births!
Name
Title
Hospital Name
Address
Address2

January XX, 2016

Dear Hospital Leader,

The three largest purchasers of health care for the State of California, the Department of Health Care Services (DHCS), the California Public Employees’ Retirement System (CalPERS), and Covered California, provide health care to approximately 17 million Californians and cover well over half of the births in the state. Together with the California Health and Human Services Agency (CHHS) and the Department of Public Health (CDPH), we are collaborating on an important state and national issue: Reducing inappropriate Caesarean deliveries (C-sections). California hospitals’ wide variation of 12 percent to 70 percent (statewide average 26.2 percent) in risk-adjusted low-risk C-section rates concerns us as payers and population health experts. The graphic on the right illustrates the range of hospital C-section rates throughout California.

We are committed to bringing each California hospital’s low-risk first pregnancy C-section rate in line with the national risk-adjusted Healthy People 2020 target of 23.9 percent. Not only would reducing the rate of first-birth C-sections reduce the risk of complications, it also reduces the likelihood of a second or more C-section. It would also reduce the cost of births to the health system. There are approximately 500,000 births annually in California and payments average $5,000 more per C-section versus a vaginal birth. If the state C-section rate is decreased by 1 percent, 5,000 C-sections would be avoided annually. We are partnering with the California Maternity Quality Care Collaborative (CMQCC), the California Health Care Foundation (CHCF), and clinical leadership across the state to implement a quality improvement initiative at hospitals with C-section rates above the national average. DHCS, CalPERS, and Covered California will also regularly update their members regarding which hospitals should be recognized for submitting data to CMQCC, participating in quality improvement, and achieving target C-section rates.
We call on you to join us in this endeavor by joining CMQCC. Already, 157 hospitals of the 250 hospitals in California with maternity service lines submit data to CMQCC. **Our goal is 100% participation of California maternity hospitals.** Working with CMQCC, hospitals have improved the quality of care they provide. Many already reduced the incidence of major maternal complications and their C-section rates among low-risk births by an average of 20 percent using CMQCC data.

CMQCC has reduced the reporting burden for hospitals and the California HealthCare Foundation has committed to supporting CMQCC through December 2016. Labor & Delivery (L&D) and Quality Managers routinely laud CMQCC as vastly simplifying their ability to track quality and patient safety. In the words of one user: “I feel like I have a secret weapon in the [CMQCC] and that I could not do my job as efficiently and completely without it.” As a hospital leader, you are critical to putting CMQCC in the hands of L&D Managers, Quality Managers and Clinicians.

CMQCC differs from other performance reporting systems that your hospital may already utilize. CMQCC provides rapid feedback, benchmarking, and analysis for measures using data that is only 45 days old. The CMQCC’s user-friendly web tool enables clinicians and managers to easily access over 30 perinatal performance metrics—and drill-down to the patient-level to identify specific improvement opportunities. Leveraging data sets that your hospital already submits to state agencies, your hospital can also automatically generate provider-level metrics, as well as state, regional, and like-hospital benchmarks to compare your performance to that of your peers.

**We ask Hospital Name to join statewide efforts to improve perinatal and maternal health by joining CMQCC by the end of January 2016.**

For a detailed description of the database, please refer to the attachment to this letter. By working together, we can reduce C-section rates to eliminate unwarranted variation and improve the health of mothers and infants. Please direct your Quality and L&D teams to Anne Castles at CMQCC (626-639-3044 or acastles@cmqcc.org) to schedule a demonstration.

Sincerely,

[Signatures]

Neal D. Kohatsu, MD, MPH
Medical Director
Department of Health Care Services

Lance Lang, MD
Chief Medical Officer
Covered California

Doug P. McKeever
Deputy Executive Officer
California Public Employees Retirement System

Diana S. Dooley
Secretary
California Health and Human Services Agency

Karen L. Smith, MD, MPH
Director
State Public Health Officer
Department of Public Health
The California Maternal Data Center
A Tool to Improve Perinatal Performance

The California Maternal Data Center (MDC) is a user-friendly online tool that helps hospitals calculate, report and improve perinatal performance, in a way that is low-burden and low cost. Participating hospitals submit patient discharge data—that they already collect—to the MDC’s secure web-based tool, which can automatically generate a wide range of perinatal performance metrics and patient-level drill-down information.

The Benefits

**Fingertip Access to Perinatal Quality Metrics and Patient-Level Drill Down Data.** Clinical and quality departments have “on-demand” access to 30 plus perinatal metrics via the MDC online tool. The MDC not only enables hospitals to drill down from the overall performance metric to the patient level, it also provides “Measure Analysis” tools for the *Elective Delivery* and *C-Section* measures to turn data into action!

**Provider-Level Metrics.** Hospitals receive provider-specific rates for 12 clinical quality measures. The provider-level metrics can be used for the Ongoing Physician Practice Evaluation (OPPE) required by the Joint Commission (TJC).

**Benchmarking.** Hospitals receive detailed benchmarking data to compare your facility to regional, statewide, like-hospital and system averages representing all California hospitals.

**Identifying Data Quality Issues that Impact Performance Results.** The quality of a hospital’s data can have a substantial impact not only on the Perinatal Care measure set performance, but also on the measures that [CalQualityCare.org](http://example.com) publicly reports on California hospital performance. Hospitals receive data quality metrics to identify hospital-specific coding issues that affect their performance results—prior to that data being reported out.

**Facilitated Performance Reporting.** MDC can support reporting of perinatal care metrics to CMS, the Leapfrog Group, the Patient Safety First (PSF) Collaborative and CCS reports.

**Population-Based Metrics.** Many hospitals choose to calculate their Perinatal Care measures based on samples of patients to minimize data collection burden. However, sample-based rates can easily skew from quarter to quarter. By combining your hospital discharge data with birth certificate data, MDC calculates the Perinatal Care measures based on the entire population of deliveries and reduces data collection burden. These population-based results are more robust and more meaningful to clinicians.

**It's Free!** Thanks to generous grant funding from the Centers for Disease Control and the California HealthCare Foundation, there are no hospital participation fees until at least January 2017.
Data Confidentiality and Security
The MDC tool instantaneously links hospital-uploaded patient discharge data with birth certificate data supplied directly to CMQCC from the California Office of Vital Records. Using state of the art encryption technology, all patient-level data is fully secured. A Participation and Business Associate Agreement defines the legal, security and confidentiality requirements to be implemented by CMQCC. The project has also received Institutional Review Board (IRB) approval from the Committee for the Protection of Human Subjects (CPHS), the state of California’s IRB.

Participation Steps

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Learn more about the MDC Quality Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CMQCC will schedule a presentation for your hospital team via WebEx or on-site visit. These one-hour sessions provide an introduction to the MDC tool.</td>
</tr>
<tr>
<td>Step 2</td>
<td>Appoint key project contacts for the MDC</td>
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<tr>
<td></td>
<td>Upon deciding to participate, contact CMQCC to designate a project administrator and the IT staffer in charge of uploading patient discharge data.</td>
</tr>
<tr>
<td>Step 3</td>
<td>Complete the Participation and Business Associate Agreement</td>
</tr>
<tr>
<td></td>
<td>CMQCC will e-mail you the Participation Agreement, which establishes the rights and responsibilities of the hospital and CMQCC. Ask authorized hospital personnel to review, sign and return the agreement.</td>
</tr>
<tr>
<td>Step 4</td>
<td>Submit data</td>
</tr>
<tr>
<td></td>
<td>▪ Upload Patient Discharge Data (PDD) directly to the MDC. CMQCC uses the same specifications as the OSHPD PDD, but recommends monthly or quarterly data submissions so the hospital receives rapid-cycle data back.</td>
</tr>
<tr>
<td></td>
<td>▪ For the optional perinatal measures, review the small set of records that require chart-based data.</td>
</tr>
<tr>
<td>Step 5</td>
<td>Participate in a training session for the MDC Quality Tool</td>
</tr>
<tr>
<td></td>
<td>CMQCC will schedule a 1.5 hour time to train your team on using the application. After the training, you’re set to use the results to target your unique clinical and data quality improvement activities.</td>
</tr>
</tbody>
</table>

Current CMDC Users Say....

