

Smart Care California (SCC)

Co-Chairs: Covered California, CalPERS, DHCS
Summary of January 29, 2018 Meeting -- #8
February 15, 2018

The main purposes of the January 29 meeting were to 1) assess SCC's progress to date as an initiative, 2) evaluate progress on the three focus areas, and 3) discuss strategies to continue advancing the work of the initiative. Bailit Health presented strategic recommendations for SCC based on analysis conducted over the past five months, and various presenters shared updates on work to advance SCC's three focus areas.

The complete meeting packet, including agenda and presentations will be available at:
<http://www.iha.org/our-work/insights/smart-care-california/meeting-materials>.

I. STRATEGIC RECOMMENDATIONS FOR SCC

Meeting Recap

Julia Logan, MD, MPH, Chief Quality Officer at DHCS introduced two guests, Michael Bailit, MBA, President, and Megan Burns, MPP, Senior Consultant from Bailit Health. This firm was engaged by the California Health Care Foundation (CHCF) to assist SCC in its strategic planning, which included an assessment of SCC, a national scan of multi-purchaser efforts and multi-stakeholder efforts to reduce low-value care, and a set of preliminary recommendations. Bailit Health's assessment of SCC found that the workgroup has accomplished a significant amount of work, participants are enthusiastic and highly engaged, and that there are both tangible and intangible benefits to participants who attend the full-day SCC workgroup meetings. There are opportunities to evolve the strategy to implement recommendations and to clarify the role of participants.

In their findings from their national scan, Bailit Health found that there were no other efforts statewide that looked like SCC. The primary force for other existing statewide collaboratives came from legislature mandates or governor's office, and there were no independent initiatives. Key factors for success of these collaboratives were strong internal leadership and a collaborative culture.

Bailit Health then presented three strategic recommendations for SCC to consider:

1. Define a logic model which visualizes the relationships among resources to operate a program, planned activities, and desired results. This recommendation includes drafting a new workgroup charter and clearly defining the role of participants
2. Implement SCC recommendations. Implementation was parsed out by audience type: payer, provider, and consumer. Options for provider implementation were further discussed as provider implementation will be needed to supplement payer implementation.
3. Intensify and broaden activities. This recommendation suggested more opportunities to convene in between the full day meetings, the use of a seasoned facilitator, and the need to create concrete annual action goals and measures (similar to the one used to [track implementation of the opioid checklist](#))

Discussion and Next Steps

- There was recognition that there is work on the three focus areas happening between the meetings by participants (for example, the C-section honor roll) and that SCC should play a larger role in highlighting the work that is being done.
- There was agreement that SCC should be tracking implementation of progress for the three focus areas so peers can compare themselves to others. Tracking progress should measure two things:
 - Outcomes such as overall opioid MME per person (with consideration that absolute and relative targets are important to not penalize the high performers)
 - Process measures of implementation, for example SCC can help track whether all plans and providers in CA have an opioid reduction strategy
- There is value in having SCC be a multi-stakeholder but purchaser-led initiative. Variation in care starts with the purchasers who lead SCC and it is important the purchasers work together to set standards for the rest of the state
- SCC can add value in developing change packages and measure targets, but it is important to recognize that not all of the care delivery in the state is organized well enough to take a change packet and implement it. This is a challenge that needs to be overcome in order to get a true tipping point for care delivery transformation across the state.
- There is a need to reach other plans and providers who are currently not a part of the workgroup, as there is a role for other organizations such as dental associations.
- SCC already has significant QI infrastructure in the room that could be leveraged specifically the California Quality Collaborative, the Safety Net Institute, and the Hospital Quality Institute.
- SCC will quantify existing implementation of recommendations to track what has been achieved and to assess where the group still needs to go.
- SCC leadership will build out the logic model and draft a new project charter by the next meeting on June 5.

II. OPIOIDS

Meeting Recap

Julia Logan began the opioid discussion by reviewing data from the California Opioid Surveillance dashboard for four measures that SCC had previously identified as high importance: Total morphine milligram equivalents (MME) per resident; Residents on >90MME Daily; Residents on Opioids/Benzos and Number of buprenorphine prescriptions. All four metrics have moved in the right direction between the 2015 baseline year and 2016. However, when the data is examined on a county level, there are still many counties doing worse than the statewide average, which indicates there is still a lot of unwarranted variation. In addition to data from the [California Opioid Overdose Surveillance Dashboard](#), Kelly Pfeifer, MD, Director, High-Value Care at CHCF added that the Urban Institute will provide a report on county-specific opioid overuse rate, treatment resources, buprenorphine rate, and other metrics to give county leaders more actionable data to set goals to address treatment gaps.

