Statewide Workgroup on Reducing the Overuse of Ineffective or Unnecessary Medical Care

Co-Chairs: CalPERS, DHCS, and Covered California

Meeting #1 – Meeting Summary

Wednesday, June 3, 2015, CalPERS Headquarters

Session 1: Workgroup Purpose and Scope

Initiators: Ann Boynton, CalPERS; Julia Logan, DHCS; Anne Price, Covered California

Ann Boynton welcomed the Workgroup, and thanked them for attending the inaugural meeting. After introductions, Julia Logan, Anne Price, and Ann Boynton each commented on the impetus for the workgroup and their organizational goals for achieving change. The common theme among all three co-chairs was the enormous opportunity improve quality and reduce costs by targeting overuse, and the commitment each organization has to providing the best possible care for their members at sustainable cost.

Session 2: Related Efforts

Initiators: Jill Yegian, IHA; Marge Ginsburg, CHCD

Jill Yegian briefly reviewed the project IHA is launching with partners around the state, funded by the ABIM Foundation and the Robert Wood Johnson Foundation. The project, Decreasing Inappropriate Care in California in Partnership with *Choosing Wisely®,* includes Sharp Rees-Stealy, Sutter Health, the California Chapter of the American College of Physicians, the Center for Healthcare Decisions, and Blue Shield of California. The team plans to target overuse through clinical interventions, consumer engagement strategies, and communication efforts targeting providers, health plans, purchasers, consumers, and policymakers across the state. The two delivery system partners will be responsible for implementing interventions to reduce three key targeted areas of overuse by 20%. Each system will report on progress against baseline data every six months, and results will be publicly available. Both systems will focus on use of antibiotics for acute bronchitis, and each will also target two additional tests or treatments – nonspecific back pain and preoperative stress testing for Sharp Rees-Stealy, imaging for uncomplicated headache and repetitive CBC and chemistry testing for inpatients for Sutter Health.

Marge Ginsburg discussed CHCD's new initiative, *Doing What Works,* aimed at eliciting the perspectives of insured Californians on the overarching question: While preserving and improving the health and healthcare resources of Californians, what strategies are most acceptable for reducing the use of medical care that is harmful and/or wasteful? The project will involve 10 half-day sessions across the state with groups of individuals covered through Medi-Cal, Covered California, and CalPERS. Case scenarios will form the basis for discussion, including at least two that are included in the Choosing Wisely campaign.

Session 3: Addressing Overuse in California

Initiators: Scott Weingarten, MD, Cedars-Sinai Healthy System; Ann Marie Giusto, RN, Sutter Health; and Marcus Thygeson, MD, Blue Shield of California

Scott Weingarten, MD, Cedars-Sinai Health System
Key Discussion Points:

- Education alone doesn't work, and decision support can play a role in quality improvement.
- Cedars programmed its EMR (made by Epic) to include 180 Choosing Wisely recommendations. When a physician attempts to order a test or treatment that is referenced on the Choosing Wisely lists, he/she receives an alert. The "soft stop" alerts are just pop-ups that provide more information and allows the physician to move on without action. The "medium stop" alerts require the physician to provide a reason before advancing.
- The alerts were implemented in August 2013. The system has been refined over time to reduce false positives (alerts incorrectly going off). Now, there are now about 300 alerts per day without significant complaint.
- For the period April 2014-March 2015, Cedars estimates $6 million in savings as well as the quality benefits associated with preventing unnecessary care.
- Data show that over time, physicians change their behavior in response to the alerts.
- A company has been created to support additional efforts in this area and is interested in collaborating with provider systems that would like to replicate Cedars' initiative, on a pro bono basis.

Ann Marie Giusto, RN, Sutter Health
Key Discussion Points:

- Variation reduction efforts started 6 years ago at Sutter Health, with the purpose of identifying opportunities to improve care and reduce costs that were welcomed by clinicians.
- Variation reduction constitutes face-to-face facilitated meetings in which unblinded data is shared with physicians who practice together in a department; if physicians aren't ready to see unblinded data, they are not ready for the variation reduction process.
- Through Sutter's efforts, variation reduction has impacted over 105,000 patients, 100 clinicians, and has resulted in savings of over $30 million dollars across the medical network.
- Examples of variation reduction efforts include vitamin D screenings, colonoscopies, blood transfusions, CT scans, and end of life care.
- Communication with physicians is a core element of the variation reduction effort. Key features of Sutter's process include creation of project charters at the outset of a variation reduction effort, and monthly emails to physicians providing progress reports on measures and trends.
- Demand has grown significantly for the variation reduction services provided by the Sutter Health team, and physicians "can't get enough of it." Without this effort, they don't know how their practice patterns compare with colleagues, and they don't know how much services cost.

Marcus Thygeson, MD, Blue Shield of California
Key Discussion Points:

- Blue Shield of California's efforts to reduce overuse fall into four main categories.

