Washington State Health Care Authority

Public Employees Benefits Board Retreat

February 4, 2016

Washington State Health Care Authority

Public Employees Benefits Board Meeting

February 4, 2016
8:30 a.m. – 3:30 p.m.

Health Care Authority
Sue Crystal A & B
626 8th Avenue SE
Olympia, Washington

Table of Contents

TAB 1

Washington State Health Care Authority

AGENDA

Public Employees Benefits Board Retreat
February 4, 2016
8:30 a.m. – 3:30 p.m.

Health Care Authority
Cherry Street Plaza
Sue Crystal Rooms A & B
626 8th Avenue SE
Olympia, WA 98501

THEME: Health Literacy – Empowering Our Members to Make Wise Choices for Their Health

8:00 a.m.	**Coffee**		
8:30 a.m.	**Welcome** **Introductions and Purpose**		Dorothy Teeter, Chair
9:00 a.m.	**Introduction** **Keynote:** • **Less Medicine, More Health: 7 Assumptions that Drive too Much Medical Care** **Q & A / Discussion**		Dan Lessler, MD Gilbert Welch, MD Dartmouth Institute for Health Policy and Clinical Research Author of "Overdiagnosis" and "Less Medicine, More Health"
10:30 a.m.	**Break**		
10:45 a.m.	**Panel: Implementing Choosing Wisely** **Washington Health Alliance - Choosing Wisely Campaign** **Virginia Mason – Reducing Inappropriate Antibiotics for Upper Respiratory Infections** **Group Health – Implementing Choosing Wisely at Group Health**	Tab 3	Marcia Peterson, Moderator Nancy Giunto, Executive Director Washington Health Alliance Norifumi "Norris" Kamo, MD, MPP Kim Pittenger, MD Virginia Mason Marc Mora, MD Group Health
12:00 p.m.	**Working Lunch** **Q & A for Panel**		
12:30 p.m.	**HCA/PEBB Program Member Engagement Initiative** **CAHPS and HEDIS Measures**	Tab 4	Scott Pritchard, PEB Lauren Johnston, PEB
1:30 p.m.	**Value-Based Purchasing: New Plan Enrollment Results**	Tab 5	Michael Arnis, PEB

1:45 p.m.	**Break**		
2:00 p.m.	**Looking Ahead to 2017**	Tab 6	Marcia Peterson, PEB
2:45 p.m.	**Finance Update**		Thuy Hua-Ly, Finance
3:15 p.m.	**Adjourn**		
3:15 p.m.	**Board Member Paperwork**		HCA HR Staff

The Public Employees Benefits Board will meet for their annual retreat on Thursday, February 4, 2016 at the Washington State Health Care Authority offices. This notice is pursuant to the requirements of the Open Public Meeting Act, Chapter 42.30 RCW.

Direct e-mail to: board@hca.wa.gov.

Washington State Health Care Authority

PEB Board Members

Name	Representing
Dorothy Teeter, Director Health Care Authority 626 8th Ave SE PO Box 42713 Olympia WA 98504-2713 V 360-725-1523 dorothy.teeter@hca.wa.gov	Chair
Greg Devereux, Executive Director Washington Federation of State Employees 1212 Jefferson Street, Suite 300 Olympia WA 98501 V 360-352-7603 greg@wfse.org	State Employees
Myra Johnson* 6234 South Wapato Lake Drive Tacoma, WA 98408 V 253-583-5353 mljohnso@cloverpark.k12.wa.us	K-12 Employees
Gwen Rench 3420 E Huron Seattle WA 98122 V 206-324-2786 gwenrench@covad.net	State Retirees
Mary Lindquist 4212 Eastern AVE N Seattle WA 98103-7631 C 425-591-5698 maryklindquist@comcast.net	K-12 Retirees

PEB Board Members

Name	Representing
Tim Barclay 7634 NE 170th ST Kenmore WA 98028 V 206-819-5588 timbarclay51@gmail.com	Benefits Management/Cost Containment
Yvonne Tate 1407 169th PL NE Bellevue WA 98008 V 425-417-4416 ytate@comcast.net	Benefits Management/Cost Containment
Marilyn Guthrie 1640 W Beaver Lake DR SE Sammamish WA 98075 V 206-715-2760 maguthrie52@gmail.com	Benefits Management/Cost Containment
Harry Bossi* 160 E Soderberg RD J-27 Allyn WA 98524 V 360-689-9275 udubfan93@yahoo.com	Benefits Management/Cost Containment

Legal Counsel
Katy Hatfield, Assistant Attorney General
7141 Cleanwater Dr SW
PO Box 40124
Olympia WA 98504-0124
V 360-586-6561
KatyK1@atg.wa.gov

*non-voting members

1/26/16

Washington State Health Care Authority
Public Employees Benefits Board
P.O. Box 42713 • Olympia, Washington 98504-2713
360-725-0856 • TTY 711 • FAX 360-586-9551 • www.pebb.hca.wa.gov

2016 Public Employees Benefits Board Meeting Schedule

The PEB Board meetings will be held at the Health Care Authority, Sue Crystal Center, Rooms A & B, 626 8th Avenue SE, Olympia, WA 98501. The meetings begin at 1:30 p.m., unless otherwise noted below.

January 7, 2016 (Board Retreat) 9:00 a.m. – 3:00 p.m.

March 16, 2016

April 13, 2016

May 24, 2016

June 22, 2016

July 13, 2016

July 20, 2016

July 27, 2016

If you are a person with a disability and need a special accommodation, please contact Connie Bergener at 360-725-0856

Updated 7/7/15

TAB 2

Washington State Health Care Authority

PEB BOARD BY-LAWS

ARTICLE I
The Board and its Members

1. Board Function—The Public Employee Benefits Board (hereinafter "the PEBB" or "Board") is created pursuant to RCW 41.05.055 within the Health Care Authority; the PEBB's function is to design and approve insurance benefit plans for State employees and school district employees.

2. Staff—Health Care Authority staff shall serve as staff to the Board.

3. Appointment—The Members of the Board shall be appointed by the Governor in accordance with RCW 41.05.055. Board members shall serve two-year terms. A Member whose term has expired but whose successor has not been appointed by the Governor may continue to serve until replaced.

4. Non-Voting Members—Until there are no less than twelve thousand school district employee subscribers enrolled with the authority for health care coverage, there shall be two non-voting Members of the Board. One non-voting Member shall be the Member who is appointed to represent an association of school employees. The second non-voting Member shall be designated by the Chair from the four Members appointed because of experience in health benefit management and cost containment.

5. Privileges of Non-Voting Members—Non-voting Members shall enjoy all the privileges of Board membership, except voting, including the right to sit with the Board, participate in discussions, and make and second motions.

6. Board Compensation—Members of the Board shall be compensated in accordance with RCW 43.03.250 and shall be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060.

ARTICLE II
Board Officers and Duties

1. Chair of the Board—The Health Care Authority Administrator shall serve as Chair of the Board and shall preside at all meetings of the Board and shall have all powers and duties conferred by law and the Board's By-laws. If the Chair cannot attend a regular or special meeting, he or she shall designate a Chair Pro-Tem to preside during such meeting.

2. Other Officers—*(reserved)*

ARTICLE III
Board Committees

(***RESERVED***)

ARTICLE IV
Board Meetings

1. Application of Open Public Meetings Act—Meetings of the Board shall be at the call of the Chair and shall be held at such time, place, and manner to efficiently carry out the Board's duties. All Board meetings, except executive sessions *as permitted by law*, shall be conducted in accordance with the Open Public Meetings Act, Chapter 42.30 RCW.

2. Regular and Special Board Meetings—The Chair shall propose an annual schedule of regular Board meetings for adoption by the Board. The schedule of regular Board meetings, and any changes to the schedule, shall be filed with the State Code Reviser's Office in accordance with RCW 42.30.075. The Chair may cancel a regular Board meeting at his or her discretion, including the lack of sufficient agenda items. The Chair may call a special meeting of the Board at any time and proper notice must be given of a special meeting as provided by the Open Public Meetings Act, RCW 42.30.

3. No Conditions for Attendance—A member of the public is not required to register his or her name or provide other information as a condition of attendance at a Board meeting.

4. Public Access—Board meetings shall be held in a location that provides reasonable access to the public including the use of accessible facilities.

5. Meeting Minutes and Agendas—The agenda for an upcoming meeting shall be made available to the Board and the interested members of the public at least 10 days prior to the meeting date or as otherwise required by the Open Public Meetings Act. Agendas may be sent by electronic mail and shall also be posted on the HCA website. Minutes summarizing the significant action of the Board shall be taken by a member of the HCA staff during the Board meeting, and an audio recording (or other generally-accepted) electronic recording shall also be made. The audio recording shall be reduced to a verbatim transcript within 30 days of the meeting and shall be made available to the public. The audio tapes shall be retained for six (6) months. After six (6) months, the written record shall become the permanent record. Summary minutes shall be provided to the Board for review and adoption at the next board meeting.

6. Attendance—Board members shall inform the Chair with as much notice as possible if unable to attend a scheduled Board meeting. Board staff preparing the minutes shall record the attendance of Board Members at the meeting for the minutes.

ARTICLE V
Meeting Procedures

1. Quorum— Five voting members of the Board shall constitute a quorum for the transaction of business. No final action may be taken in the absence of a quorum. The Chair may declare a meeting adjourned in the absence of a quorum necessary to transact business.

2. Order of Business—The order of business shall be determined by the agenda.

3. Teleconference Permitted— A Member may attend a meeting in person or, by special arrangement and advance notice to the Chair, A Member may attend a meeting by telephone conference call or video conference when in-person attendance is impracticable.

4. Public Testimony—The Board actively seeks input from the public at large, from enrollees served by the PEBB Program, and from other interested parties. Time is reserved for public testimony at each regular meeting, generally at the end of the agenda. At the direction of the Chair, public testimony at board meetings may also occur in conjunction with a public hearing or during the board's consideration of a specific agenda item. The Chair has authority to limit the time for public testimony, including the time allotted to each speaker, depending on the time available and the number of persons wishing to speak.

5. Motions and Resolutions—All actions of the Board shall be expressed by motion or resolution. No motion or resolution shall have effect unless passed by the affirmative votes of a majority of the Members present and eligible to vote, or in the case of a proposed amendment to the By-laws, a 2/3 majority of the Board .

6. Representing the Board's Position on an Issue—No Member of the Board may endorse or oppose an issue purporting to represent the Board or the opinion of the Board on the issue unless the majority of the Board approve of such position.

7. Manner of Voting—On motions, resolutions, or other matters a voice vote may be used. At the discretion of the chair, or upon request of a Board Member, a roll call vote may be conducted. Proxy votes are not permitted.

8. Parliamentary Procedure—All rules of order not provided for in these By-laws shall be determined in accordance with the most current edition of Robert's Rules of Order [RONR]. Board staff shall provide a copy of *Robert's Rules* at all Board meetings.

9. Civility—While engaged in Board duties, Board Members conduct shall demonstrate civility, respect and courtesy toward each other, HCA staff, and the public and shall be guided by fundamental tenets of integrity and fairness.

10. State Ethics Law—Board Members are subject to the requirements of the Ethics in Public Service Act, Chapter 42.52 RCW.

ARTICLE VI
Amendments to the By-Laws and Rules of Construction

1. Two-thirds majority required to amend—The PEBB By-laws may be amended upon a two-thirds (2/3) majority vote of the Board.

2. Liberal construction—All rules and procedures in these By-laws shall be liberally construed so that the public's health, safety and welfare shall be secured in accordance with the intents and purposes of applicable State laws and regulations.