This is one of the easiest to use, comprehensive quality improvement tools I have ever seen.
David Lagrew MD, Chief Integration and Accountability Officer, Memorial Care Health System

I absolutely love the richness of this data that we can take to our medical staff and administrative teams to see how well we are doing and where we need to focus on our quality improvement.
Kristi Gabel, Perinatal CNS, Sutter Roseville Medical Center

CMDC has helped us improve our 39 week elective deliveries. We went from 22% to 5% by getting accurate data and this team helped us to keep focused. The MDC team is excellent. They are quick to answer your questions is a way you can understand. They have a positive, knowledgeable and action oriented team. I am so happy to be part of this.
Debbie Groth, Director, Maternal and Child Health, El Camino Hospital, Mountain View

My administration is amazed at how fast I am able to provide data, pull together reports, and create a presentation. I feel like I have a secret weapon in the MDC and that I could not do my job as efficiently and completely without it.
Kim Marquardt, RNC-OB, BSN, Perinatal Clinical Data Analyst, Tri-City Medical Center

We are loving the MDC! It has truly expanded our quality reporting and ongoing analysis.
Cynthia Fahey, MSN, RN, Clinical Quality Coordinator, Community Memorial Hospital, Ventura

Learn More
Visit the MDC website at www.cmqcc.org to learn more about participating and to see the web tool in action, or contact CMQCC at datacenter@cmqcc.org or 626-639-3044.
5.03 Appropriate Use of C-Sections

Contractor agrees to actively participate in the statewide effort to promote the appropriate use of C-sections. This ongoing initiative sponsored by Covered California, DHCS and CalPERS as well as major employers is coordinated with CalSIM, and has adopted the goal of reducing NTSV (Nulliparous, Term Singleton, Vertex) C-section rates to meet or exceed the national Healthy People 2020 target of 23.9 per cent for each hospital in the state by 2019. In addition to actively participating in this collaborative, Contractor shall:

1) Work collaboratively with Covered California to promote and encourage all in-network hospitals that provide maternity services to enroll in the California Maternity Quality Care Collaborative (CMQCC) Maternal Data Center (MDC).

2) Annually report in its application for certification the C-section rate for NTSV deliveries and the overall C-Section rate for each of its network hospitals for the hospital's entire census.

3) Adopt a payment methodology progressively to include all contracted physicians and hospitals serving Enrollees, such that by 2019, payment is structured to support only medically necessary care and there is no financial incentive to perform C-sections. Contractor must report on its design and the percent of hospitals contracted under this model in its annual application for certification.

4) Covered California expects Contractor to only contract with hospitals that demonstrate they provide quality care and promote the safety of Enrollees. Beginning with the application for certification for 2019, Contractors must either exclude hospitals from networks serving Enrollees that are unable to achieve an NTSV C-section rate below 23.9 per cent from provider networks or to document each year in its application for certification the rationale for continued contracting with each hospital that has an NTSV C-Section rate above 23.9% and efforts the hospital is undertaking to improve its performance.
Summary of Key Activities to Reduce Unnecessary C-Sections in California

February 22, 2015

Quality Improvement

- **C-Section “Bundle”:** National, multi-stakeholder effort by the National Council on Patient Safety in Women’s Health; produced a “bundle” (evidence-based document at 30,000 foot level) about what providers should do to reduce primary C-sections/promote normal vaginal birth. Because its members include every major maternity care-related specialty society in the U.S., the contents of this document have substantial support and elevates the C-section issue. Released October 2015.

- **C-Section Toolkit:** CMQCC-led, multi-stakeholder effort to produce an on-the-ground provider toolkit to operationalize the “bundle” (i.e., practical, “how to” manual for providers that includes items like checklists and patient education materials). Release date expected March 2016. Like other CMQCC toolkit, wide national uptake is expected. (CHCF funded)

- **C-section Quality Improvement Collaborative:** Statewide effort to implement the toolkit in 60 hospitals throughout the state, with a special focus on Los Angeles, San Diego and Orange counties where birth and C-section rates are highest. Scheduled to launch Spring 2016 when the toolkit is released (CHCF funded).

- **ACOG + Nursing Speakers Bureau:** CMQCC will work to train a cadre of MD and RN speakers who will be available to hospitals and other providers as speakers. Will being when QI Collaborative beings. (CHCF funding pending).

- **Hospital Quality Institute (HQI) Support of C-section Efforts:** HQI will analyze its patient safety data related to C-section to add additional insights into the CMQCC QI Collaborative. It will also conduct interviews with high-performing small/rural/community hospitals to cull and share lessons learned. (CHCF funding pending)

- **Strategic Planning Re: Expanding Midwifery Care in California:** PBGH is conducting key informational interviews and other activities to develop a strategic plan for expanding midwifery care in the state (Yellow Chair Foundation funded)

Data/Transparency

- **California Maternal Data Center:** CMQCC continues to operate and expand the Data Center which is core to all C-section (and other maternity)-related activities in the state. (CHCF and CDC funded)

- **CMQCC Sustainability Planning:** CMQCC is working with an external business consultant hired by CHCF to help them develop a plan for self-sustainability. A new hospital membership fee model was introduced in February 2016 for implementation starting in January 2017. (CHCF funded)

- **Incorporating Physician Group Maternity Measures into Value-Based Payment:** IHA is analyzing maternity metrics (including C-section) at the medical group level to determine if they
can be incorporated into IHA’s Value-Based Pay-for-Performance program; an Issue Brief will be produced. (CHCF funded)

- **CDPH Development of Population Maternity Measures:** Together with a team from UCLA, CDPH is developing population-based maternity metrics to track the health of California’s mothers and babies over time. (CalSIM funded)

**Payment & Purchaser Requirements**

- **Payer Engagement:** PBGH is planning and hosting a series meetings in Southern California to engage hospitals and payers in a dialogue about how they can work together to lower the primary C-section rate. CalPERS has agreed to be an anchor payer at these meetings. (CHCF funded)
- **Purchase/Value Network Toolkit:** PBGH is producing a toolkit for purchasers; maternity care is one of the focal areas and consumer experience measures related to maternity are also under consideration. (Arnold Foundation funded).
- **Covered California Contracts:** As part of Covered California’s contracting discussions now underway with plans, it is putting forth possible encouragements and requirements.
- **Letters to Hospitals:** Letters to hospitals from DHCS, Covered California, CDPH, and CalPERs highlighting the need to lower the rates of unnecessary C-sections in the state, and asking them to participate in the Maternal Data Center and quality improvement efforts on this topic.

**Patient/Consumer Engagement**

- **Consumer Reports Phase 1:** Consumer reports is conducting direct outreach to hospitals in Southern California (CHCF funded)
- **Social Media Analysis:** Monitor 360 is conducting an analysis of C-section discussions on social media data to learn what is being discussed, which messages resonate with consumers and which do not. This work will inform CHCF’s future consumer engagement planning. Results will be shared publicly. (CHCF funded)

**Public Policy**

- **AB 508:** This bill proposes measures for maternity care; details under discussion now.

**Cross-cutting**

- **Statewide Workgroup on Reducing Overuse:** This workgroup, which grew out of CalSIM planning discussion, is chaired by Covered California, Medi-Cal, and CalPERS, and staffed by the Integrated Healthcare Association (IHA). They have selected C-section reduction as one of three key areas of focus. (CHCF Funded)

*Funding not yet officially approved by CHCF; review underway now.*
Topic 2: Imaging for Low-Risk Back Pain
Meeting Materials
Statewide Workgroup on Reducing Overuse

Discussion Document on Approaches to Low Back Pain (LBP) Imaging

CalPERS, February 2016

What Can the SWGRO Do?

