

## **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

### **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

After the discussion, participants contributed at least one idea on 1) what the Workgroup could do together and , 2) what their own organization could do to reduce C-section rates.

### **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 in 10 healthcare dollars is spent on spine pain in the U.S.
- The current care flow for patients faced with back pain is a maze of options with no clear sign posts. Care is fragmented and outcomes highly variable.
- 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
- Team has forecast that they will achieve a conservative 25% savings.

Jill then asked participants to contribute at least one idea on 1) what the Workgroup could do together and 2) what their own organization could do to reduce imaging for nonspecific low back pain.

### **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

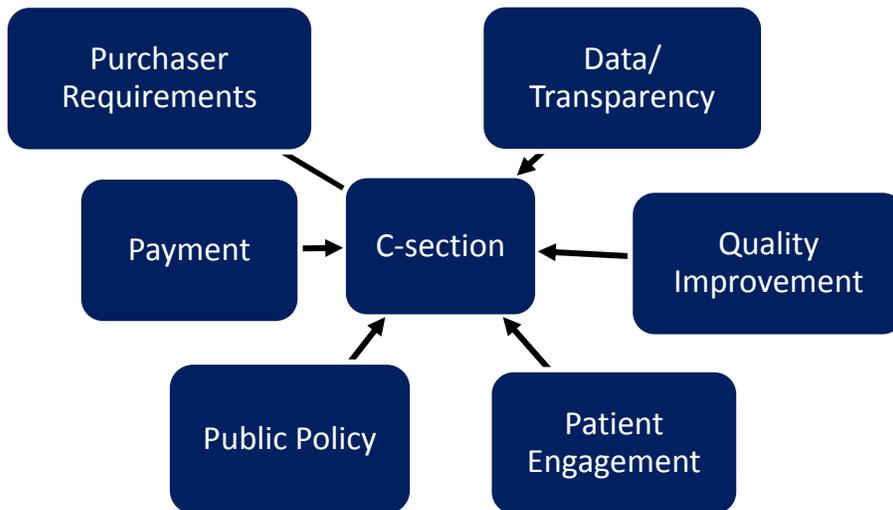
Jill then asked participants to contribute at least one idea on 1) what the Workgroup could do together and 2) what their own organization could do to reduce opioid dependence.

**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.