TAB 3

Public Employees Benefits Board Retreat

"Health Literacy – Empowering our Members to Make Wise Choices for Their Health"

Nancy A. Giunto

February 4, 2016

WASHINGTON HEALTH ALLIANCE

Leading health system improvement

Washington Health Alliance Consumer Initiatives

"Choosing Wisely

"Own Your Health"

"The Patient Experience"

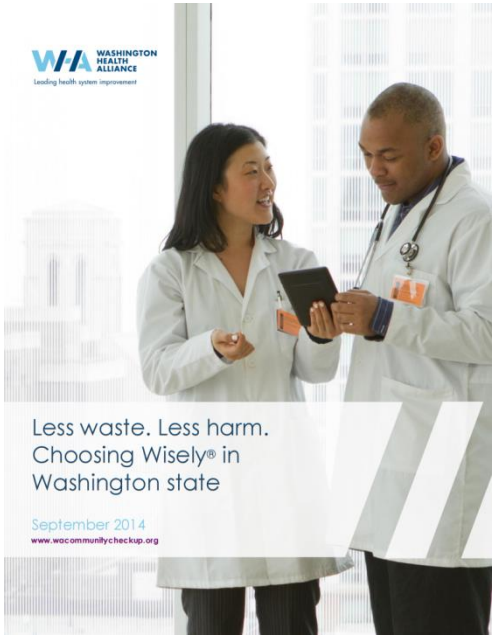
"The Savvy Shopper"

Choosing Wisely

- National initiative helping physician-patient conversations about overuse of tests and procedures.
- Collaboration with WSMA and WSHA.

Choosing Wisely®

An initiative of the ABIM Foundation



Two New Projects with "Choosing Wisely"

Patient Story Platform – Links data to actual accounts of life changing stories

Why Won't Doctors Accept Each Other's X-rays?

On 2 Nov, 2015

"This lack of communication is a deep problem in our healthcare system, and it exposed me to harm and wasted my insurance company's money."

Read More →

I Never Questioned the Safety of Having MRIs With Contrast

On 7 Oct, 2015

"I know that all of my doctors were looking out for my best interest and prescribing the tests they thought necessary."

Read More →

Another Day, Another Doctor, but the Same Tests

On 21 Sep, 2015

"Why did they need to keep repeating the same tests so many times within such a short timeframe?"

Read More →

Stakeholder Groups for Choosing Wisely

11 stakeholder groups

Goals:

1. Collaborative communication model to tailor messages to specific group.
2. Comprehensive Communication Tool Kit.
3. Action plan for ongoing improvement and measures of success.

Own Your Health

- Alliance's consumer engagement campaign
- Goal is to help consumers manage their own health and health care
  - Themes include importance of having a primary care provider, understanding health care quality
- Website and customized communication materials
- PEBB has been an active participant
- Plans underway to expand and relaunch the website in 2016

Patient Experience Report

What is the difference between patient experience and patient satisfaction?

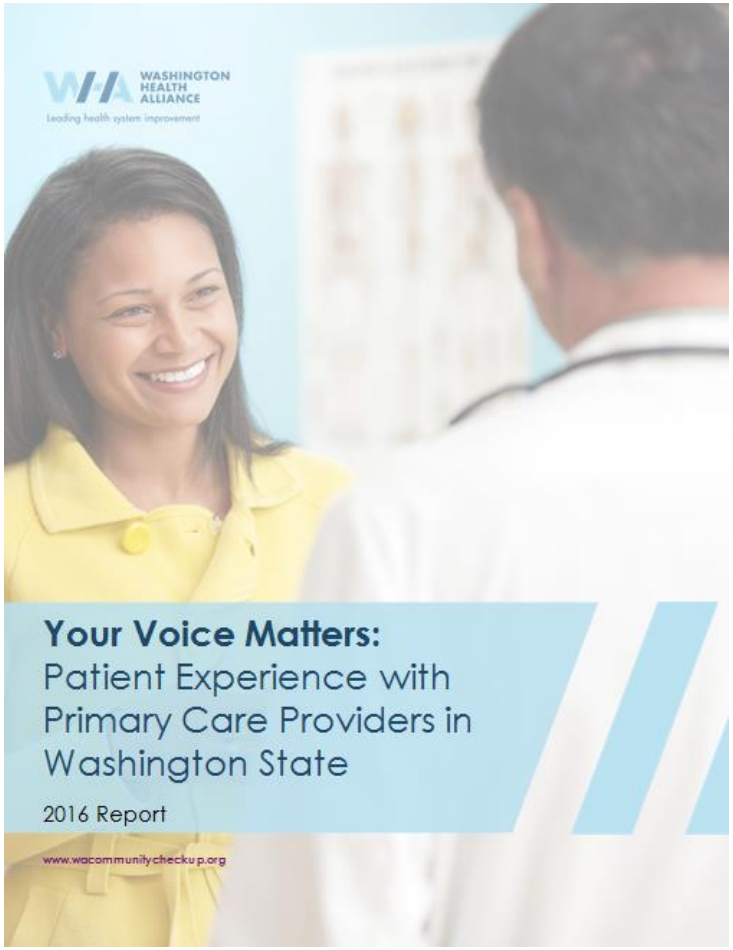
What does the Patient Experience Survey cover?

- **Ease in getting timely appointments, care, and information**
- **How well providers communicate with patients**
- **How well providers use information to coordinate care**
- **Whether office staff personnel are helpful, courteous, and respectful**
- **Patient's overall rating of provider**

Patient Experience Report

Publicly available comparable results **for 75 medical groups and 266 clinics in 185 locations in 14 counties across the state based on fall 2015 survey**

- This is the only report of its kind in Washington
- Both medical group and clinic results will be available on the Alliance's Community Checkup website next month: **www.WAcommunitycheckup.org**
- Special thanks to 7 health plan partners who helped us generate patient lists



The Savvy Shopper

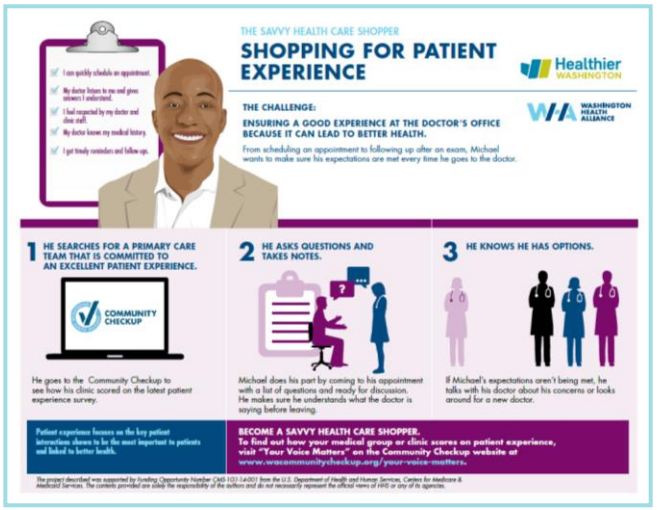
March 1 Conference: "Moving the Health Care Market to Value: Leveraging the Power of Purchasers"

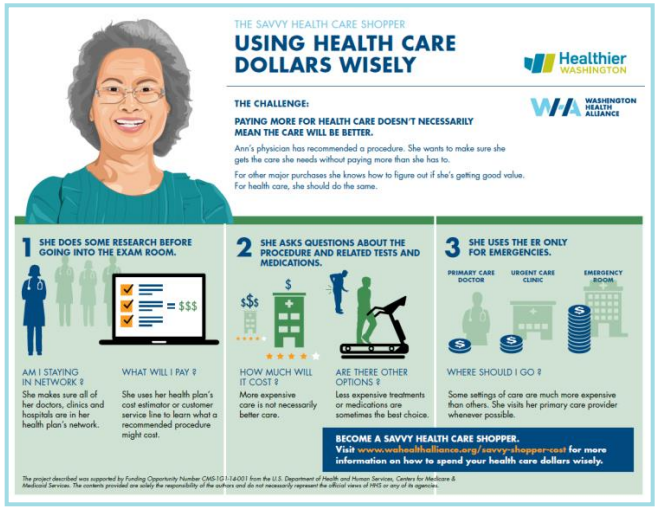
Educational series is a key element of the value-based purchasing effort

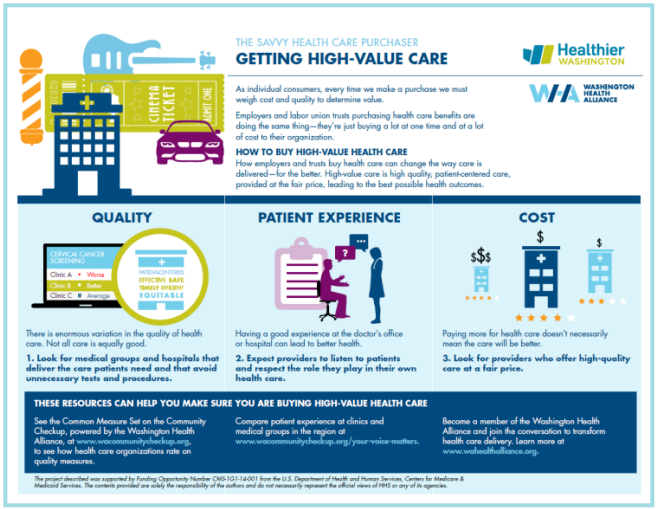
Goals:

- **Help consumers be better purchasers of care**
- **Help purchasers educate employees about how to purchase care**
- **Assist brokers who advise employers about benefit design**
- **Provide a tool for health plans who are asked by their customers for help.**

Infographics to Educate Consumers







Video Format Helps Visual Learners

Questions/comments?

Choosing Wisely at Virginia Mason

Reducing Inappropriate Antibiotics for URIs

Norris Kamo MD, MPP, Kim Pittenger MD

WA HCA PEBB Retreat

February 4th 2016

Upper Respiratory Infection Basics

- **URIs are common:**
  - By far the **most common cause** of physician visits in the US
- **URIs are costly:**
  - Estimated annual economic impact of non–influenza-related URIs: **$40 billion**[5]
- **URIs are treated inappropriately:**
  - **41% of all 101 million antibiotic prescriptions** written per year in US ambulatory care are for URI
  - Pre-visit expectations for antibiotics can run as high as **50%**

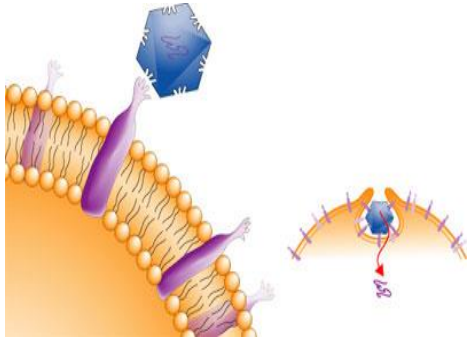
Virginia Mason in 2011

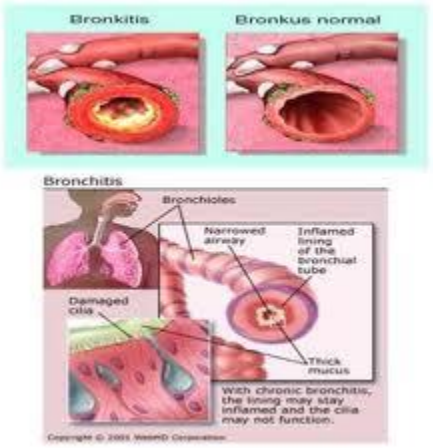
2011 Puget Sound Health Alliance Community Checkup

In 2011 at Virginia Mason, inappropriate antibiotics were prescribed for:

- Bronchitis at **82%** of visits
- Upper Respiratory Tract Infections at **56%** of visits

URI: Traditional Value Stream





24 hrs | 24 hrs | 0.25 hrs

48-72 hrs | 120 hrs | 48-72 hrs | 1 hr

ACADEMIC DETAILING

Acute Cough Illness (Acute Bronchitis) is an acute respiratory infection with a normal chest radiograph that is manifested by cough with or without phlegm production that lasts for up to 3 weeks. (*Chest 2006;129:95S-103S).*

Empiric antibiotic treatment is not indicated for acute bronchitis.