- Traditional – this category includes prior authorization and value based contracting, and the narcotics safety initiative (goal of reducing narcotic use by 50%)
- Shared decision-making, including decision aids, decision coaching, and measuring the quality of patient decisions
- Patients as change agents, including Choosing Wisely efforts targeting ACOs and members (e.g. "Ask 5", antibiotic overuse), patient advisory councils, and support for lay/citizen empowerment
- Advanced illness care, including a pilot with UCSF on palliative care, a California Advanced Illness Collaborative (in development), and a multi-payer MAPD hospice concurrent care pilot that would reverse the hospice carve-out (in development).

Session 4: Workgroup Activities in Year I
Initiator: Ann Boynton, CalPERS

Ann led a discussion about related to the target areas for the Workgroup and the most promising approaches to pursue. Discussion points raised in each area are highlighted below.

What should the Workgroup focus on?

- Starting place for Workgroup is Choosing Wisely initiative, with clinical focus. Given the large number of recommendations in Choosing Wisely, segmentation of recommendations to identify the most relevant/impactful could be useful in deciding on specific focus areas.
- Criteria proposed to consider in targeting efforts started with the list in the discussion document (from the Bailit report), and broadened to include several additional items:
    - Potential to prevent harm/relative risk to patient safety
    - Frequency and cost of problem – account for a relatively large share of cost
    - Data completeness and ability to report the extent of the problem -- feasible to track progress with existing data
    - Practice variation within the state
    - Literature on extent of overuse
    - Established, tested, and available evidence-based clinical pathways
- Alignment opportunity – Medicare reimbursement will require that radiologists consult clinical guidelines by 2017. Two ways to view this development as it relates to the Workgroup's potential focus areas: 1) definitely going to occur, so not a good area to focus; 2) opportunity to support change that must occur.
- Suggestions for areas of focus:
    - Imaging (X-rays, low-back pain) –radiation exposure is a major patient safety issue, and exposure among kids has increased significantly
    - Blood transfusion – inpatient was specifically suggested
    - C-section rates – opportunity to collaborate with other organizations, including CMQCC and CHCF, and leverage Workgroup efforts
    - Overuse of medications, particularly antibiotics, antipsychotics

- Overuse of opioids -- CURES database being revamped (v2.0), will allow easier access for physicians to their own prescribing data vs. comparative benchmarks
- Palliative care – suggestion to include POLST/advance directive, countered by observation that the issue there is underuse, not overuse

Pathways to create change – what are the most promising approaches to pursue?

- Key behavioral interventions to change provider behavior are: 1) systems redesign (e.g. hardwiring alerts into EMR); and 2) comparative data/feedback (e.g. Sutter's variation reduction efforts).
- Workgroup's approach needs to acknowledge that there are two distinct groups of clinicians: those practicing in a group, and those in individual practice. They have distinct capabilities, resources, receptor sites for efforts such as this one. Taking Sutter's variation reduction approach to scale across the state, or implementing Cedars' approach to hardwiring Choosing Wisely into the EMR will be much more effective in systems than in practices of 1-2 physician.
- Purchaser contracting has both benefits and drawbacks as a strategy for the Workgroup to pursue. Purchasers have a very large hammer, particularly the co-chair organizations, given the scale of their membership. If CalPERS or Covered CA requires a contractual change, the health plans can then advocate for changes to existing practices that may otherwise be low priority. At the same time, the contractual process is a blunt tool with a long time-horizon; CalPERS is currently closing the 2016 negotiations. One potential next step could be to create and share "model" contract language that purchasers have found to be effective, e.g. related to performance guarantees.
- Hierarchy of opportunities to influence behavior/create change: policy mandate is the most difficult but the biggest impact (e.g. seat belts); purchaser/plan; provider (primary care, specialist), consumer.
- Consumer "education" not sufficient as mechanism for change, but can be an important part of broader strategy

Other Observations and Considerations

- Provider systems are overwhelmed, with many initiatives competing for scarce resources. Any Workgroup effort needs to be conscious of the landscape and add value for providers.
- Workgroup should: 1) stay focused; 2) start small; 3) declare a feasible intention and make it happen.
- Distinction between ineffective care/overuse and preference-sensitive care. Ineffective care simply shouldn't be done, and this is the focus of the Choosing Wisely initiative. Preference-sensitive care depends on the patient's values and wishes, and is the area for shared decision-making. Preference-sensitive care is overuse only if the patient doesn't want it.
- Provider-facing messaging should focus on clinical excellence. Timing is good given that physicians are increasingly concerned about being dropped from networks ("narrowed out").

Session 5: Wrap-Up/Next Steps
Initiators: Ann Boynton, CalPERS

Ann suggested that the next Workgroup meeting be held in Southern California, and that meetings alternate between Northern and Southern California to distribute the travel burden among participants. Bill Henning of IEHP offered to host the next meeting, and Ann asked the Workgroup members to be on the lookout for a scheduling poll. The next workgroup meeting will be held in October, and the Workgroup members will likely be asked to convene in small subgroups prior to that meeting so that progress can be made before the next in-person meeting.