

Statewide Workgroup on Reducing Overuse

Co-chairs: Covered California, CalPERS, DHCS

Meeting #4 – Meeting Summary

Wednesday, August 31, 2016, CalPERS

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

WELCOME AND INTRODUCTIONS

Initiators: *Lance Lang, MD, Covered CA; Jill Yegian, PhD, IHA*

Lance Lang welcomed the members of the workgroup and thanked them for attending the first in-person meeting as part of the new two-year grant from the California Health Care Foundation (CHCF). Jill Yegian provided an overview of the work group including the co-chairs, purpose, and three focus areas (Cesarean section for low-risk, first-time births; imaging for low back pain; opioid dependence). She highlighted the workgroup's action priorities:

- Enable action – curate and disseminate tools for purchasers/plans, providers, and patients/consumers
- Create a dashboard to track progress on select measures
- Explore development of recognition awards for performance on C-section
- Convene regular meetings in support of the co-chairs' leadership and collective action

Jill described ways in which the workgroup overall and the participants could contribute, including creating a vision; partnering with other national and state efforts; communicating about the importance of reducing overuse; and producing tools to support engagement by various audiences such as policymakers/purchasers, providers/clinicians, and consumers/patients/family. Multiple levers are available to reduce overuse: 1) purchaser requirements, 2) patient engagement, 3) quality improvement, 4) data transparency, 5) payment, and 6) public policy.

OVERVIEW OF STATEWIDE WORKGROUP: ROLE, PROGRESS, NEXT STEPS CO-CHAIR UPDATE – PROGRESS, RELATED ACTIVITIES

Initiators: *Lance Lang, MD, Covered California; Kathy Donneson, PhD, CalPERS; Neal Kohatsu, MD, DHCS*

Each of the co-chairs provided a brief overview of their thoughts on progress of the workgroup to date and next steps. Lance Lang indicated that Covered CA is aiming for a tipping point in which practices are adopted that benefit the whole population. They are seeking variation reduction coupled with achievement of performance targets by all clinicians. Kathy Donneson stated that CalPERS has been focused on low back pain; they had initially planned to focus on imaging for low back pain but are considering a broader approach to managing low back pain and how it is approached from a clinical and benefit design standpoint. Neal Kohatsu stated that while it is easy to get lost in the weeds of data collection and process measures, it's important for there to be alignment of the meeting participants and a focus on the outcomes the group is trying to achieve that will help transform the health care delivery system. All three co-chairs agreed that the group has made solid progress in the last year as it has worked to build consensus and identify best practices statewide.

OPIOID OVERUSE IN CALIFORNIA: PRIORITIES FOR ACTION

Initiator: *Kelly Pfeifer, MD, CHCF*

Kelly Pfeifer set the stage for this discussion by noting that a key strategy for reducing opioid use is to make it easier for providers to do the right thing in terms of treating patients and make it harder for them to do things that are riskier. She and other meeting attendees noted that the US Surgeon General recently sent a letter to all physicians to raise awareness of the opioid epidemic; the letter was accompanied by a pocket guide summarizing the CDC treatment guidelines on the use of opioids for chronic pain. Kelly emphasized the importance of using the evidence base to help patients get the right treatment and reduce opioid use in four types of situations: reducing new starts, addressing patients already on opioids and getting them on safer regimens, getting people who are addicted into treatment, and increasing the availability of naloxone to reduce overdose deaths. She noted that there are 16 opioid safety coalitions in 24 counties across CA where a broad group of stakeholders are working together to decrease opioid overuse and overdose death.

Kelly walked through the materials identifying action steps for health plans beginning on p. 11 of the meeting packet (e.g., 4-part prescription for the opioid epidemic, formulary approaches supported by research, examples of formulary policies, common components of health plan clinical guidelines) and asked the group whether these recommendations resonated within their organizations.

Key Discussion Points:

- The specificity in the CHCF health plan report in terms of identifying innovations (e.g., items to discuss with health plan medical directors to drive alignment of best practices) was appreciated. The importance of phrasing recommendations in a “what to do” vs. “what not to do” frame and addressing any barriers to implementation was noted, along with the importance of spreading these innovations to all patient populations and implementing effective benefit designs.
- The group discussed performance measures and the importance of not focusing only on the percent of a doctor’s patients who are prescribed opioids since opioids are appropriate for some patients; there is a need for a balancing measure. Workgroup members raised other issues such as addressing outliers and helping physicians who prescribe more opioids than they should, as well as measuring physician education around opioid prescribing. It was suggested that identifying and addressing physician and patient needs be the top priority, with metrics, which are essential, to follow.
- A health plan representative shared that they are using their formulary and prior authorization requirements to shape physician prescribing behaviors. They developed a policy to support a physician telling a patient that the plan doesn’t cover an opioid while offering alternatives such as referrals to acupuncturists or chiropractors, along with other medications that are covered. An important goal is to achieve a balance between under- and over-prescribing.
- A holistic approach to reducing opioid overuse is likely needed, including benefit design, support for providers, and patient engagement. Priorities include focusing on providers on the front lines who really need help (e.g., there is a need to address physician burnout and stress related to

opioid prescribing), and ensuring that care is patient-centered.