- Meta-analyses of randomized, controlled trials all concluded that routine antibiotic treatment is not justified (*BMJ 98;316:906; Chest* 2006;129:95S-103S).

The presence of purulent sputum is not predictive of bacterial infection.

- >95% of patients with purulent sputum do not have pneumonia (*J Chron Di 1984;* 37:215).

URI Basics: The Evidence

Ann Fam Med

Table 2

Mean Days of Any Cough, Daytime Cough, Nighttime Cough, and Productive Cough

Outcome First Author, Year	Patients Studied	Days of Cough Mean (SD)
Any cough		17.8[a]
Williamson, 1984	32	28.6
Nduba, 2008	275	15.3 (4.3)
Scherl, 1987	15	17.8
Little, 2005	269	21.3 (5.8)
Butler, 2010	1,230	17.3 (6.6)
Daytime cough		12.7[a]
Stott, 1976	103	10.3 (3)
Verheij, 1994	69	16.2 (3.2)
Nighttime cough		10.4[a]
Stott, 1976	84	8.9 (3.1)
Verheij, 1994	69	12.2 (2.7)
Productive cough		13.9[a]
Williamson, 1984	32	13.7
Scherl, 1987	15	17.4
Verheij, 1994	69	13.3 (3)

Note: standard deviation shown only if reported by the original study.

[a]Weighted mean.

Ann Fam Med

Mismatch:

- **Patients expect 8-9 days**
- **Mean duration 18 days**

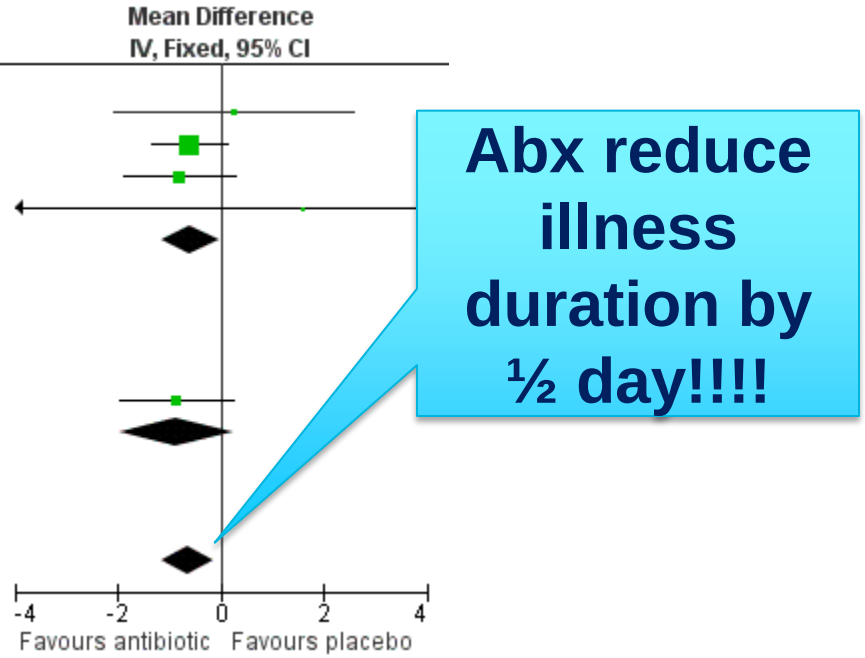
Therefore they seek care…
Therefore we try to DO
SOMETHING!!!

Ebell MH, Lundgren J, Youngpairoj S. How long does a cough last? Comparing patients' expectations with data from a systematic review of the literature. Ann Fam Med. 2013 Jan-Feb;11(1):5-13. doi: 10.1370/afm.1430.

URI Evidence: Acute bronchitis

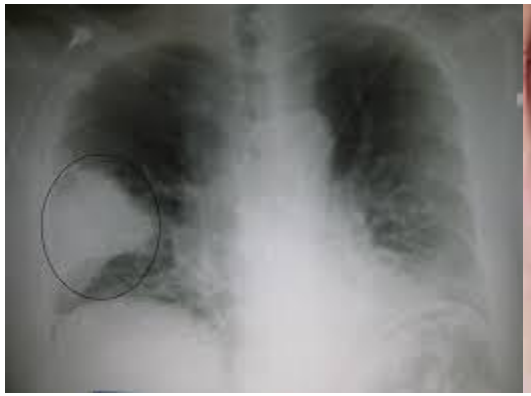
Figure 6. Forest plot of comparison: Days of feeling ill, outcome: mean number of days of feeling ill.

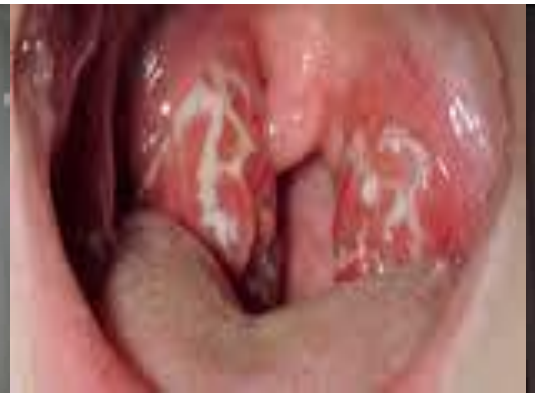
Study or Subgroup	Antibiotic Mean	SD	Total	Placebo Mean	SD	Total	Weight	Mean Difference IV, Fixed, 95% CI
8.1.1 Acute bronchitis studies								
King 1996	3.92	4.24	25	3.67	4.35	27	4.9%	0.25 [-2.09, 2.59]
Stott 1976	3.8	2.2	84	4.4	2.7	91	50.1%	-0.60 [-1.33, 0.13]
Verheij 1994	4.3	3	71	5.1	3.5	69	22.7%	-0.80 [-1.88, 0.28]
Williamson 1984	20.1	11.2	37	18.5	12.9	31	0.8%	1.60 [-4.20, 7.40]
Subtotal (95% CI)			**217**			**218**	**78.5%**	**-0.58 [-1.16, -0.00]**
Heterogeneity: Chi² = 1.19, df = 3 (P = 0.76); I² = 0%								
Test for overall effect: Z = 1.97 (P = 0.05)								
8.1.2 Subgroup with no placebo control								
Little 2005	8.12	5.1	194	8.98	5.8	180	21.5%	-0.86 [-1.97, 0.25]
Subtotal (95% CI)			**194**			**180**	**21.5%**	**-0.86 [-1.97, 0.25]**
Heterogeneity: Not applicable								
Test for overall effect: Z = 1.52 (P = 0.13)								
Total (95% CI)			**411**			**398**	**100.0%**	**-0.64 [-1.16, -0.13]**
Heterogeneity: Chi² = 1.38, df = 4 (P = 0.85); I² = 0%								
Test for overall effect: Z = 2.45 (P = 0.01)								
Test for subgroup differences: Chi² = 0.19, df = 1 (P = 0.66), I² = 0%								

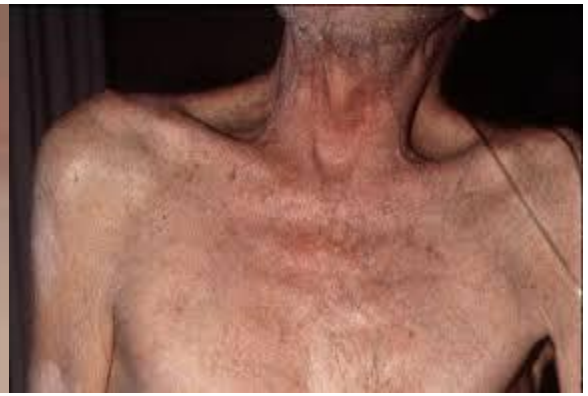


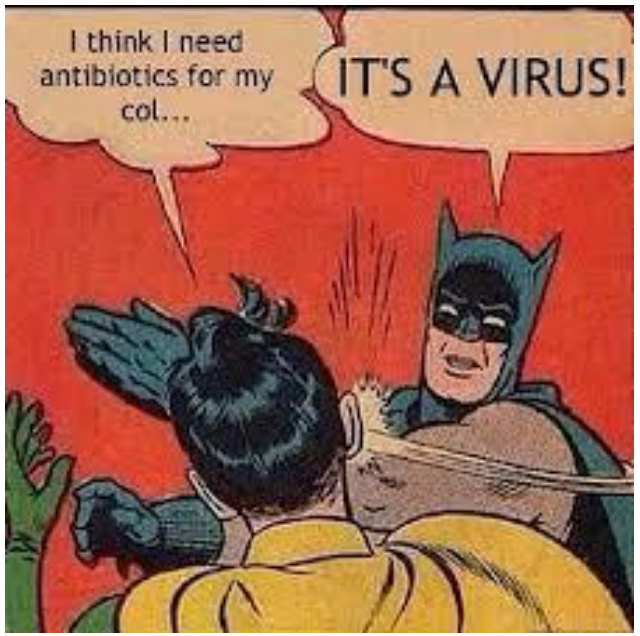
Smith SM et al. Antibiotics for acute bronchitis. Cochrane Database of Systematic Reviews 2014. DOI: 10.1002/14651858.CD000245.pub3

URI Basics









DPC Improvements

RN PHONE CARE

Scheduler: “I’m so sorry to hear that you are not feeling well. Based on your symptoms, there are a few options we have for you. I have a nurse available that can talk to you about your symptoms and see if there is anything we can do for you over the phone.”

RN: “I’m going to ask you some questions which will help us decide whether treating your symptoms at home is best for you, or if coming into the clinic is indicated.”