- Promote clinical decision support (CDS) systems (for example by means of contracts between purchasers and health plans requiring provisions in subcontracts with providers)
- Encourage evidence-based alternatives to surgery (e.g., yoga¹)
- Seek improvements in the HEDIS measure²
- Disseminate educational materials for providers and members with LBP
- Share with SWGRO stakeholders the best practices of Choosing Wisely grantees and others

Questions for SWGRO:

1. Are these the highest priorities, or are there others?³ For example:
   a. Since Medicare is going to require CDS for advanced imaging, should the SWGRO focus elsewhere?
   b. Should SWGRO set a statewide target?

2. How could interested parties contribute to the priorities? For example, what additional value can SWGRO provide to the Consumer Reports / Choosing Wisely efforts?

³ Examples of strategies used in other SWGRO topics that may or may not work for LBP imaging: recognition of providers, regional collaboratives, benchmarks (due to questions about HEDIS measure), public messaging and social media not targeted to persons with LBP, development of practice guidelines.
Medicare Requirements Related to Clinical Decision Support
Protecting Access to Medicare—Diagnostic Imaging Provision

H.R.4302 – Protecting Access to Medicare Act of 2014 (Sec. 218. Quality incentives for computed tomography diagnostic imaging and promoting evidence-based care)


Provision Overview: The Protecting Access to Medicare Act (PAMA) was signed into law on April 1, 2014. The law included a mandate that any physician ordering advanced diagnostic imaging exams for Medicare patients must consult government approved appropriate use criteria (AUC) using a qualified Clinical Decision Support tool (CDS) in order to receive Medicare payment. The Centers for Medicare and Medicaid (CMS) is required to determine what AUC are valid, and which CDS tools are qualified.

What is Appropriate Resource Criteria? A collection of individual criteria, that is evidence based, and has been developed (or endorsed) by national professional medical specialty societies (or provider-led entities), to support providers in making appropriate treatment decisions for patients. Individual criteria links a specific clinical condition, one or more services, and an assessment of the appropriateness of services.

How does the mandate work? The provider performing the test must provide evidence on the claim that the ordering physician consulted AUC, specify which CDS tool was used, and whether the exam adhered or did not adhere to AUC. The mandate does not require that the ordering provider actually adheres to AUC criteria, rather just that they consulted AUC. The ordering provider must provide the documentation on the claims in order to be paid.

What imaging services are included and excluded? The mandate applies to CT, MRI, nuclear medicine and PET exams. X-ray, fluoroscopy, and ultrasound exams were excluded.

In what setting is this provision applicable? The mandate applies to exams ordered and performed in physician offices, hospital outpatient departments (including the emergency department), and ambulatory surgical centers. It does not apply to inpatient services, emergency situations, or on exams ordered by providers who meet the hardship criteria (e.g. limited internet access in rural areas).

The Four Main Components of the AUC Program & the Original Timeline*

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
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<tbody>
<tr>
<td>November 15, 2015</td>
<td>CMS will specify appropriate use criteria for advanced imaging</td>
</tr>
<tr>
<td></td>
<td>- Criteria must be developed (or endorsed) by national professional medical specialty societies/provider-led entities.</td>
</tr>
<tr>
<td>April 1, 2016</td>
<td>CMS will publish a list of qualified CDS mechanisms</td>
</tr>
<tr>
<td>January 1, 2017</td>
<td>Providers must include information about CDS mechanism to receive payment (program’s “go live” date)</td>
</tr>
<tr>
<td>January 1, 2020</td>
<td>CMS will establish a process for identifying outlier ordering providers</td>
</tr>
<tr>
<td></td>
<td>- On an annual basis, CMS will use two years of data to identify 5% of total ordering providers who are outliers based on low adherence to AUC. Outlier providers will be required to obtain prior authorization when ordering imaging studies.</td>
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<tr>
<td></td>
<td>- Criteria for identifying outlier providers will be developed by stakeholders and the Medicare Evidence Development and Coverage Advisory Committee (MEDCAC)</td>
</tr>
</tbody>
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*UPDATE*: On October 30, CMS announced it was unable to meet the deadline for the publication of approved CDS tools by April 1, 2016. CMS intends to publish the list of qualified tools in late June or early July with a final rule expected by November 1, 2016. Providers will not be required to adhere to the AUC consultation requirements by January 1, 2017; the date of implementation has not yet been released.
Low Back Pain Imaging: California Data for 2014 and Related Activities

The issues associated with patient safety and wasteful spending due to unnecessary and inappropriate imaging for low back pain has gained increasing attention. The Choosing Wisely® campaign has targeted imaging for low back pain as a high-priority service to target, and 5 of the 7 project teams in the second round of the ABIM Foundation initiative to spread Choosing Wisely have adopted low back imaging as an area of focus and the ambitious target of 20% reduction from baseline over the 3-year project. Two of those five teams are in California – the IHA-led team, with Sharp Rees-Stealy in San Diego; and the UCLA/LA County DHS team.

The measure of low back pain imaging, which is a HEDIS measure, assesses “the percentage of members who had a primary diagnosis of low back and who did not have an imaging study (X-ray, magnetic resonance imaging [MRI], computed topography [CT] scan) within 28 days of diagnosis.”

In California, data are available on low back imaging at the plan level for Medi-Cal managed care, commercial HMO, and commercial PPO. Sources include: Department of Healthcare Services for the Medi-Cal Managed Care health plan data, Office of the Patient Advocate (OPA) for HMO/PPO Commercial health plan data, and Integrated Healthcare Association (IHA) for Commercial HMO medical group data. Scores show how well each plan or medical group did at making sure patients with low back pain did not receive unnecessary imaging studies. Higher scores indicate that patients received the right care at the appropriate time.

Related Activities

In addition to annual measurement and reporting at the plan and physician organization, low back imaging has been included in several related efforts in California.

- The Transforming Clinical Practice Initiative led by the Pacific Business Group on Health’s California Quality Collaborative, for which IHA will expand its existing online reporting portal and frequency of data collection. CMMI requested inclusion of imaging for low back pain as a cost of care measure over the 4-year project. During the first year, relative improvement is targeted for 5% in year 1, and 20% in years 2-4.
- Low back pain imaging is one of three measures that will be displayed in an insert in Consumer Reports Magazine in January 2016 as part of the DOCTOR project, in which IHA is participating and contributing data. (Other measures are checking for cancer composite and diabetes care composite.) CR billiard ball symbols will be used, and will display four performance categories that align with the OPA cutpoints of 25\textsuperscript{th}, 50\textsuperscript{th}, 90\textsuperscript{th} percentiles from the previous year.
- California Healthcare Compare, a database created by the California Department of Insurance and launched in September, features data contributed by IHA on low back pain imaging alongside other measures: [http://www.cahealthcarecompare.org](http://www.cahealthcarecompare.org)
- The use of MRIs for low back pain imaging is one of four case studies being used in the Center for Healthcare Decisions’ Doing What Works project. This is a statewide public engagement effort to capture the views and values of low-to-moderate income Californians on the strategies they believe are most acceptable for reducing overuse. Results will be available in Spring 2016.
Medi-Cal Managed Care
HEDIS 2014 Use of Imaging Studies for Low Back Pain

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser North - Sacramento</td>
<td>93.02</td>
</tr>
<tr>
<td>Partnership HealthPlan of CA - Sonoma</td>
<td>90.56</td>
</tr>
<tr>
<td>Partnership HealthPlan of CA - Napa/Solano/Yolo</td>
<td>89.17</td>
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<td>Anthem Blue Cross Partnership Plan - San Francisco</td>
<td>89.11</td>
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<tr>
<td>Alameda Alliance for Health - Alameda</td>
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<td>Anthem Blue Cross Partnership Plan - Alameda</td>
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<td>Kaiser South - San Diego</td>
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<td>Contra Costa Health Plan - Contra Costa</td>
<td>87.85</td>
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<td>Santa Clara Family Health Plan - Santa Clara</td>
<td>86.37</td>
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<td>Anthem Blue Cross Partnership Plan - Tulare</td>
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<td>Health Net Community Solutions - Sacramento</td>
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<tr>
<td>Partnership HealthPlan of CA - Mendocino</td>
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<td>Central CA Alliance for Health - Monterey/Santa Cruz</td>
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1 High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.
2 Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.
NA = A Not Applicable audit finding because the MCP’s denominator was too small (i.e., less than 30).
S = The measure is publicly reported based on audit results; however, since the MCP’s numerator was less than 11, DHCS suppresses displaying the rate to satisfy the HIPAA Privacy Rule’s de-identification standard.
Note: HEDIS 2014 rates reflect 2013 measurement year data.
Performance Results—Use of Imaging Studies for Low Back Pain

Note:
- The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.