RESOURCES ON OPIOIDS BY TARGET AUDIENCE: OVERVIEW

Initiator: *Karen Shore, PhD, Transform Health/IHA*

Karen Shore described how potential resources on opioids for the three audiences (patients, providers, purchasers/plans) were identified and the criteria against which they were reviewed. She summarized the types of resources and shared a few sample resources for each audience. Feedback was sought from the group on whether the spreadsheets included the right categories, resources, and criteria.

Three meeting participants were asked to provide initial remarks to kick off a feedback discussion. Their comments are summarized below:

- Jim Leo, MD, MemorialCare (provider resources) – suggested identifying the top 3-5 resources that can be incorporated into electronic medical records (EMRs) and printed for patient or provider use. The CDC website has a lot of easy-to-access and digestible information. One gap noted was information on limiting new starts.
- Julie Morath, RN MS, HQI (provider resources) – suggested culling best practices and including information for providers such as nurse practitioners, dentists, etc. She suggested that case studies be included, with a carefully curated compendium of effective approaches.
- Beccah Rothchild, Consumer Reports (patient resources) – suggested additional criteria for inclusion of resources such as accessibility (e.g., readability <6 grade reading level, font size, available in languages other than English).

Key Discussion Points:

- Gaps included: 1) what to do when a patient first has pain or when pain is anticipated after surgery, 2) how to help manage patient expectations regarding pain, 3) information for providers on tapering, and 4) materials that are in formats that do not require reading.
- There was a desire to intervene upstream, with suggestions including: 1) focusing on mindfulness/wellbeing/stress reduction/managing depression; 2) creating a culture of compassion around pain; 3) using evidence to decrease use of opioids in perioperative situations, 4) engaging pharmacists so that they have a role in patient education when an initial prescription is given; and 5) adopting a population health approach to treating chronic pain.
- There was a concern that while it is possible to create change through the use of these types of resources in highly integrated systems, it will be much more challenging in less structured environments.

Meeting participants engaged in an exercise where they were asked to provide 1) additional feedback on the provider and patient resources, 2) how they could be used in their organizations, and 3) how they could be disseminated.

- Ideas for *use within their organizations* included: Share with partner organizations, make available on websites and patient portals, podcasts for members, integrating into EMR alerts,

educational webinars, and conference presentations.

- Ideas for *broader dissemination* included: Health fairs, PSAs (e.g., with athletes talking about managing pain), presentations in schools, social media, creating a toolkit with resources, incorporating into EMRs and clinical decision supports, and sharing in e-newsletters.

WHAT CAN THE CO-CHAIRS DO TO PROMOTE AND SUPPORT CHANGE?

Initiators: *Lance Lang, MD, Covered California; Kathy Donneson, PhD; CalPERS Neal Kohatsu, MD, DHCS*

Lance Lang asked for suggestions on how plans can make sure that physicians are aware of and using newest treatment approaches. Responses included: 1) focus on primary care leaders who can help shape provider behavior initially and work with less-connected providers in upcoming years, 2) focus on physicians in highly integrated groups which may be more prone to under-treatment, and 3) reframe the issue away from the opioid epidemic to focus on management of chronic pain.

The group discussed the goal of having naloxone readily available, and some problems with the accessibility of naloxone were noted. Some pharmacies are refusing to stock it because it is a risk to them and requires 30-45 minutes of counseling time when it is dispensed.

Neal Kohatsu discussed DHCS' work related to opioids, including expanding the capacity of primary care physicians to address pain, promoting policies aligned with safe opioid prescribing, having its pharmacy group address policy barriers to naloxone distribution, fostering guideline adoption, identifying system approaches that are effective, and learning about/disseminating best approaches. DHCS is working to see how they can best support efforts at the provider group/provider and health plan levels.

Kathy Donneson suggested a variety of approaches for reducing opioid overuse in a fragmented system: using formularies to control quantity limits and days supplied, using an appeals process to determine medical necessity, and using pharmacy benefit managers (PBMs) to do peer-to-peer education.

The group discussed how to measure its success over the next 12 months. It was suggested that a roadmap be developed that identifies how to make progress on all three areas over time, and that the group aim for some early wins and start with areas that are low effort/high impact. Also discussed was the desire to get resources out to the various audiences as soon as feasible, with a priority placed on getting information from providers to patients. This was paired with a caution that resources couldn't simply be pushed out – there is also a need to change the culture in terms of expectations about opioids and pain; providers, purchasers/plans, and patients/families all have a role to play in this.