ACUTE RESPIRATORY ILLNESS TEMPLATE IN EMR

Virginia Mason Medical Center

CHIEF COMPLAINT: **Acute respiratory illness**

ASSESSMENT/PLAN:

[_] Upper Respiratory Infection / [_] Acute Bronchitis _
- Antibiotics not indicated, counseled on potential side effects, risk for invasive drug-resistant bacteria, counseled patient that URI typically resolves in 7 to14 days and cough may persist for weeks or months after resolution of other symptoms. (B)

[_] Symptomatic recommendations (for all): hydration, rest, saline nose sprays, sinus irrigation humidified air, throat lozenges, saltwater gargles (C)
[_] Acetaminophen and/or 1st-generation antihistamine with pseudoephedrine (A)

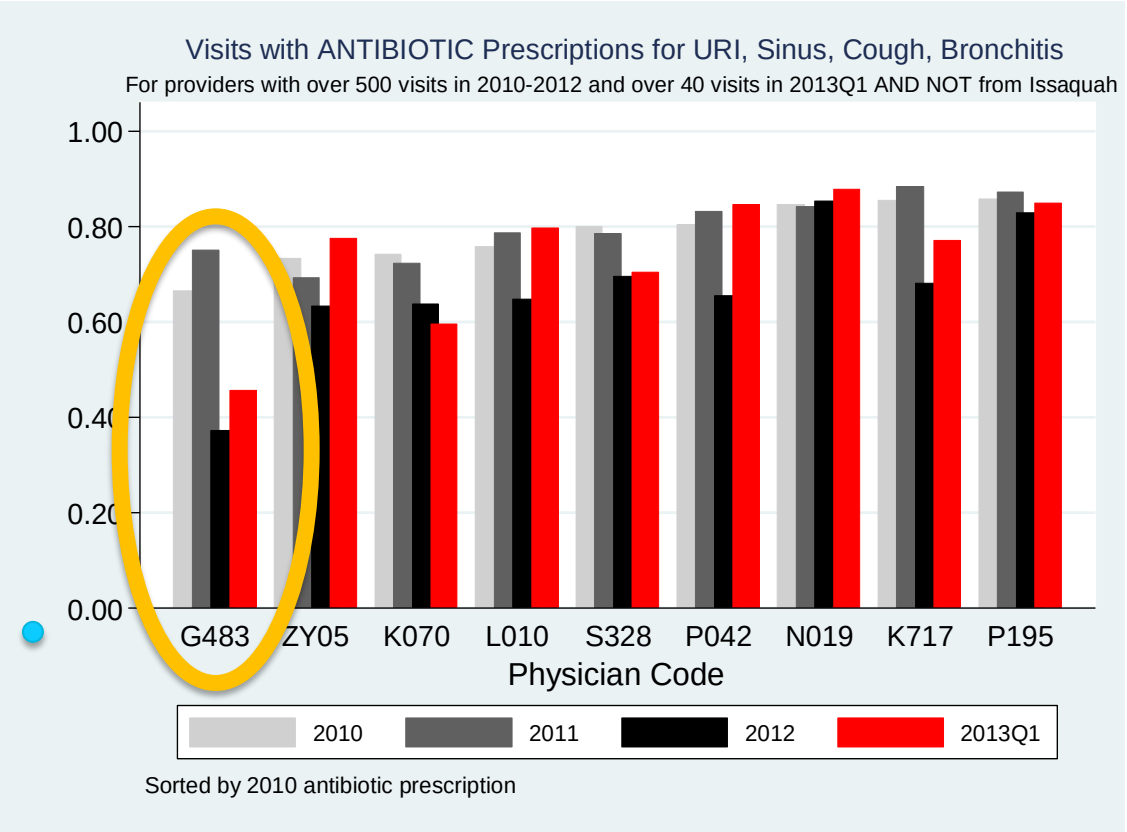
Ye Old Zpak report

A	B	C	D	E	F	G
				SMITH	10	11
Bellevue	**Prior Period**	**Current Period**		STONE-POORE	25	29
FAIRCHILD	52	57		TASNEEM	2	3
LARSON	67	65		**Grand Total**	**224**	**268**
NORSEN	99	119				
POTTS	16	20		**Issaquah**	**Prior Period**	**Current Period**
RAKOTZ	36	39		BUSHNELL	22	21
TENG	40	49		KAY	125	123
TRIGG	34	43		KIRSHNER	34	27
TUTTLE	51	44		LEVY	46	50
Grand Total	**395**	**436**		LU	77	79
				NAIMAN	120	140
GIM	**Prior Period**	**Current Period**		NAIR	2	2
BAILEY	25	28		THIBERT	25	22
BENDER	11	11		VIRA	89	91
BUCHER	11	10		**Grand Total**	**540**	**555**
BURNSIDE	1	1				
CUNNINGHAM	46	63		**Kirkland**	**Prior Period**	**Current Period**
DIPBOYE	5	6		BETSCH	145	162
DUZE	38	44		DIANGI	47	35
EINTRACHT	19	22		FURLONG	16	15
FERGUSON	25	24		GOLDBERG	41	55
FRECHETTE	18	18		KAINE	127	142
GREGERICH	3	0		KAPLAN	1	1
HAYASHI	15	14		MORRISON	80	81
HORWITCH	3	4		PAPLOW	58	64
KASSAB	43	51		PITTENGER	5	7
LINDBERG	34	44		ROGERS	36	38
PATTISON	4	5		SHAW	47	55
RYAN	3	9		SUHR	117	120
SACHTER	10	10		**Grand Total**	**720**	**775**
SMITH	5	3				

DPC Improvements

What can we learn from each other?

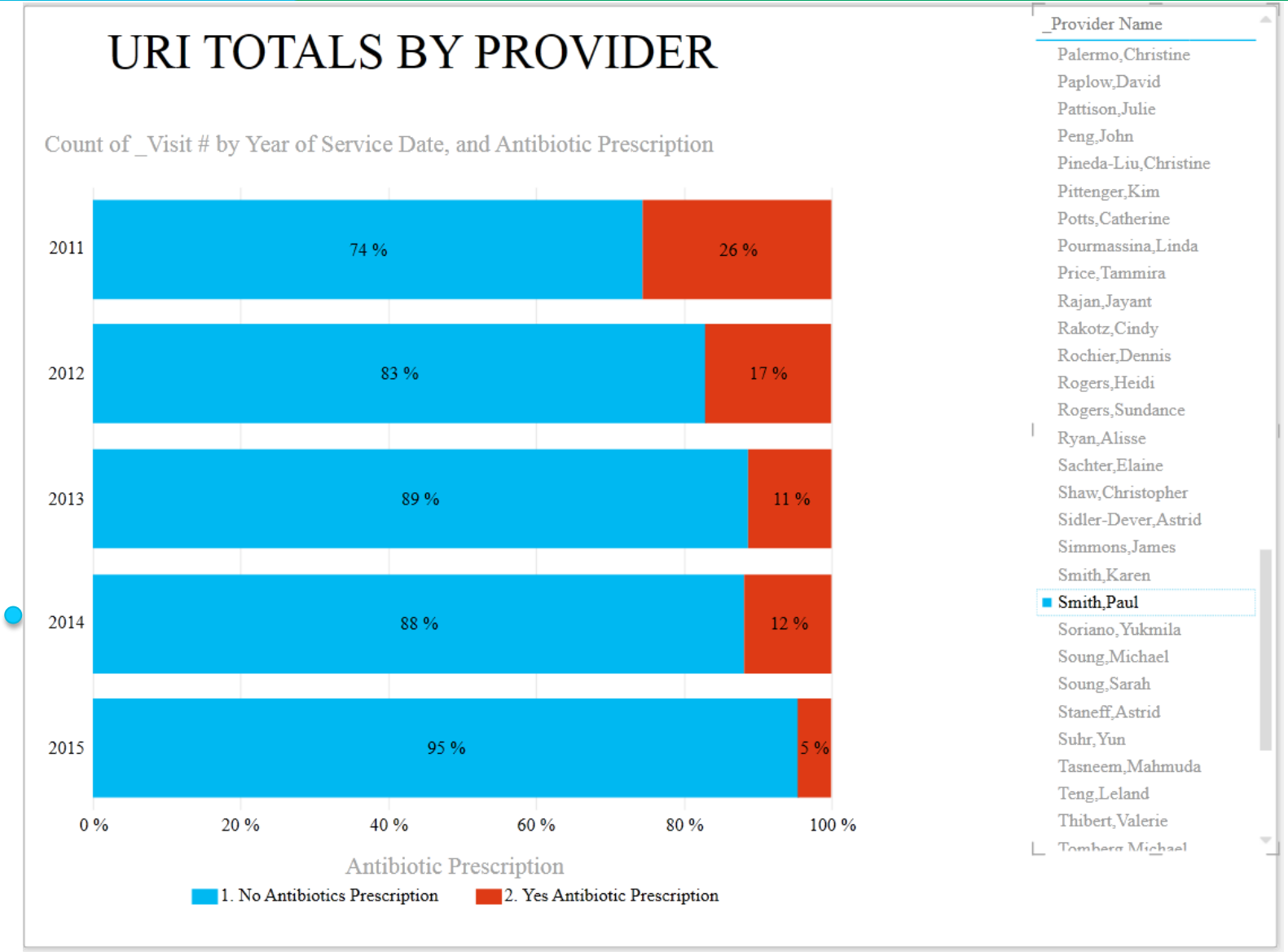
Z-PAK REPORT



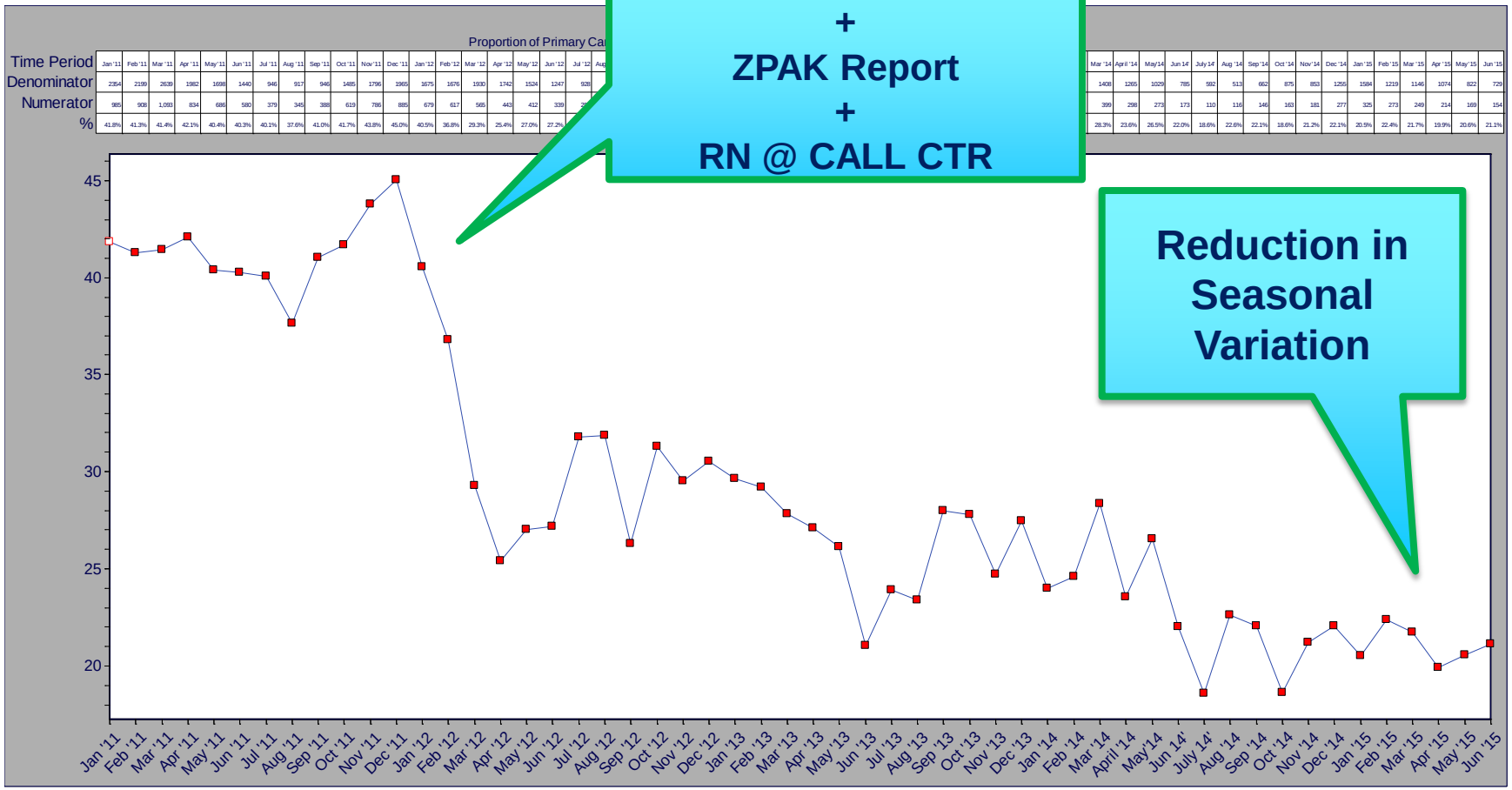
DPC Improvements

What can we learn from each other?