HEDIS 2014 Use of Imaging Studies for Low Back Pain
By Model Type

- COHS: 81.48
- GMC: 80.67
- Two-Plan: 80.03

HEDIS 2014 rates reflect 2013 measurement year data.
Imaging for Low Back Pain

Commercial HMO Medical Group

Note: Chart distribution shows all 161 PO’s for LBP measure. Only a subset of names are displayed due to space constraints.

Source: Integrated Healthcare Association MY 2014 Commercial HMO Data
Source: MY 2014 HMO Plan Level Data- OPA Health Care Report Card
Source: MY 2014 PPO Plan Level Data- OPA Health Care Report Card

*= Score that ranks a health plan in the top 10% of all commercial HMO health plans in the U.S.
Topic 3: Opioid Overuse
Meeting Materials
Call to Action on Opioids: 20/20/2000 goal

Drop opioid prescribing by 20%, drop opioid overdose rates by 20%, and save 2000 lives by 2020

Why act now?
Opioid overdose deaths quadrupled in the last 15 years; drug overdose deaths now surpass deaths from auto accidents. Neonatal abstinence syndrome tripled in the last decade, and the demand for addiction treatment has risen 9-fold. Recent studies estimate the cost of this epidemic is $18-72 billion\(^i\) per year. Insurers pay in excess of 70 billion per year from diversion.\(^ii\) Enough prescription painkillers are prescribed to medicate every Californian around the clock for a month every year. Like most societal ills, the impact is far worse on the poor, with 5.7 times the death rate for Medicaid beneficiaries.\(^iii\)

What got us here?
The epidemic has many causes, including false advertising claims and aggressive marketing, heavy pharma influence on medical boards and regulatory agencies (“pain is the 5\(^{th}\) vital sign”), direct-to-consumer advertising, growing obesity, and poor understanding of risks of long-term opioid use: death, addiction, adverse health effects, and impact on brain function.

What have we learned?
- Doses above 100 mg morphine equivalents increase the death rate 9-fold
- 67% of people taking opioids continuously for 90 days still take them 2 years later
- Addiction crosses all class and race barriers, up to 25% of chronic opioid users.
- Opioids work poorly to control chronic pain, and often worsen function (particularly for headache, back pain, and fibromyalgia); in addition, chronic opioid use is associated with sleep apnea, hypogonadism, neonatal abstinence syndrome, and falls and fractures among the elderly.

What can we do?
1. **Support safer prescribing practices**: provide the training, tools and educational resources clinicians need to make more informed prescribing decisions:
   - **Acute pain**: use small amounts of opioids for brief periods, in limited conditions
   - **Chronic pain**:
     - Opioid-naïve: avoid new starts
     - Opioid-dependent: support patients through slow tapers to safer doses and regimens

2. **Support clinicians through evidence-based payer and health plan interventions** (examples in appendix):
   - **Reinforce safer prescribing choices through formulary controls and opioid safety programs**
   - **Provide clinicians with regular data and feedback** regarding members on high-risk regimens, or high-risk prescribing practices
   - **Develop payer contract requirements** supporting evidence-based opioid safety programs
   - **Design benefit structures to provide access nonopioid treatment options**, including alternate treatments and addiction treatment
   - **Provide electronic health record decision support where feasible**

3. **Support community efforts through coalitions**: spread community-wide prescribing standards, and increase access to naloxone and medication-assisted addiction treatment.

4. **Consider a united policy agenda**, focused on opportunities (e.g. CURES) and potential threats (e.g. mandates for high-cost abuse-deterrent formulations).
Metrics (data source in parentheses)

Goal by January 2019:
Drop opioid prescriptions and opioid volume by 20% across California
Drop opioid-related ED visits and death by 20% (compared to current rates, would save 2000 lives)
Double number of buprenorphine prescribers
Triple CURES registrations and CURES hits

Core Adult Measure Set for Medicaid: Use of Opioids at High Dosage (Medicaid plans: specs to be released in the spring)

Measures from CDPH and CURES (will be available on public websites with ongoing updates)
I. Core measures (by county and zip code)
   1. Deaths (all cause drug overdose deaths; heroin deaths; prescription opioid deaths) per 100,000 (CDPH)
   2. Opioid-related nonfatal ED visits (age-adjusted per 1000 – CDPH)
   3. # of opioid prescriptions per 1000 residents (excluding buprenorphine)
   4. Mg morphine equivalents (MME) per day per resident (excluding buprenorphine)
   5. Hydrocodone (Norco or Vicodin, 5mg) per resident per year (based on MME – social math metric, easier for public to understand than MME)

II. CURES measures (CURES, reported by Brandeis): measures on the 2.0 prescriber alert list
   1. Residents per 1000 on more than 100 mg MME daily (for at least 30 days)
   2. Residents per 1000 on more than 40 mg methadone daily (for at least 30 days)
   3. Residents per 1000 on combo opioids/benzos (for at least 30 days)
   4. Residents per 1000 on 90 sequential days of opioids
   5. Residents per 1000 using more than 6 prescribers or 6 pharmacies in 6 months

III. Buprenorphine (addiction treatment) utilization and measures (CURES, reported by Brandeis)
   1. Buprenorphine prescriptions per 1000 residents
   2. Number of buprenorphine prescribers (name, address, # by zip and count)
   3. Number of active buprenorphine prescribers (name, address, # by zip and count) (at least one prescription)

IV. CURES utilization measures (CURES)
   1. Number registered prescribers (waivered)
   2. Number registered pharmacists
   3. Number of CURES hits
**Educational resource list** (draft as of 020916)

**CDC:**

**Physicians for Responsible Opioid Prescribing** has some great videos and training materials: [http://www.supportprop.org/](http://www.supportprop.org/)


**Partnership Health Plan of California,** Managing Pain Safely, Provider educational videos and resources: [http://www.partnershiphp.org/Providers/HealthServices/Pages/Managing-Pain-Safely.aspx](http://www.partnershiphp.org/Providers/HealthServices/Pages/Managing-Pain-Safely.aspx)

**Stanford free on-line CME:**

Appendix: Evidence-based health plan interventions

The following is a list of health plan opioid safety interventions, with the evidence and references where available. Several references taken from The Prescription Opioid Epidemic: An Evidence-Based Approach, consensus paper from Johns Hopkins public health, November 2015.

1. Implement “Medical and pharmacy home” or “lock-in” programs: identify users of multiple prescribers or pharmacies, and assign to one prescriber and/or one pharmacy for controlled meds:
   a. 2012 CDC review of the evidence in Medicaid programs
   b. Oklahoma Medicaid department found that its program reduced doctor-shopping, utilization rates of controlled substances, and emergency room visits, saving $600 per person in 2009.