TRACKING OVERUSE OF OPIOIDS: CDPH DASHBOARD

Initiator: *John Pugliese, PhD, CDPH*

John Pugliese provided an overview of a new dashboard that CDPH has been developing in collaboration with the Office of Statewide Health Planning and Development (OSHPD), Department of Justice, and CHCF. The goal is to provide a tool with enhanced data visualization that integrates statewide and

county-specific overdose and opioid prescription data. The dashboard will enable tracking of progress toward several short- and long-term goals targeted by California's Prescription Drug Overdose Prevention program. Data can be reviewed at the state and county levels to show where the opioid overdose epidemic is most acute (i.e., by county and zip code), and how it has changed over time in these areas. The website includes: deaths (by type of drug), emergency department visits and hospitalizations related to drug overdoses, and prescription data from the CURES database.

Key Discussion Points:

- The group was enthusiastic about the dashboard, and appreciative of the CDPH staff's interest in partnering with users to maximize the website's utility.
- There was some concern about the timeliness of the data, and CDPH staff indicated that they are working to streamline access to new data and shorten the time lag.
- A distinction was made between data for clinical management of patients, which needs to be near-real time, and the dashboard data – which is most useful for identifying hot-spots and monitoring progress against baseline.
- There was a request that CDPH share the data dictionary with the group. Note: subsequent to the meeting, a beta version of the website is available and includes a link to a data dictionary: https://pdop.shinyapps.io/ODdash_v1/

C-SECTION RECOGNITION AWARDS FOR HOSPITALS

Initiators: *Lance Lang, MD, Covered California; Stephanie Teleki, PhD, CHCF; Sarah Lally, IHA*

Lance Lang kicked off the discussion, providing an overview of the recommended approach for hospital-level recognition awards for performance on C-sections. For the first year, the group co-chairs recommended developing an “honor roll” award that recognizes hospitals with C-section rates for low-risk, first-time birth under the “Healthy People 2020” threshold of 23.9%. It is anticipated that the recognition will come from the Secretary of California Health and Human Services (CHHS) on behalf of Covered California, CalPERS, DHCS, and PBGH. The co-chairs, together with CHHS, will work together to hold a press conference to showcase hospitals that meet the 2020 target in October to coincide with the public reporting of the C-section rates for the second half of 2015.

Key Discussion Points:

- It will be important to consider a more robust award methodology in the future. Several ideas were proposed including: 1) a top performer award that includes a more stringent criterion that prioritizes protecting against unintended consequences brought on by efforts to reduce the C-section rate; and 2) a “most improved” award to ensure lower performing hospitals are encouraged to participate in activities that lead to improvement.
- Award branding is a key concern with the new recognition award. The name for the Overuse Workgroup should be updated before the awards are distributed.

Overall the workgroup members were supportive of the proposed approach to recognize hospitals with C-section NTSV rates under the “Healthy People 2020” threshold of 23.9%. Next steps will include organizing a subgroup, led by Covered California and CHHS, to organize the October awards/press event.

LOW BACK PAIN

Initiator: *Jill Yegian, PhD, IHA*

Kathy Donneson stated that the initial charge to CalPERS was to focus on the overuse of imaging for low back pain. This is because imaging is overused (e.g., xrays taken and repeated, patients often sent for expensive MRIs). They decided to expand the mission to look at management of chronic low back pain, noting the significant overlap with the use of opiates. They plan to take a more holistic approach and look at treatment alternatives, the evidence base for chronic pain pathways, nonsurgical vs. surgical options, decision support tools, and variation in diagnostic testing and treatment. Areas of focus include: 1) tools to help members/patients understand that there are care alternatives; and 2) benefit design related to physical therapy, chiropractor, and acupuncture visits.

Key Discussion Points:

- The group discussed the importance of getting people into care very quickly – ideally the same day but definitely within 30 days and before a physician prescribes an opioid.
- Several organizations and care models were discussed for consideration including Stanford/CERC, Kaiser Permanente Southern CA, and Virginia Mason – one or more of these groups will be contacted about presenting at the January 2017 workgroup meeting. The workgroup members would especially like to hear about outcomes measured and the source of any cost savings.

NEXT STEPS AND ACTION ITEMS

Jill Yegian summarized the day’s discussion:

- 1) In terms of workgroup priorities, there was general agreement around the four areas identified related to opioids: reducing new starts, tapering, medication assisted treatment (MAT), and naloxone availability.
- 2) Feedback on opioid resources – need to narrow to even fewer resources, materials should be integrated through EMRs and disseminated to other partners (e.g., pharmacies, dentists), need to think about potential differences for providers in integrated systems vs. non-integrated.
- 3) CDPH dashboard preview – appreciate partnership with CDPH and look forward to possibly overlaying different types of data and patient alerts tracking over time. Will request and share data dictionary (see note above).
- 4) C-section – proceed with plan for Secretary’s awards, ideally in October.
- 5) Low back pain – the group is very interested in this topic; IHA will plan content and identify guest speakers for January meeting.
- 6) Renaming workgroup – CHCF volunteered to lead a subgroup to generate alternative names for the workgroup prior to the October C-section awards.