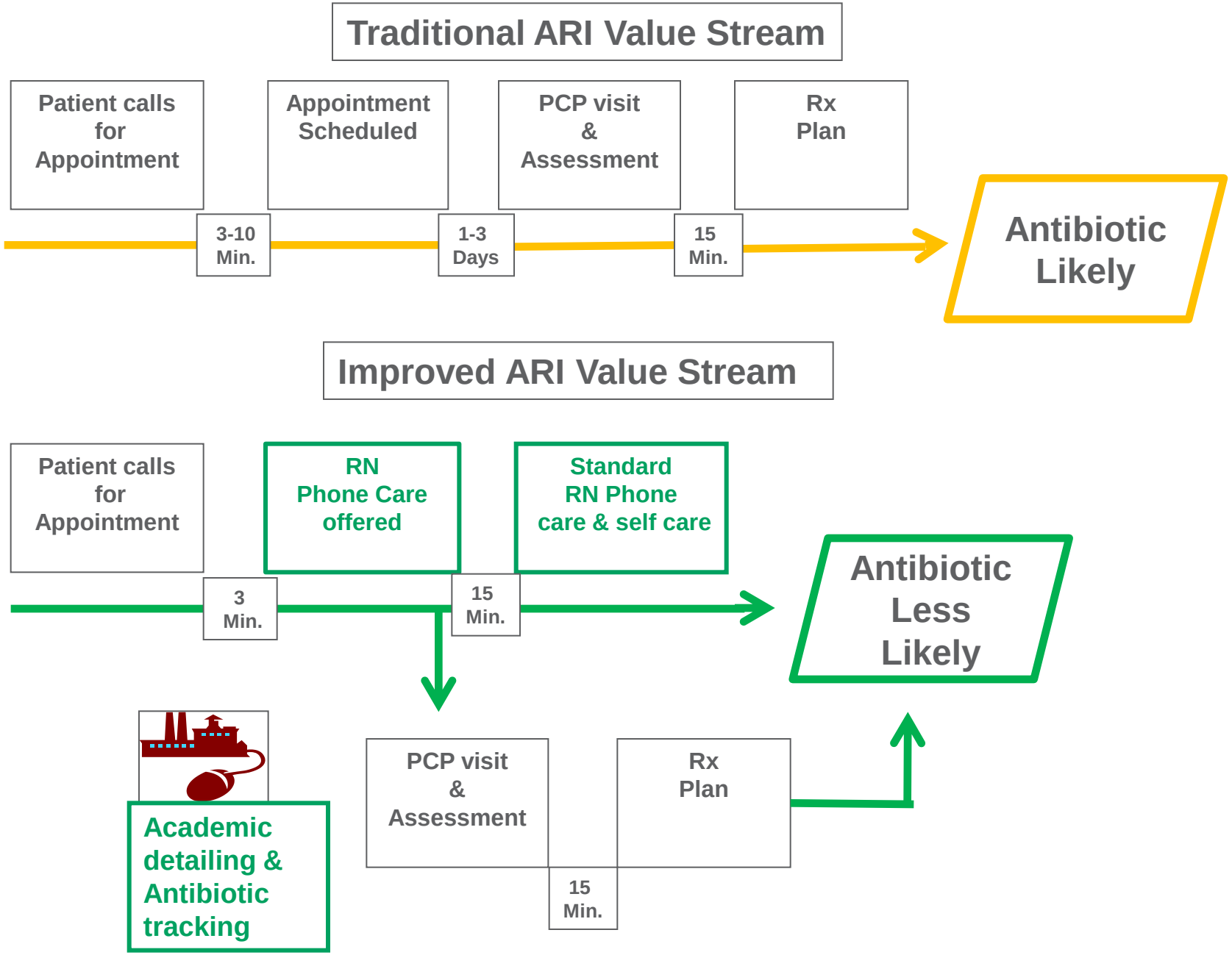
Z-PAK REPORT



DPC Improvements



Proportion of URI-related visits with antibiotic prescription 2011 through June 2015


Traditional ARI Value Stream
Patient calls for Appointment
Appointment Scheduled
PCP visit & Assessment
Rx Plan
3-10 Min.
1-3 Days
15 Min.
Antibiotic Likely
Improved ARI Value Stream
Patient calls for Appointment
RN Phone Care offered
Standard RN Phone care & self care
3 Min.
15 Min.
Antibiotic Less Likely
Academic detailing & Antibiotic tracking
PCP visit & Assessment
Rx Plan
15 Min.

Intended and Unintended Consequences: Coding shift and reduced demand for URI visits

Acute Respiratory Illness	2010	2011	2012	2013
Sinusitis	5,081 (34)	5,183 (35)	3,553 (27)	3,115 (28)
Cough	2,121 (14)	2,057 (14)	2,803 (22)	2,363 (21)
Bronchitis	**2,610 (17)**	**2,285 (15)**	**1,005 (8)**	**749 (7)**
Other ARI	5,187 (35)	5,487 (37)	5,584 (43)	5,100 (45)
Total	**14,999 (100)**	**15,012 (100)**	**12,945 (100)**	**11,327 (100)**

Table 1. Coding shift- Primary Diagnosis* by year
* Primary Diagnosis codes:
Sinusitis- 461.*, 473.*
Cough- 786.2
Bronchitis- 466.*, 490.*
Other ARI- 460.*, 464.*, 465.*

Visits for acute respiratory illness trended down over 4 years, but total visit volume did not decrease and overall patient satisfaction increased

Lessons Learned

1. Use transparent performance data as a lever for change
2. False dichotomy between appropriate care and patient satisfaction
3. Libertarian Paternalism at work: Build systems to make it easy to do the right thing (transparency, templates, data, phone care)

Pittenger et al. “Improving acute respiratory infection care through nurse phone care and academic detailing of physicians.” J Am Board Fam Med. 2015 Mar-Apr;28(2):195-204. doi: 10.3122/jabfm.2015.02.140197.

Thank you! Questions?

Choosing Wisely at Group Health

Efforts to Reduce Low Value Care and Improve Shared Decision Making

Marc Mora MD
Chief Medical Officer
Group Health
PEB Board Retreat February 2016

Choosing Wisely Builds on Existing Efforts

Group Health has a long history of using evidence based clinical improvement to reduce low value care

<u>Three complementary efforts</u>

1. Evidence based clinical improvement – Choosing wisely type interventions
2. Understanding variation in the "propensity to act"
   - Transparent sharing of the variation in global utilization of services (imaging, referrals, etc)
3. Shared decision making improvement work

Initial Choosing Wisely Measures

GroupHealth

"Goldilocks" approach to cervical cancer screening

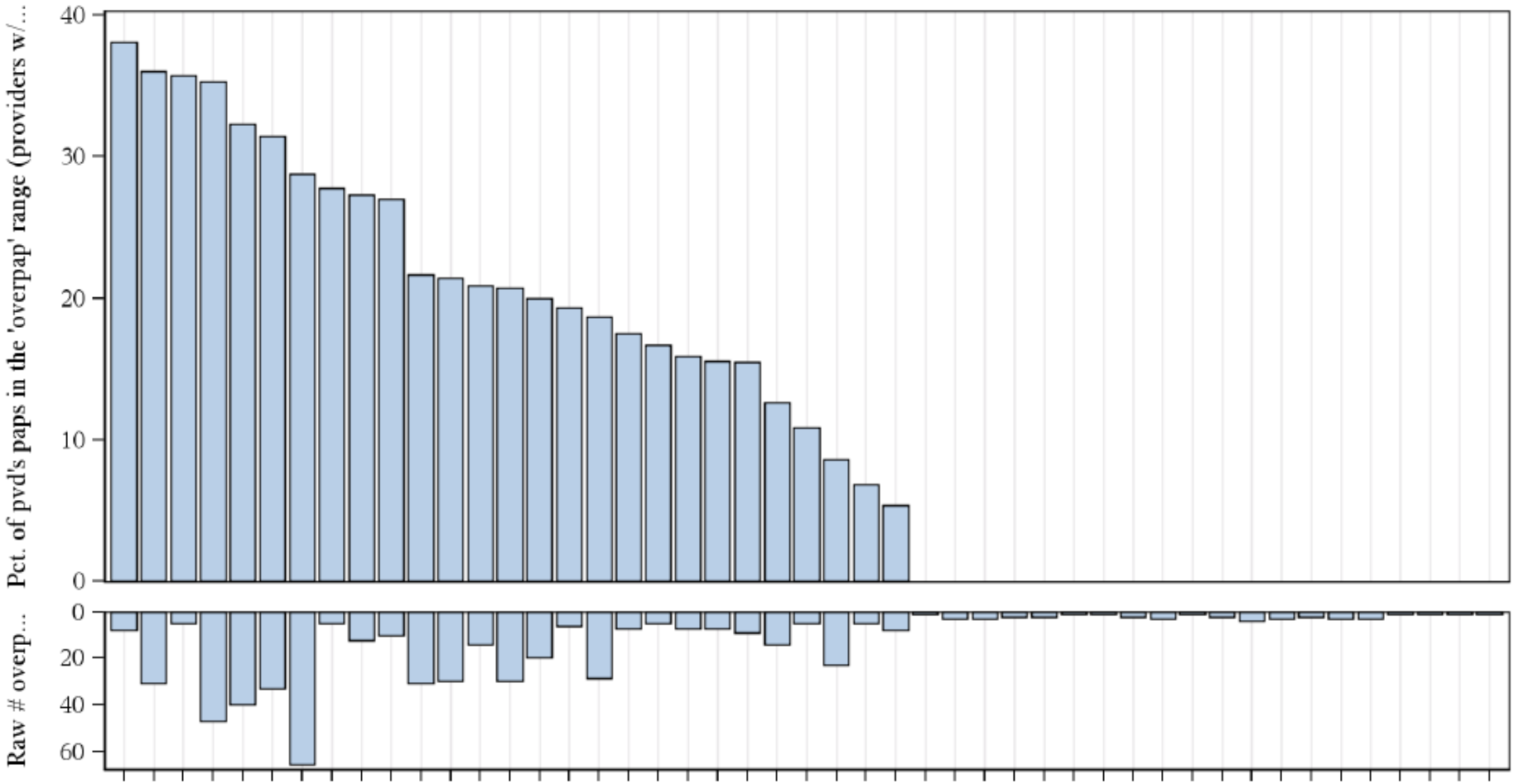
- We are targeting "just right" and avoiding to much and to little