2. Leverage formulary rules to promote opioid safety:
   a. General support for formulary changes:
      i. Partnership Health Plan dropped total prescription volume by 43% and high-dose opioid use by 33% by a combination of formulary changes, community coalition work, and prescriber education and outreach (presentation, CPCA conference, October 2015)
      ii. Southern California Permanente Medical Group decreased OxyContin use by 72%, and decreased the number of patients on high-dose regimens (>130 MME) by 29%. Through a combination of formulary changes, provider dashboards, clinical decision support, and education (Health Affairs blog 2015).
   b. Rationale for specific formulary changes:
      i. Require authorization review for high-dose opioids (CDC: >90 mg morphine equivalents): Patients taking over 100 mg morphine equivalents per day have almost a 9 times greater risk of overdose death. “Use of opioids at high dose” is a 2016 Medicaid HEDIS measure.
      ii. Remove the highest-dose opioid formulations from the formulary. These formulations allow small mistakes to have lethal consequences. If a patient takes 1-2 extra OxyContin 80 mg tablets, it may lead to hospital admission or death: each tablet is equal to 24 5mg-Norco. Alternatively, one 80mg tablet used recreationally by an opioid-naïve patient could cause death, particularly in combination with alcohol or other drugs. The same risk is true for the highest-dose version of morphine, fentanyl, and other opioids.
      iii. Limit new starts (e.g. PA required for more than 30 tablets if opioid-naïve): 67% of patients taking opioids at 90 days are still taking daily opioids after 2 years. Blue Cross Blue Shield of Massachusetts reported in 2014 that requiring a prior authorization for more than 30 days of opioid therapy reduced prescriptions by 20% for common opioids (e.g. Percocet) and 50% for long-acting drugs, and cut total prescriptions of narcotic painkillers by an estimated 6.6 million pills in 18 months.
      iv. Remove analgesic methadone from formulary: Methadone accounts for 5-19% of opioids prescribed, yet it contributes to 31% of opioid overdose deaths: MMWR 2012.
      v. Require authorization for benzo/opioid combinations: 30% of opioid deaths involve benzo/opioid combinations: Southern Oregon Pain Guidance.
      vi. Add buprenorphine to formulary (commercial plans only): in addition to increasing access to addiction treatment, adding buprenorphine to the formulary allows prescribers to convert
patients from high-risk, high-dose regimens to buprenorphine for pain, which dramatically decreases the risk of overdose death, while continuing to control pain and prevent withdrawal (Khanna 2015). Use of a butrans patch allows a transition without withdrawal symptoms (Kornfeld 2015). Note: buprenorphine for Medi-Cal plans is a carve-out (for pain and for addiction treatment) and is managed by State Fee-for-Service Medi-Cal.

vii. Remove Soma from formulary. Soma is only indicated for short-term use, and yet is commonly used long-term. Soma is a component of the “holy trinity” (benzos, Soma and opioids) and is widely abused. Pharmacy Times 2014.

viii. Remove codeine cough syrup from formulary. Minnesota Medicaid limited total MED to 120 mg and excluded promethazine with codeine syrup and carisoprodol due to concomitant abuse and insufficient evidence to support their clinical benefit when used together.viii

3. Prescriber education and outreach

a. Develop algorithms to identify patients on high-risk regimens and/or high-risk prescriber patterns.
   i. Criteria for high-risk regimens could include use of multiple prescribers, multiple dispensing pharmacies, using benzos and opioids together, and/or exceeding a threshold of morphine milligram equivalent (MME) dose.
   ii. Criteria for high-risk prescribing patterns could include top 1% for several measures: # prescriptions, total mg volume of prescriptions, # patients on >90 mg morphine equivalents, # patients on benzo/opioid combinations, etc.

b. Send letters to prescribers about high-risk regimens (particular patients). Prescriber letter interventions based on PBM algorithms have been shown to decrease members’ controlled substance score and controlled substance drug claims. Aetna reported in 2014 that its PBM “Pharmacy Misuse, Waste and Abuse” program reduced opioid prescriptions among 4.3 million members by 14 percent between January 2010 and January 2012.x

c. Send letters to outlier prescribers. The state of Tennessee found that 50 top prescribers accounted for 14% of prescriptions; their prescription rates dropped 18% the year following the letter, and 36% were no longer in the top 50 (Brandeis communication, December 2015). Since health plans and medical groups cannot use CURES, health plan data is one of the few mechanisms to identify suspected “pill mills” with a high volume of opioid prescriptions -- typically younger patients traveling long distances for prescriptions. With the goal of ensuring that prescriptions for controlled substances are appropriate, one pharmacy chain identified 42 controlled substance outlier prescribers out of more than 1 million prescribers. After allowing for appeal, 36 prescribers had their prescriber dispensing privileges removed, reducing more than 100,000 doses of high-risk drugs prescribed per month. Abusive Prescribing of Controlled Substances.

d. Perform academic detailing for select outlier prescribers: Based on the proven effective techniques of pharmaceutical reps, academic detailing uses brief, in-person interactions to promote effective care, and has been shown effective in changing prescriber behavior. Health Affairs; Cochran meta-analysis.
e. **Promote use of CURES.** States implementing a requirement for all prescribers to check the Prescription Drug Monitoring Databases (CURES in California) prior to prescribing controlled substances dropped the number of patients using multiple prescribers by 36% (**Florida**) and 50% (**Kentucky**).

f. **Support Project ECHO to change prescriber behavior:** unpublished data from Partnership Health Plans shows that ECHO decreased total volume of opioid prescriptions before and after the clinic providers participated in Project ECHO; a significant difference compared to controls. A formal evaluation of Project ECHO run by UC Davis is due Spring 2016; early data shows changes in prescription volume and in self-assessed prescribing behavior.

4. **Member outreach and case management:**
   a. **Refer patients on high-risk regimens to case management.** An Aetna-run Behavioral health Medication Assistance Program involves nurses and psychologists working with physicians to evaluate members who could be at risk for addiction and those with a history of opioid abuse or who are in treatment. According to Aetna, this program has shown “a 30 percent improvement in opioid abstinence rates; a 35 percent reduction of in-patient hospital admissions and a 40 percent decrease in total paid medical costs.”

   b. **Provide general member education on opioid risks and limitations of benefit in chronic pain.** Member education is usually part of a comprehensive package addressing the epidemic; it is difficult to find evidence for education alone.

5. **Participate in opioid safety community coalitions:**
   a. **Rationale for participating.** Although not widely studied, coalitions allow coordination of efforts across sectors, and can prevent unintended consequences from one health care sector acting alone. In Oregon, the rapid implementation of strict opioid prescribing guidelines in the county delivery system led to a large volume of patients seeking care elsewhere, overwhelming the ability of community clinics to manage them. If one medical system fires its patients, the problem shows up elsewhere – in emergency departments or other practices. Tightening opioid prescribing practices (such as emergency department guidelines) without also increasing access to addiction treatment can divert patients to street drug and heroin use.

   *Project Lazarus* is a community-based coalition in Western North Carolina, launched to address the high opioid overdose rate. The coalition focused on monitoring and surveillance data, promotion of naloxone, community activation, and education of primary care providers. The overdose rate in Wilkes County dropped 38% from 2009 to 2010; in 2008, 82% of overdose decedents received an opioid analgesic from a Wilkes prescriber compared with 10% in 2010.

   b. **Prevention of opioid refugees.** Increasing heroin use and overdose rates appear to be linked to patients who are suddenly cut off from opioids after long-term use (whether licit or illicit) and seeking other supplies. Community coalitions allow coordination of efforts between competing medical systems, public health, the medical society, law enforcement, and addiction treatment. CHCF is supporting 26 counties across California in developing opioid safety coalitions; most have at least one health plan participating.

6. **Promote expanded access to naloxone (overdose antidote).** Strong evidence exists for naloxone preventing deaths in the presence of heroin use; emerging evidence also supports co-prescribing of
naloxone with chronic opioid use. [http://prescribetoprevent.org/] Naloxone can be dispensed by a pharmacist in California without a prescription.