Kelly Pfeifer then gave an overview of the work being done to support the implementation of SCC recommendations (which relates back to Bailit Health's second strategic recommendation for SCC). CHCF is currently [requesting proposals](#) from consultants and other organizations who wish to be included in a resource catalogue for health plans and providers, and CHCF will be funding the

development of a toolkit that health plans can use to implement a comprehensive opioid safety initiative. Additionally, CQC is hosting a provider convening in March to discuss the development of a provider change package and best practices for opioid management. SCC plans to survey health plans again in one year to reassess implementation of strategies to curb the opioid epidemic.

Discussion and Next Steps

- Opioid addiction is complex. There is currently a culture of fear surrounding the opioid epidemic and primary care physicians often are not comfortable taking care of patients on high dose opioids. The right messaging is critical because it is easy to do the wrong thing (e.g. “firing patients” who take opioids, refusing to prescribe opioids, decreasing opioid dosage without considering the individual needs of the patients).
- One strategy that a provider organization implemented is hiring a pain management doctor, a psychologist and pharmacists to support PCPs in taking care of patients on opioids.
- An EHR toolkit containing 3-5 things that provider organizations can implement was discussed as a useful tool. Current SCC participants have used EHRs in the following ways:
 - To extract data that can be shared with providers monthly to provide feedback on performance and to initiate discussions with outlier prescribers.
 - To implement EHR-based clinical decision support tools that provide data at the point of care and trigger a provider to take action. For example, any patient prescribed an opioid within the first six months has an alert fired to get a urine screen. Clinical decision support can also be programmed to pull up a patient’s history of overdose, and prescription for naloxone.
 - To identify patients for outreach who need to complete a standardized pain contract.
- SCC should look to leverage infrastructure that already exists and decentralize knowledge about programs like Project ECHO in order to make this improvement work more sustainable.
- There are plans who are interested in using academic detailing to improve provider prescribing behavior
- One message that SCC can support is that there is no wrong door for medication assisted treatment (MAT) for opioid addiction. MAT should be easier to get than drugs on the street and can be offered in multiple settings within the health care system (primary care, emergency departments, and hospitals) but can also be offered in other settings like jails and residential treatment facilities.

III. LOW BACK PAIN

Meeting Recap

Kathy Donneson, PhD, Chief, Health Plan Administration Division and Richard Sun, MD, MPH, Chief, Clinical Programs and Appeals Section, Health Plan Administration Division at CalPERS provided an overview of CalPERS’s and SCC’s low back pain work to date and reminded the group of the decision to move from a focus on low back pain imaging to appropriate care for low back pain. Richard Sun then introduced Angela Kline, MPH, Senior Project Manager at IHA who presented an overview of IHA’s Cost and Quality Atlas tool, which provides geographic variation of data by payer and product type, and how it could potentially be used to further the work of SCC and its participants. Specific to low back pain, the

Atlas contains data on patients diagnosed with low back pain, data on appropriate use of imaging for low back pain, and selected frequency of back procedures.

Tony Linares, MD, Regional VP, National Medical Director, Anthem and Kian Raiszadeh, MD, CEO and Co-Founder, SpineZone described a collaboration to address back and neck pain that could be applied in a large employer and a PPO population. The SpineZone program includes an online assessment to assess functioning (e.g. walking, dressing, anxiety, depression) to calculate a patient's risk score. Patients then receive online coaching or a more intensive in-person clinic program. The program focuses on improving functional outcomes but also tracks pain outcomes and medication usage. Patients have seen improvements in function, less pain and less anxiety and depression. There has also been evidence of cost savings with the biggest percentage of savings from reduction in hospitalizations. The program has served over 10,000 patients to date and is a rapidly expanding platform for health systems looking for a turnkey program for managing back pain assessment and treatment.