PSA screening in older men

Deployed

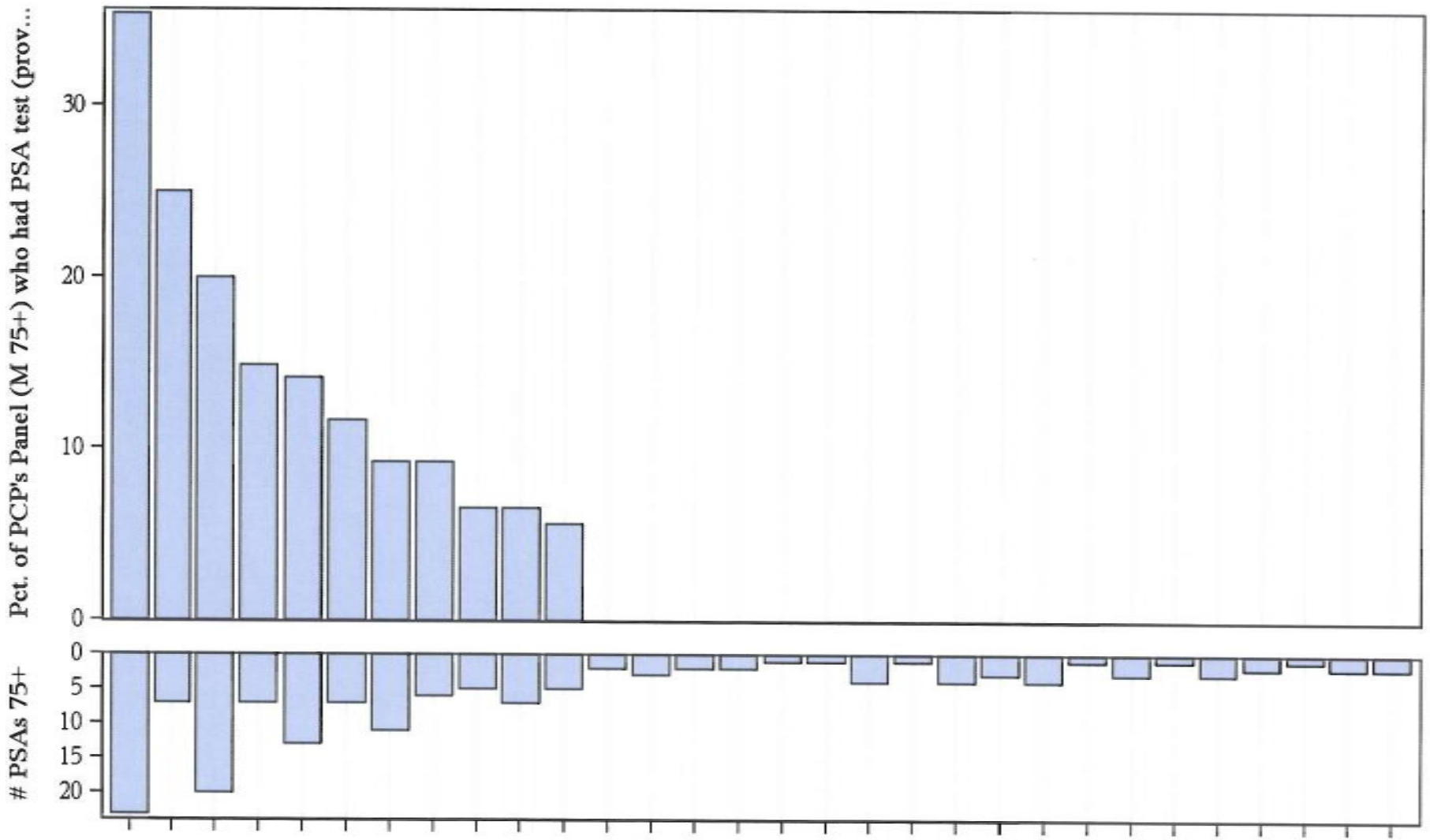
- The "why" of choosing wisely
- What are current guidelines, how are we measuring, and what difference does it make to reduce (harms and costs)
- Individual performance reports and epic tools
- Trigger tool to provide timely feedback on overuse
    - "I remember that patient and what I was thinking

Example: Proportion of “too frequent” paps in women over age 21 years with number at risk in lower part of figure

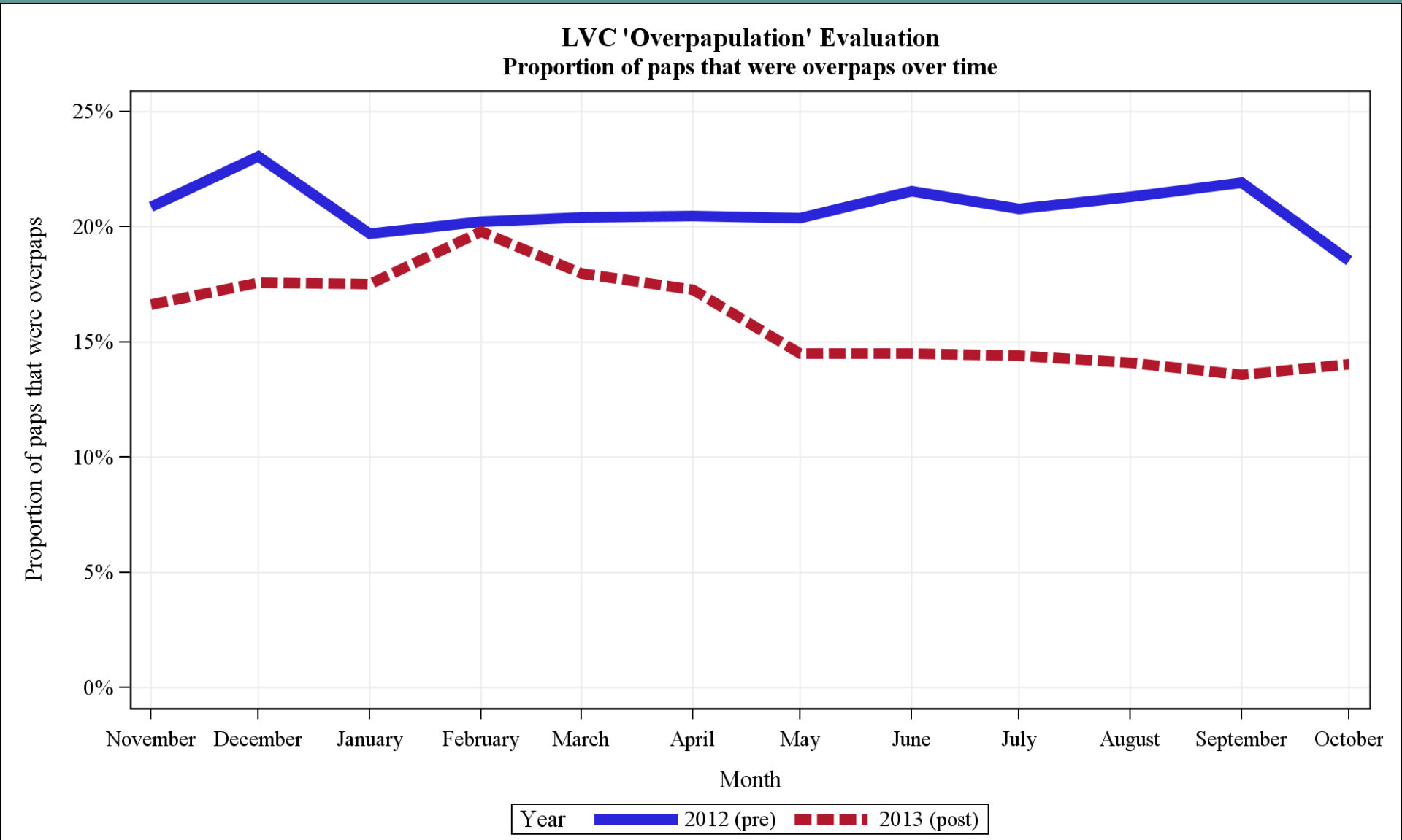


Cervical cancer screening for average risk women is recommended every 3 years, ages 21 to 65. Recognizing that there are a small number of women who should get paps at a one year interval (follow up of previous abnormals, or high risk populations), "over-papulation" is defined as a pap smear that falls between 15 months and 30 months from a prior pap smear.

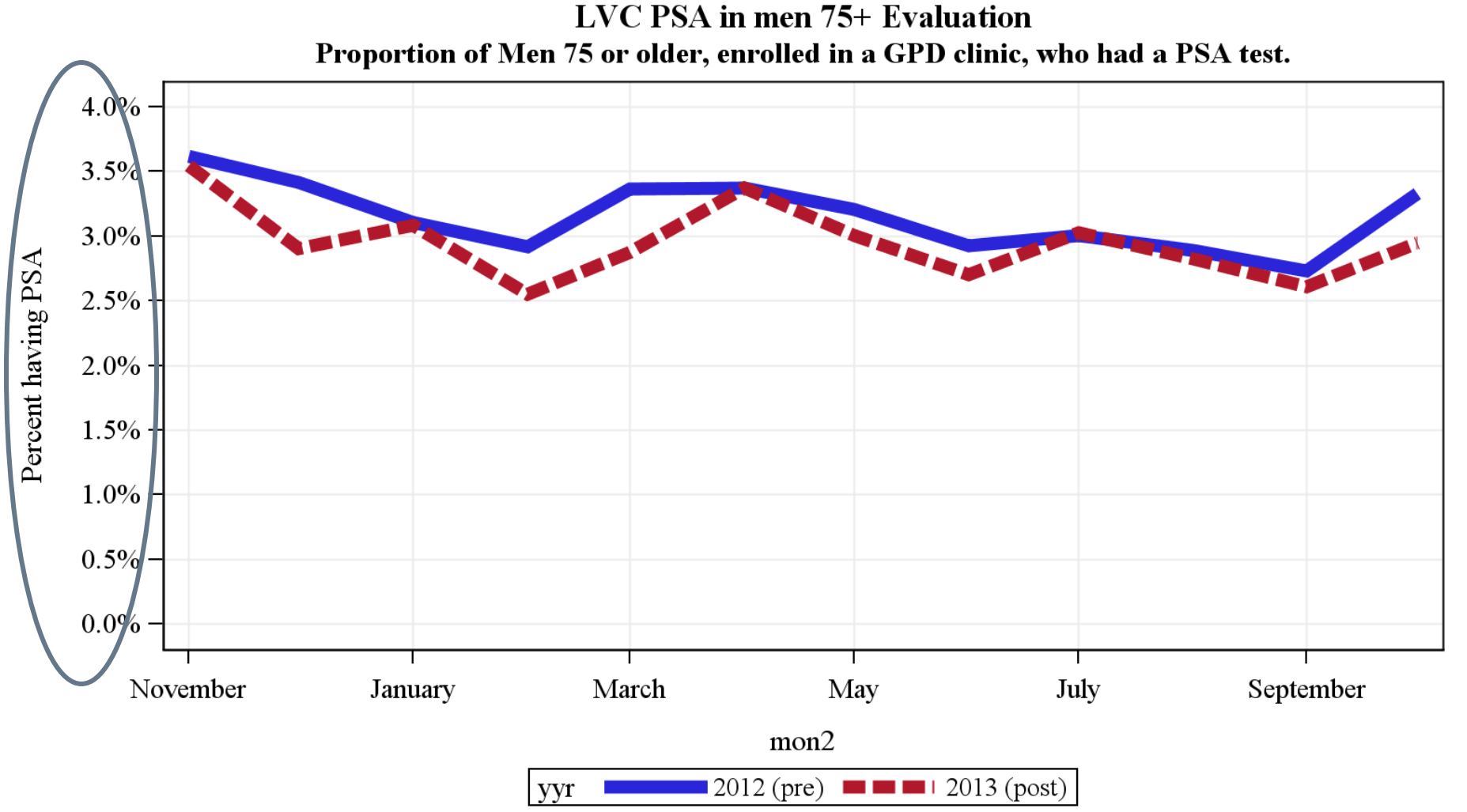
Example: Proportion of panel aged 75+ with PSA test in 2012 with number at risk in lower part of figure



26% Reduction In Too Frequent Paps



Small Statistically Insignificant Decrease In PSA Testing in Men Over 75



Program file: \\groups\data\CTRHS\CHS\pardre1\repos\choose wisely\programs\psa eval report.sas

Group Health Ongoing Work

Chemotherapy at the end of life

Consumer Reports handouts in urgent care settings

2015 grant

- Imaging for headache
- Overpapulation
- Antibiotic use for URI

Headache Imaging

GroupHealth

Neurology and Urgent Care (n too small for PC)

Prov ID	Head HEI Orders	HA HEI Order Per 100 HA Visit	HA HEI Order Per100 HAPt
A	577	11	32
B	488	23	57
C	452	8	28
D	434	9	22
E	351	9	22
F	281	13	24
G	248	12	29
H	254	3	11
I	248	4	13
J	209	13	31
K	174	4	10

Urgent Care

Antibiotics for sinusitis

Imaging for low back pain

CT for headache

Choosing Wisely®

An initiative of the ABIM Foundation

ConsumerReportsHealth

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

ABIM FOUNDATION

Antibiotics for a sore throat, cough, or runny nose

When children need them—and when they don't

If your child has a sore throat, cough, or runny nose, you might expect the doctor to prescribe antibiotics. But most of the time, children don't need antibiotics to treat a respiratory illness. In fact, antibiotics can do more harm than good. Here's why:

Antibiotics fight bacteria, not viruses.
If your child has a bacterial infection, antibiotics may help. But if your child has a virus, antibiotics will not help your child feel better or keep others from getting sick.