7. **Participate in Emergency Department Information Exchanges.** After implementation of a program for real-time information exchange among emergency departments and health plans in Washington, medically unnecessary ED prescriptions dropped by 24%. Emergency visits for frequent and extreme users dropped by 5 and 15%.

8. **Synergy – deploy multiple interventions at once.** Partnership Health Plan decreased the number of high-dose prescriptions in their counties by 33% by a combination of formulary restrictions, provider education (e.g. Project ECHO telementoring), and regional coalition support. Total opioid prescriptions declined by 43% in 15 months. (CPCA presentation October 2015). Kaiser Permanente launched an integrated, multi-pronged strategy across the state with similar results.

9. **Promote opioid safety through Pay for Performance programs.** Several plans have included pain management and opioid safety measures in their P4P. SFHP credits a P4P measure in the development of opioid review committees at community clinics in their network (personal conversation 2015).

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i [http://www.pdmpexcellence.org/content/economic-costs-epidemic](http://www.pdmpexcellence.org/content/economic-costs-epidemic)


x Aetna. Aetna Helps Members Fight Prescription Drug Abuse. 9 January 2014

xi Aetna. Aetna Helps Members Fight Prescription Drug Abuse. 9 January 2014
An Epidemic Of Another Kind

A silver badge with interlocking lines at the top of a triangle represents awareness of drug overdose and its effects. Worn worldwide on August 31 [1], the symbol demonstrates support to those fighting through addiction and others bearing the burden of grief from injury or loss. On that day—and every other day in the United States—44 people [2] will die of overdose from prescription painkillers. These deaths have more than quadrupled [3] in the past decade and a half. Today, more people die from prescription opioid overdose than from heroin, cocaine, and all other drugs combined, an alarming trend that led the U.S. Centers for Disease Control to declare it an epidemic [4] in November 2011.
Opioids are medications that treat pain in many contexts, from post-surgical relief to chronic severe back pain to end-of-life care. Two of the most common forms are oxycodones, often sold under the brand names OxyContin® and Percocet®, and hydrocodones, sold as Vicodin®. Both are powerful narcotics. Americans are the number one consumer of these drugs, accounting for almost 100 percent of hydrocodone prescriptions and 81 percent of oxycodone prescriptions worldwide. In the United States, more than two million people are addicted to these medications.

These drugs became more readily available to patients in the late 1990s, and prescription rates nearly doubled between 1998 and 2013. This epidemic is the unintended consequence of policy and practice that was supposed to benefit patients and keep them safe. A solution to this kind of systemic problem that affects the health, social, and economic welfare of society requires a large-scale, comprehensive course of action. The healthcare delivery system is ground zero. This article describes how Kaiser Permanente, one of the nation's largest not-for-profit health plans, is working to reduce opioid abuse among its more than 10 million members, and offers insight for the healthcare system as a whole.

How We Got Here

Beginning in the late 1990s, patient advocacy organizations began asking the medical community whether pain was being under-treated. In 1999, the Veterans Health Administration launched the "Pain as the 5th Vital Sign" initiative, urging doctors to assess pain at every visit. Soon, other major health care accreditation and regulatory authorities, such as the Joint Commission on the Accreditation of Healthcare Organizations, joined the movement to improve pain management.

At the same time, specialty societies, such as the American Geriatric Society and the American Pain Society, promoted the use of opioids for treating chronic, non-cancer pain. The prevailing wisdom among physicians, supported by research, reinforced the misconception that opioids would not create dependence or addiction and could be used safely for long-term treatment of pain. Pharmaceutical companies also aggressively marketed the drugs to providers and patients.

With all these forces at work, it is not surprising that physicians became more comfortable prescribing opioids for less severe pain. Fewer than 20 years after pain became the 5th vital sign, these changes in practice—while intended to improve pain management—have also led to a major increase in overuse, misuse, abuse, diversion, overdose, and death associated with these medications.
Kaiser Permanente’s Systemic Approach To The Epidemic

To combat this systemic quality problem, health care providers need a systemic solution. Kaiser Permanente began to develop such a solution after doctors reported that opioids were presenting safety issues. Kaiser Permanente’s approach includes seven “levers” to address the problem from multiple angles.

Evidence-Based Treatment Guidelines

Misinformation about the use of opioids for chronic, non-cancer pain was a key driver of widespread overuse and abuse in the U.S. Kaiser Permanente physicians developed up-to-date evidence-based treatment guidelines for the proper use of these medications. Guidelines include:

- Focusing on alternatives to opioid therapy as a first-line treatment for chronic, non-cancer pain;
- Providing non-drug treatment options (such as meditation, guided imagery, and Tai Chi);
- Treating patients with the lowest dose of opioids possible, for the shortest duration necessary (in general, less than a 100 mg morphine equivalent dose per day, with no more than a 30-day supply at a time);
- Monitoring patients at risk for opioid abuse via questionnaires, urine drug tests, and prescription history on state prescription drug monitoring databases;
- Recognizing “red flag” behaviors that suggest dependence, misuse, or abuse (such as the need for escalating dosages, requesting refills before they are due, or requesting name-brand drugs, which carry a high “street” resale value); and,
- Using documentation tools to ensure communication and collaboration within and across specialties.

Prescriber Education And Training

Treatment guidelines are supported by education and training at various levels throughout the system. Prescribers can easily access guidelines and other information on opioids via Kaiser Permanente’s online Clinical Library. Individual coaching is also available on how to have difficult conversations \(^{[12]}\) with patients who may be misusing their medications or who are requesting additional, unnecessary opioids.

Patient Education

Many at-risk patients do not know how potentially addictive opioids can be, so it is important to engage them early on about the safe use of their medications. To increase awareness, patients prescribed these drugs receive written educational materials and
can view additional information on opioids through Kaiser Permanente's online health record, My Health Manager.

Population Health Management

Identifying patients at high-risk of opioid misuse and abuse is crucial to using opioids safely. Because it is an integrated delivery system that includes inpatient, outpatient, and pharmacy care and coverage, Kaiser Permanente can use both pharmacy and electronic health record data to identify these patients, alert doctors, and refer patients to treatment for opioid dependence or addiction if needed.

The Role of the Pharmacist

Pharmacists play two important roles in Kaiser Permanente's comprehensive approach to opioid management. First, they identify abusive drug seeking behaviors in patients. These include: requesting refills before they are due, submitting multiple requests for more medication, having multiple prescribers, or going to multiple pharmacy locations. Second, pharmacists monitor physicians who may be at risk of high prescribing.

Access to Coordinated Substance Use Treatment

Patients who become addicted to opioids require high-quality substance use treatment services. A multidisciplinary team comprised of primary care, specialists, addiction services, and behavioral health uses the electronic health record system to coordinate care across specialties.

Leadership Support

Strong and visible leadership provides the support needed for physicians, pharmacists, and other clinicians to implement these strategies. Messaging from leaders and all members of the health care team ensures a consistent focus on patient safety.

The Impact: Best Practices Spread, Opioid Use Declined

Adoption of these strategies has led to a decline in use of opioids across most of Kaiser Permanente's service area, which includes eight states and the District of Columbia. In Kaiser Permanente Southern California, an early adopter of opioid prescription reduction strategies, initial interventions were effective. OxyContin® (oxycodone) use declined 72 percent between January 2010 and December 2013. Additionally, the number of at-risk members on high doses of opioids (greater than 120 mg/day morphine equivalent dose) declined 29 percent between March 2012 and December 2013.

Looking at a more recent and broader measure across Kaiser Permanente's entire
service area, between December 2013 and July 2015, the average decline of morphine milligram equivalents per patient for all opioids was about 15 percent. (Note: the measurement of morphine equivalents enables potency comparison among opioids.) In spite of this success there is still much work to be done.