Discussion and Next Steps

- There was interest in exploring the applicability of this program to Medi-Cal patients. The SpineZone online product could be optimized for Medi-Cal patients but is not yet provided to Medi-Cal patients.
- It is important for the primary care team to stay involved when a patient goes to a program like SpineZone. PCPs who have a contract with SpineZone are able to refer patients directly into the program. SpineZone sends the initial assessment to the PCP and updates the primary care team as the patient progresses through the program.
- In terms of how SpineZone fits with SCC's efforts, CalPERS will be testing the online version of their program with their PPO population as a first or second line treatment for low back pain and will report back on implementation of the program.
- The presentation revealed that the spectrum of patients with nonspecific low back pain is more nuanced than acute vs chronic. There are some patients who have started conservative treatment after the onset of pain who are not making progress and need more guidance on appropriate treatment pathways.
- There was consensus that SCC should focus on the period shortly after the onset of back pain.

IV. C-SECTION FOR LOW RISK FIRST TIME BIRTHS

Lance Lang, MD, Chief Medical Officer at Covered California introduced Cathie Markow, MBA, BSN, Administrative Director for the California Maternal Quality Care Collaborative (CMQCC), who described the great progress California has made in reducing C-section for low-risk, first time births (NTSV rate). According to the latest [Smart Care Honor Roll](#), [111 hospitals](#) have achieved or surpassed the 23.9% target for low-risk, first birth C-section (based on 2016 OSHPD data). 86 hospitals have made the honor roll twice. As of December 2017, CMQCC's hospital membership included 85% of all maternity hospitals in the state, which account for 90% of the deliveries in the state. There are about 40 maternity hospitals who are currently not members. For the past year and a half, CMQCC has been working closely with hospitals with a >23.9% NTSV C-section rate as part of a QI collaborative to reduce C-sections and promote vaginal birth.

Lance Lang led a discussion on current implementation of the [SCC menu of payment and contracting options](#). Covered California has been doing site visits with all of its plans. Large network plans have been making progress; Covered California is working with smaller plans, who have less market power, to make it easier to work with their hospitals to improve. CalPERS has included NTSV C-section as a performance measure for 2018-2023 contracts, and HMO plans are at risk for C-section deliveries. CalPERS is also designing a healthy mom/baby program that encourages mothers to engage with their OB/GYN over the course of pregnancy and provides moms incentives for vaginal birth. Inland Empire Health Plan has also included the NTSV metric in their hospital P4P program and are looking into implementing maternal safety bundles, including process measures that can be incentivized. PBGH has also had regional discussions to try to encourage hospitals to join CMQCC.

Stephanie Teleki, PhD, Director, Evaluation & Impact at CHCF, provided an update on the creation of consumer engagement materials. The original plan was to develop one education video that addresses variation in C-section rates and why a woman should be careful about getting a C-section. However, focus groups revealed two key missing pieces of information: 1) why unnecessary C-sections are happening and 2) who is on the care team (midwife, doula, labor and delivery nurse, childbirth educator, etc.). There are now additional videos in development to address these two areas. The release of the videos and print materials is scheduled for late Q1/early Q2 2018. Secret shopper testing of the patient education materials has also revealed important patient testimonials. For instance, one pregnant woman who viewed the materials believed she was going to have a C-section because she had a family history of C-sections, but since viewing the materials, she is planning to have a vaginal birth. SCC will explore how these testimonials can be used in efforts to reduce C-sections.

Discussion and Next Steps

- C-section is a project in maturity: guidelines exist, a validated common goal/target exists, there is coaching, good data, purchaser requirements, payment reform, and now consumer tools. All of these things together can move the needle. C-section is the best model for statewide multi-stakeholder improvement that SCC can apply to future topics.
- While C-section is a mature model with proven success, there is still work to be done. There is an over-representation of the “haves” at Smart Care meetings and there is a need to engage other providers, especially those in rural areas.
- Plans often struggle with getting providers to engage and resort to using “sticks” rather than carrots to get providers to improve. Some plans are holding collaboratives to engage providers; one purchaser would like to hold regional meetings with both providers who are not engaged and those who are engaged.
- There was a reminder to engage other groups who have a stake in reducing C-sections, especially labor and delivery nursing associations.
- SCC will continue its efforts related to C-sections, will increase transparency of tracking implementation efforts, and will investigate how to get data out more rapidly.

Next meeting scheduled for Tuesday, June 5, 2018 in Northern California.