- Most colds and flus are viruses.
- Chest colds, such as bronchitis, are also usually caused by viruses. Bronchitis is a cough with a lot of thick, sticky phlegm or mucus. Cigarette smoke and particles in the air can also cause bronchitis. But bacteria are not usually the cause.
- Most sinus infections (sinusitis) are also from viruses. The symptoms are a lot of mucus in the nose and post-nasal drip. Mucus that is colored does not necessarily mean your child has a bacterial infection.

In most cases, antibiotics will not help your child.
Usually, antibiotics do not work against colds, flu, bronchitis, or sinus infections because these are viruses. Sometimes bacteria cause sinus infections, but even then the infection usually clears up on its own in a week or so. Many common ear infections also clear up on their own without antibiotics.

Some sore throats, like strep throat, are bacterial infections. Symptoms include fever, redness, and trouble swallowing. However, most children who have these symptoms do not have strep throat. Your child should have a strep test to confirm that it's strep, and then, if they're needed, the doctor will prescribe antibiotics.

Engaging Front Line Providers

The questions we asked…focus groups with purpose:

- Understand how individual level reports with complete transparency were received
- What additional tools are needed to reduce low value care delivery
- What additional measures (from Choosing Wisely or other) should be added

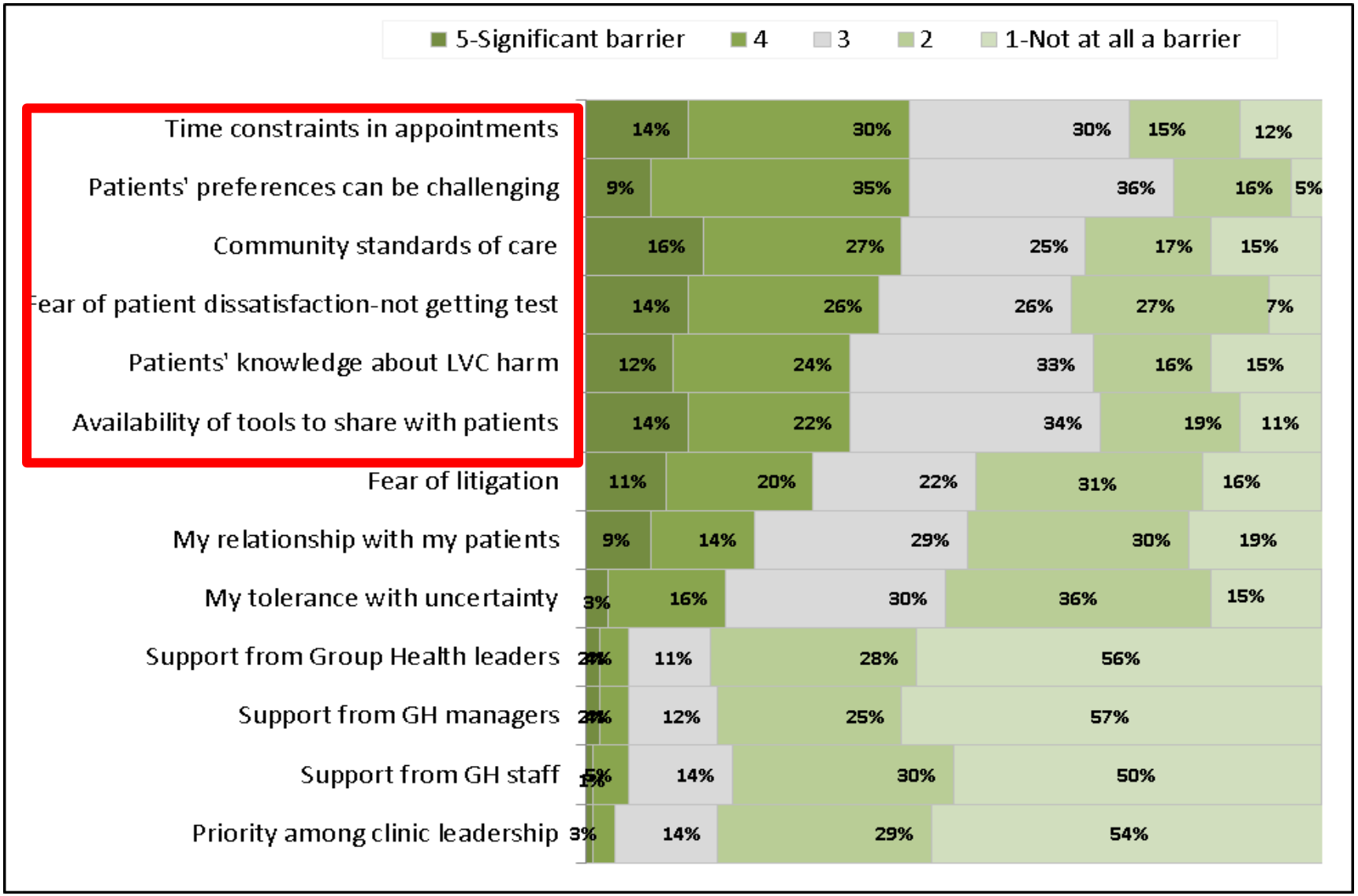
Provider Focus Group Findings

"I was taken aback because I didn't realize how high my referrals were…I need to take a closer look at my reflexes"

"Having information on the cost of my panel made me start to think about the costs for different things"

"Seeing my information helped me be more self-aware of my practice behavior – that's probably a good start"

Barriers to Decreasing Low Value Care

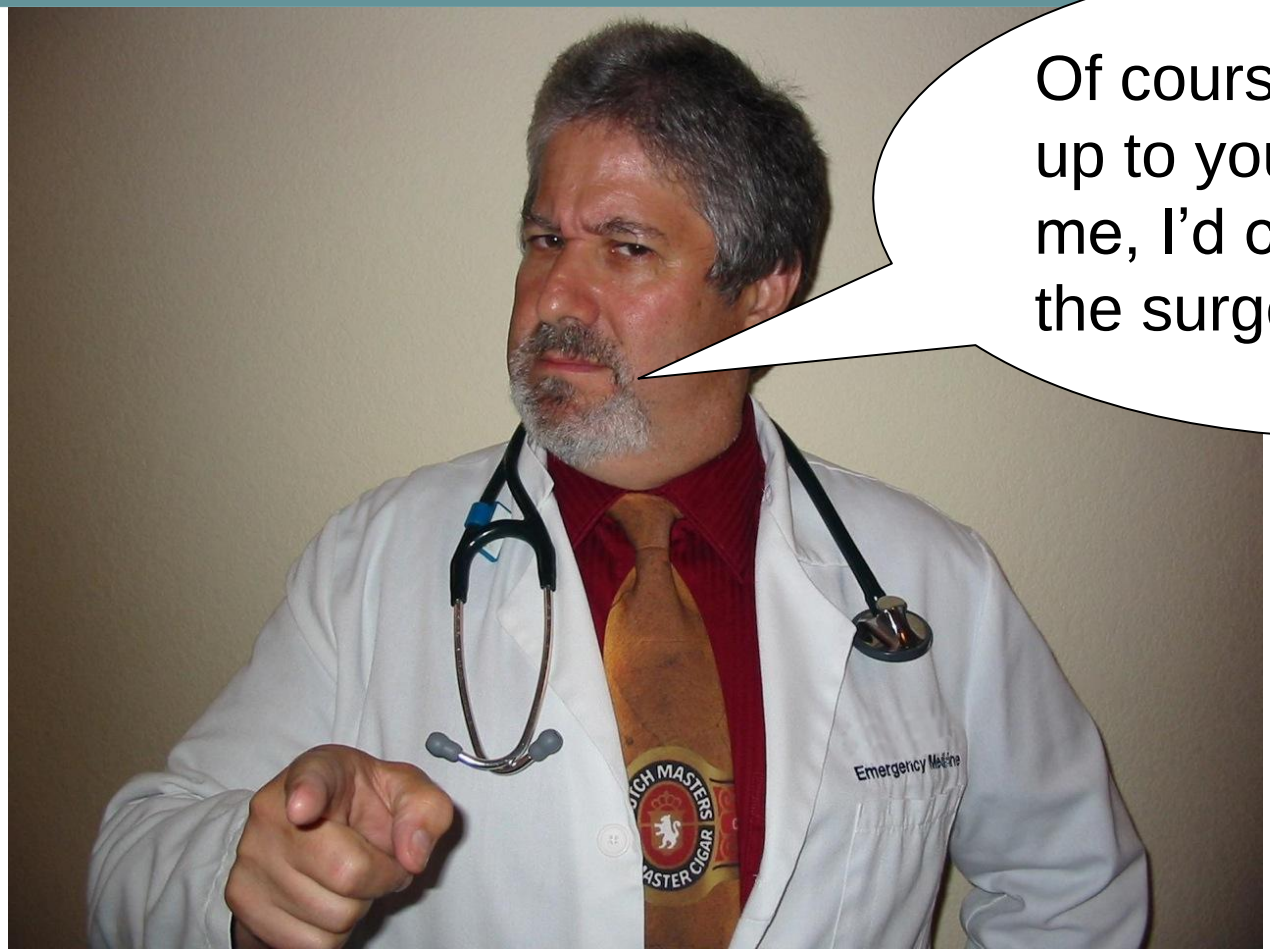



IMPLEMENTATION
• System-wide
• Video-based patient decision aids
• 12 preference-sensitive conditions related to elective surgeries