Addressing The National Epidemic

Of course, a single health care delivery system can only do so much to address an epidemic that lives beyond its walls and within the community it serves. In addition to focusing on internal processes and improvements, health care providers can ensure their clinical teams receive ongoing education on the safe use of opioids, which may be the single most important step to addressing the root causes of this epidemic. For the next generation of physicians, graduate medical education curricula should include more information on pain management and best practices for opioid treatment. For physicians currently in practice, continuing medical education has substantially increased the availability of safe opioid-prescribing courses.

A tremendous need also exists for public awareness about pain and pain management. Communities can come together to agree upon safe prescribing practices. For example, the Los Angeles County Prescription Drug Abuse Medical Task Force [13]—a collaborative of physician and nursing groups, hospital associations, and public health and community clinic representatives—worked with 75 local hospitals (including Kaiser Permanente) to adopt a common set of opioid prescribing and treatment guidelines in emergency departments. Many of the State Medical Boards have also updated their pain management guidelines to incorporate the most current information on opioid use. Eventually, consistency in treatment guidelines across all types of care, from cancer to orthopedics, will allow for safer use of opioids.

Nearly every state has established prescription drug monitoring programs to track medication refills and prescribing patterns across all prescribers and pharmacies, whether part of the same system or not. However, these programs are only effective in reducing opioid use if they can provide information in real time, and if prescribers and pharmacists use them. Twenty-one states [14] have passed laws requiring prescribers to register with prescription drug monitoring programs, and 24 states [15] require prescribers to check databases under certain circumstances. States and health care organizations should continue efforts to make databases easier to access — such as integrating them into electronic health records and making data available among states.

Funding of federal and state programs [16] will bolster these initiatives. In July 2015, the U.S. Department of Health and Human Services announced more than $100 million in funding [17] for states and community health centers to help combat opioid abuse,
encourage innovative treatment approaches, and expand treatment and services for substance abuse. The Obama Administration also provided funding \[^{18}\] to make the overdose antidote, Naloxone, a decades old drug, more available for emergency responders and private citizens, such as family members of addicts. However, it will take additional resources, time, and effort by both the public and private sectors to truly reverse the tide of the opioid epidemic.

Using the example of Kaiser Permanente's experience in reducing opioid prescription rates, these interventions and others like it are extending from the federal level to states and communities. It will take this kind of systemic solution to solve this societal problem so that next August 31, we will have more lives to celebrate and fewer to mourn.

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The misuse of prescription painkillers (opioids) is a significant and growing public health problem. Nationwide, opioid-related deaths increased by 200% since 2000, and rates in certain California regions are among the highest in the country. CHCF is working with partners across the state to decrease opioid-related deaths by 20% in three years.

Our strategy generally tracks the Obama Administration’s opioid initiative, which prioritizes three evidence-based areas of impact: 1. safer prescribing practices, 2. access to medication-assisted addiction treatment, and 3. community access to overdose medication (naloxone).

Key Projects

Opioid Safety Coalitions: Many factors lead to opioid overuse, addiction, and death; coalitions bring together health plans, advocates, hospitals, public health, medical societies, treatment centers, law enforcement, and others to work together and find creative ways to solve the opioid epidemic in local communities. CHCF is providing technical assistance to 16 coalitions in 24 counties across California. www.chcf.org/opioidregional

Care Integration Planning Grants: Health plans and clinics are challenged to address the needs of frequent users of emergency departments (EDs), a high percentage of whom are dependent on prescription painkillers or other substances. To address these challenges, CHCF is supporting eight health plan/ provider teams to develop new care models and funding strategies to support better care for complex patients. www.chcf.org/careintegration

The California Health Care Foundation (CHCF) is leading the way to better care for all Californians, particularly those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

We inform policymakers and industry leaders, invest in ideas and innovations, and connect with changemakers to create a more responsive, patient-centered health care system.
Initiative Highlights

Safer Prescribing

Clinicians need training to incorporate the latest knowledge on chronic pain, safer opioid prescribing, and opioid dependency and addiction. CHCF supports the following efforts:

**Primary Care Residency Programs** are promoting a culture of safer prescribing in teaching centers, and developing curricula about opioid safety, addiction, and the management of complex patients. Nine residency programs participated in a CHCF-funded action group. [http://bit.ly/1yN9EdY](http://bit.ly/1yN9EdY)

**Project ECHO** (Extension for Community Health Outcomes) is a platform to expand primary care skills in pain management and safer prescribing. Weekly 60-minute videoconferences combine didactics and case discussions. Registration is accepted on a rolling basis; clinics are encouraged to join with the sponsorship of a health plan. [http://bit.ly/1mATzCZ](http://bit.ly/1mATzCZ)

**Webinar Recordings** provide insights from leaders within residency programs, clinics, and health plans working to change the culture of opioid prescribing. Learn from the approaches used by Care Oregon, Partnership HealthPlan of California, San Francisco General, Petaluma Health Center, and others. [http://bit.ly/1LOvgMo](http://bit.ly/1LOvgMo)

Medication-Assisted Treatment

Patients who are suddenly cut off from prescription painkillers are at high risk of street drug use or overdose. Access to medication-assisted treatment, using medications proven to lower death rates and increase retention in treatment, is a core component of CHCF’s efforts.

**CHCF Conferences** feature nationally known experts to inform California leaders about new models of care. Dr. Corey Waller of the Center for Integrative Medicine shared his experiences with incorporating medication-assisted treatment into a comprehensive care program. [www.chcf.org/events/2015/clinics-high-utilizers](http://www.chcf.org/events/2015/clinics-high-utilizers)

**Training Resources** from the Substance Abuse and Mental Health Services Administration (SAMHSA) provide education on buprenorphine for physicians. [http://1.usa.gov/1OvrGqx](http://1.usa.gov/1OvrGqx)

**The Providers Clinical Support System** is a resource linking new buprenorphine prescriber with mentors to help work through challenges and build comfort with offering this treatment in any office practice. [www.pcssmat.org](http://www.pcssmat.org)

Naloxone: Preventing Overdose Deaths

The medication naloxone prevents deaths from prescription painkillers when administered immediately upon an overdose by restoring breathing and consciousness. Increasing access to naloxone is a core component of CHCF’s efforts.

**Educational Materials** help clinicians understand the case for prescribing naloxone for patients taking prescription painkillers, and how to educate patients about preventing overdose deaths. CHCF supported the San Francisco Department of Public Health to develop informational materials and study the impact of academic detailing, or on-site physician education. [http://bit.ly/1MYjU7o](http://bit.ly/1MYjU7o)

For more information, contact Dr. Kelly Pfeifer, kpfeifer@chcf.org, Director of CHCF High-Value Care.
Don't Let Zeal for Stopping Opioid Epidemic Create a New Class of Refugee

Kelly Pfeifer, Director, High-Value Care

January 14, 2016

News feeds are filled with painful images of people fleeing their home countries because of war, criminal violence, or political chaos. Here in the United States, a different kind of refugee population is growing: people losing homes and families to a prescription painkiller addiction that started in a doctor's office.

In 2012, physicians wrote a stunning 259 million prescriptions for opioid pain medications. We are seeing levels of opioid prescribing previously found only in hospice settings. This is leading to harm — addiction, heart problems, breathing problems, fractures, disability, and death — without effectively addressing the underlying causes of pain. The casualties are mounting. Since 1999, about 140,000 Americans have died of overdoses. In 2013, the death toll was more than 16,000, and the issue has frequently taken center stage during the 2016 US presidential campaign.

Within the medical community, a growing consensus has emerged over the need for physicians to self-correct. Perhaps it isn't surprising that some clinics and large health systems are dismissing patients from their practices, saying, "We don't treat pain with opioids anymore."

We must not let the pendulum swing too far and turn everyone away. Desperate patients increasingly are turning to alternatives like heroin to ease the painful symptoms of opioid withdrawal — and they end up dying as a result.

Physicians Embrace CDC Guidance

That's why we need to adopt the new US Centers for Disease Control and Prevention (CDC) draft guidelines on chronic pain. The CDC guidelines recommend that we use opioids cautiously, that we not start a new generation of people on chronic daily opioids, and that we help people on high-risk regimens transition to safer doses. These recommendations clearly emphasize the need for a slow taper, because dismissing patients from a practice "can adversely affect patient safety, could
represent patient abandonment, and could result in missed opportunities to provide potentially lifesaving information. The guidelines can reduce the frequency of people being abruptly cut off from medications they have taken for years.

The CDC guidelines contain a thorough review of the evidence, are thoughtful and patient-centered, and make common sense. I haven't met a doctor who doesn't like them. A new Sermo survey of 1,600 physicians found 87% said they would welcome and use the guidelines.

More than 4,000 people and organizations filed public comments on the guidelines. Many were positive but quite a few comments were critical of the guidelines and blamed the CDC for demonizing painkillers. Sample comments: "We are being tortured by the medical community because the doctors are so afraid to prescribe." "Are you trying to kill us?" "What the CDC is doing...should be considered a crime against humanity." "I get punished for what junkies and addicts do."

These critical comments are surprising, because the guidelines explicitly caution prescribers against stigmatizing patients. "Opioids are not good or bad," says Dr. Andrea Rubinstein, chief of pain medicine at Kaiser Permanente in Santa Rosa. "They are a molecule — one that can create great benefit and can cause egregious harm."

The worst type of harm that can happen to a person, of course, is death, and most people who die from opioids are taking drugs prescribed by their own doctor. This fact seems counterintuitive, until you look at some of the super-potent pills being prescribed for common conditions. For example, one 80-milligram Oxycontin pill, typically taken three times a day, is equivalent to 16 Vicodin tablets. If a patient forgets whether he took his bedtime pill and takes another — or if a teenager takes one at a party — it is like swallowing a handful of pain pills.

**Food, Water, and Dopamine — the Keys to Survival**

Years of taking high-dose opioids change the dopamine system, the brain's reward and motivation network. "You need three things to survive — food, water, and dopamine," says Dr. Corey Waller, a Michigan-based pain and addiction specialist and a sought-after speaker on the opioid epidemic. "If you take opioids long enough at high enough doses, the dopamine system breaks. New studies show that that the brain takes years to recover, and sometimes it never does."

As we rein in excess prescribing, we need to ensure that patients on high-dose regimens have clinicians equipped to either help them taper to a safer dose or switch them to a safer option like buprenorphine. The guidelines make it clear that buprenorphine, the first medication for opioid use disorder that can be prescribed or dispensed in physician offices, has an important role to play in tackling this problem. Buprenorphine is a very potent, long-acting opioid painkiller that stabilizes the dopamine system in the brain and prevents withdrawal. However, it acts like an "anti-opioid" (antagonist) in a very important way: It doesn't stop people from breathing, so the risk of death plummets. Understanding this fact helps opponents
realize why "treating a drug problem with a drug" is so effective — 50% of people stay in treatment, instead of 7%. The death rate for people on buprenorphine is a small fraction of the death rate for those with no treatment, according to the American Society of Addiction Medicine's practice guideline for the use of medications in the treatment of addiction involving opioid use. Buprenorphine is an option for pain patients as well — even for those without addiction who are taking high-risk levels of painkillers. "Many of my patients are never able to get off opioids," says Rubinstein. "But if I transition them to buprenorphine they can lead normal lives, and they won't die from an overdose."

We spent years trying to do the right thing by treating patients' pain, but now the right thing must be redefined. Above all, we cannot turn our back on the opioid refugee.

I applaud the national safe prescribing movement, and we at CHCF are supporting community coalitions across California to implement safer prescribing practices. But good prescribing guidelines will still not be enough for patients who already are dependent or addicted. The CDC guidelines can show us a good path if we don't misinterpret them. Let's honor the core of our profession: take care of people, and do no harm.
Blue Shield of California’s – Narcotic Safety Initiative
Salina Wong, PharmD

State Workgroup on Reducing Overuse, Feb. 29, 2016

A 3-year effort to reduce opioid use by 50% among Blue Shield’s members with chronic non-cancer pain by reducing the number of people (1) on high dose chronic opioids, (2) converting from short- to long-term (>90 days) opioid treatment, and (3) reducing Rx quantity supplied and refills for new starts.

Strategies include:
- Enhancing medication coverage policies and formulary management
- Engaging our provider community to practice prudent prescribing and proactive care management
- Creating awareness of issue & programs to manage chronic pain, addiction, and substance abuse
- Mitigating fraud, waste, and abuse

Activities to date:
1. Formulary changes to limit cumulative dose (120 mg MED/day or less) use of high risk long-acting opioids for non-cancer pain
2. Enhanced prior authorization using evidence-based guidelines to evaluate indication for use, rationale for opioid and dose, use of other “holy trinity” medications, and prescriber’s plan for care (monitoring & taper)
3. Narcotic case review with interdisciplinary team (pharmacists, nurses, physicians, quality & credentialing, experts, investigators)
4. CURES sign-up events with the DOJ (5 in 6 months with 300+ provider registrants in 2015)
5. Prescriber narcotic utilization reports for individual providers and IPA medical directors
6. Public advocacy, state & federal initiatives

What’s next?
- Improve patient support programs
  - Comprehensive chronic pain management program
  - Access to naloxone
  - Promote drug disposal programs
- Implement enhanced control measures/benefit design in partnership with regulators
- Evaluate impact on ER visits and admissions due to accidental opioid overdose/poisoning, and combined medical/pharmacy costs for chronic non-cancer pain.
- Continue partnerships with state & national groups/coalitions

Challenges
- Insufficient chronic pain management programs
- Member pressure on the healthcare system
- Difficulty differentiating pain specialists from narcotic prescriber mills – no standards
- Lack of accreditation standards for substance abuse treatment “clinics” / non-evidence based practices, but high patient demand
Kaiser Permanente Opioid Safety Framework:

How to approach the complex problem of unsafe opioid use

1. Acknowledge the problem with data – create a compelling call to action.

2. Ensure strong leadership commitment – opioid safety is a top priority

3. Build collaboration – create teams of multiple stakeholders, organized and tasked to address the problem

4. Provide mandatory clinician education – focused on evidence, desired behavior change, and tools to change

5. Share reliable data – give providers specific data regarding patients on high-risk regimens; reach out to high-prescribing clinicians; use comparative performance feedback, etc.

6. Support safer prescribing guidelines through policies and procedures. Revise formulary to exclude unsafe or high-risk medications, doses, or med combinations, limit quantities, restrict certain drugs to specialists, create a limit for daily maximum opioid dose, create policies on early refills, etc.

7. Deploy decision support tools -- leverage EMR for best practice alerts, protocols, pre-review, online DR.ADVICE

8. Use peer support and pressure – start local multi-disciplinary review teams to compare actual practice with policies and guidelines, and give feedback and recommendations

9. Reinforce pharmacist/pharmacy "corresponding responsibility" – use policies and procedures, escalation based on “red flag” criteria, and empower pharmacists to not fill prescriptions when there are signs of diversion or misuse, and to prevent early refills.

10. Create inter-specialty support agreements – give primary care providers support to manage complex patients by ensuring good communication with pain management, addiction medicine, physical medicine, psychiatry, and neurology. Create referral guidelines and policies that support best practice, through eConsult and online DR.ADVICE.

11. Adopt Emergency Department and Urgent Care guidelines and practices (e.g. American Academy of Emergency Medicine)

12. Support patient/consumer education/communications (develop educational materials and train member services)

13. Collaborate with community coalitions – support spread of community safer prescribing standards, access to medication-assisted treatment, and increased use of naloxone.