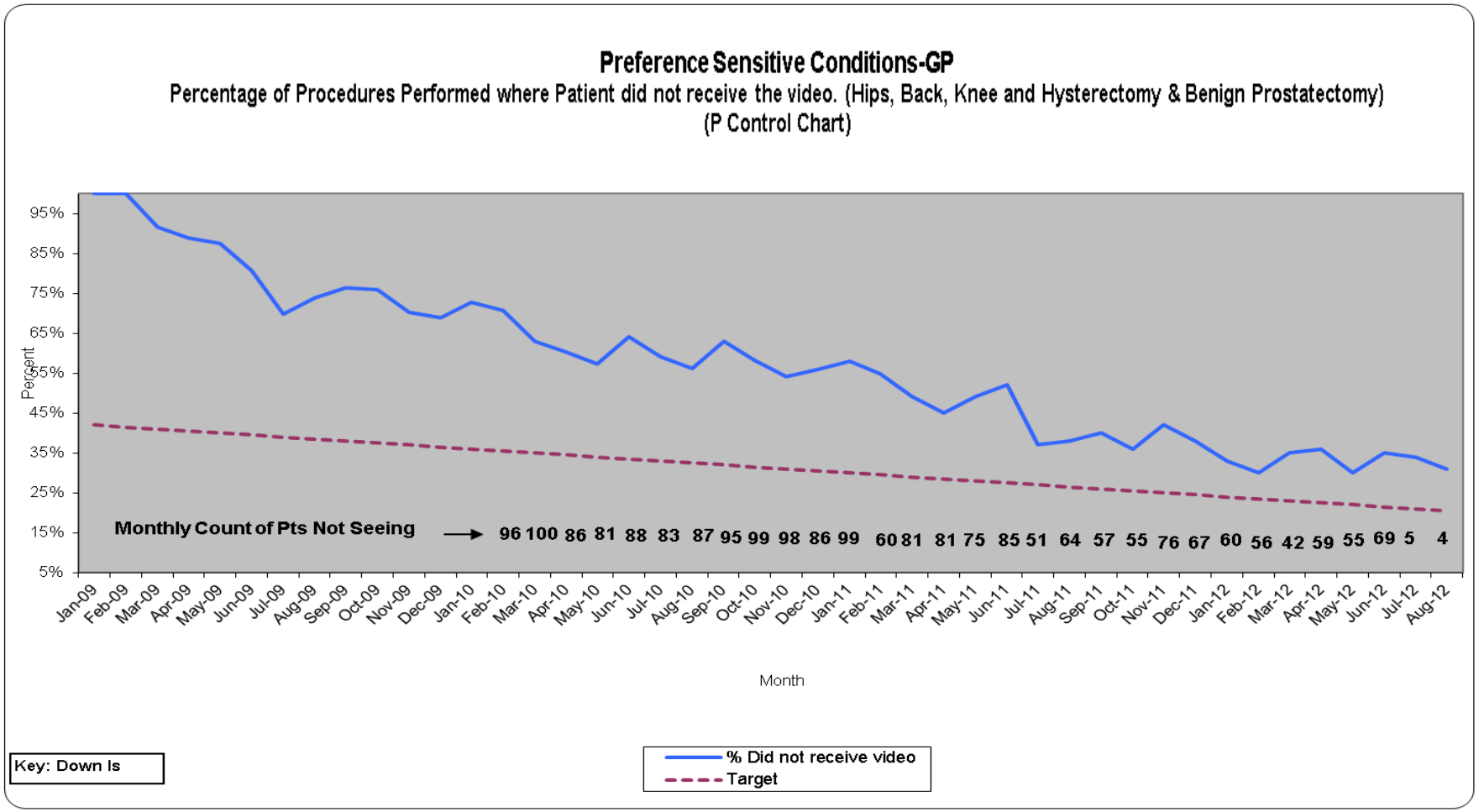

EXPECTED OUTCOMES
• Improve patient knowledge
• Improve patient satisfaction
• Establish actual rate of demand
• Reduce unwarranted variation

I Already DO Shared Decision-Making

GroupHealth



Process Measure – "defect measure" Shows Fewer Missed Opportunities for DA Delivery



GroupHealth

SHARED DECISION MAKING

By David Arterburn, Robert Wellman, Emily Westbrook, Carolyn Rutter, Tyler Ross, David McCulloch, Matthew Handley, and Charles Jung

DOI: 10.1377/hlthaff.2011.0686
HEALTH AFFAIRS 31,
NO. 9 (2012): –

Introducing Decision Aids At Group Health Was Linked To Sharply Lower Hip And Knee Surgery Rates And Costs

ABSTRACT Decision aids are evidence-based sources of health information that can help patients make informed treatment decisions. However, little is known about how decision aids affect health care use when they are implemented outside of randomized controlled clinical trials. We conducted an observational study to examine the associations between introducing decision aids for hip and knee osteoarthritis and rates of joint replacement surgery and costs in a large health system in

introduction of decision aids was associated with 26 percent fewer hip replacement surgeries, 38 percent fewer knee replacements, and 12–21 percent lower costs over six months. These findings support the

preferences, may reduce rates of elective surgery and lower costs.

David Arterburn (arterburn.d@ghc.org) is a general internist and associate investigator at Group Health Research Institute and an affiliate associate professor at the University of Washington, in Seattle.

Robert Wellman is a

Carolyn Rutter is a biostatistician and senior investigator at Group Health


96%
OF
2,156
PATIENTS
SURVEYED
Decision aid videos
helped me understand
my treatment choices


95%
OF
2,139
PATIENTS
SURVEYED
Decision aid videos
helped me prepare to
talk with my provider

Shared Decision-Making Video

Moving Forward

National CW grant with WSMA/WHA/Swedish/GHC

- Too frequent paps
- Imaging for Headache
- Antibiotics for URI

Chemo at the end of life

Continued investment in SDM (Maternity DAs, training for all staff)

Continue to promote the use of peer comparison data to improve conversations within our group

Appendix

Details of Choosing Wisely Intervention

- Clinic and provider specific distribution of “overuse”
  - Distribution to clinic chiefs for discussion at clinic meeting
- Disseminated with:
  - Orientation to resource stewardship and Choosing Wisely
  - Measurement information
    - What are our guidelines; why concerned about overuse; what and how are we measuring; what difference does it make to reduce overuse for these specific measures (includes specific harms and costs)
  - Tools:
    - EPIC SmartPhrases to talk with patients about why these tests are not recommended
    - Podcasts

Details of Trigger Tool Intervention

- Provide feedback within 4 days of test ordering
- Real-time, systematic identification:
  - Too frequent paps
  - PSA testing in men over 75
- Requires chart review – about 30 seconds per chart
- Standard Email sent out to ordering clinician and chief
  - Information about the specific test, including patient ID and date of ordering
  - brief summary of clinical issue and link to a published "clinical pearl" about the topic

Focus Group Findings: Information Providers Want

- Up-to-date
- Outcomes, not process
- Actionable
- Clear guidelines for targets for “excellence”
- Cascade of costs for low value services
- More information/training on how to have conversations about handling uncertainty and saying “no” to patients

Findings From Our Medical Group Survey
Group Health Providers Believe…

- Resource stewardship reports useful
- There is pressure from patients to order more tests
- They have changed their practice in the last 12 months to decrease low value care
- Their patients listen to them
- Conversations are increasing with patients about unnecessary testing
- Are more comfortable discussing low value care with patients than with other providers

Shared Decision-Making

- Use leads to more conservative patient choices, and a 25 percent decrease in rates of surgeries for preference-sensitive conditions*
- Users felt the decision aid video and booklet helped them:
  - Better understand their condition
  - Understand treatment alternatives
  - Have more informed conversations with their doctor
- Example Outcomes:
  - 26% to 38% fewer joint replacement surgeries and 12% to 21% lower costs**
  - 27% to 32% lower rates of surgery or treatment for men with prostate conditions***

Treatment options videos/booklets

- Hip osteoarthritis
- Knee osteoarthritis
- Chronic low back pain
- Acute low back pain
- Spinal stenosis
- Herniated disc
- Coronary artery disease
- Benign Prostatic Hyperplasia
- Uterine fibroids
- Abnormal uterine bleeding
- Early stage breast cancer
- Breast reconstruction
- Ductal carcinoma in situ
- Bariatric surgery
- Torn meniscus (booklet only)
- Early Knee Osteoarthritis (booklet only)

* Stacy et al., Cochrane Database of Systematic Reviews 2014.
** Health Affairs, September 2012. 31:2094-2104
*** AM J Manag Care. 2015;21(2):e130-e140

TAB 4

HCA/PEBB PROGRAM MEMBER ENGAGEMENT INITIATIVE

Washington State Health Care Authority

Value-Based Purchasing (VBP) & Member Engagement

- HB 2572 requires HCA to increase value-based contracting and other payment incentives that promote quality, efficiency, cost savings, and health improvement.
- Healthier Washington aims to drive 80% of state-financed health care and 50% of the commercial market to VBP by 2020.
- Fundamentals Map Key Goal of Triple Aim: Better Health, Better Care, Lower Cost.
- Member engagement is a critical component of achieving these VBP requirements and goals.

Health Literacy

"The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."

(Ratzan and Parker, 2000)

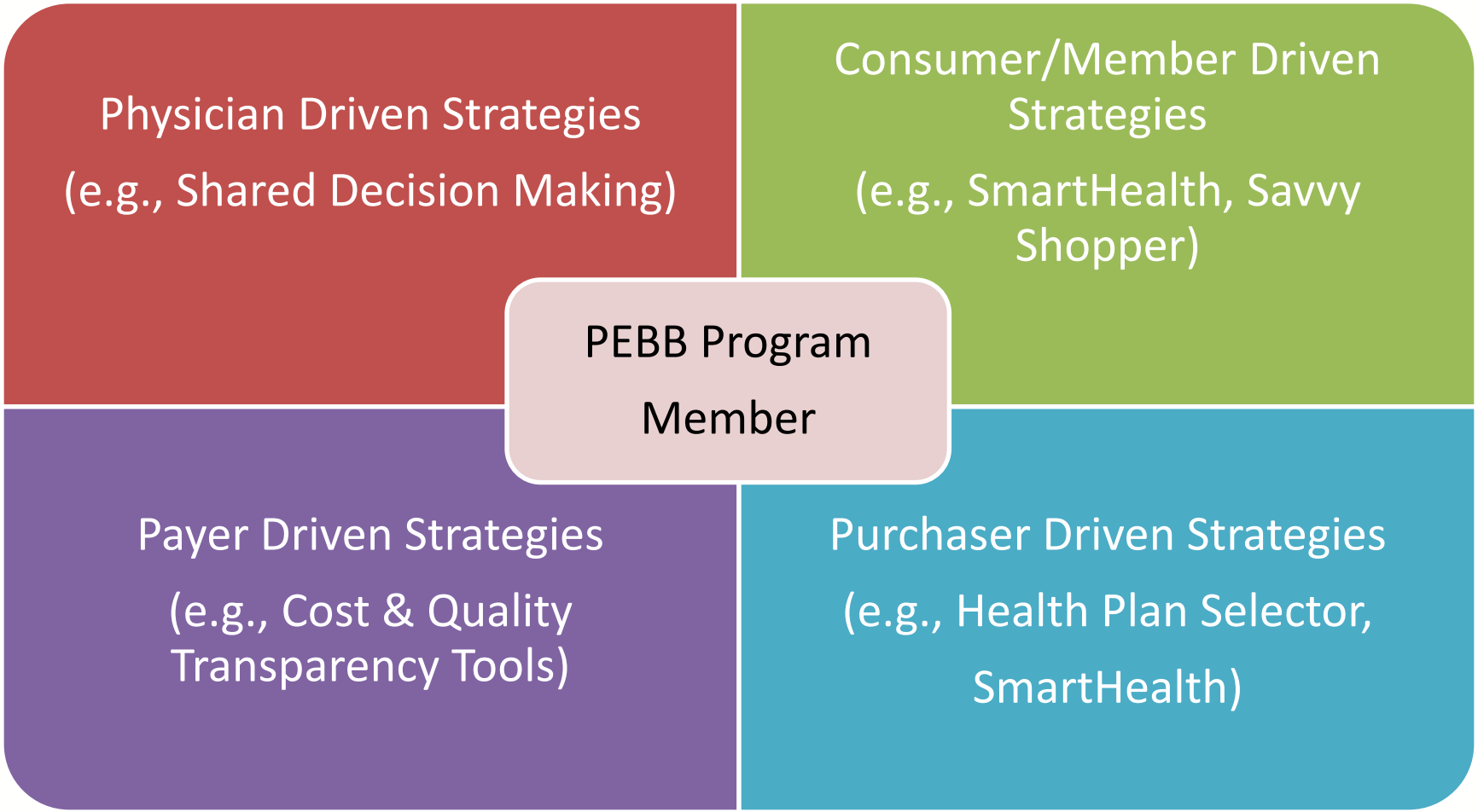
Goal: Every PEBB Program member will have the right information, at the right time, in order to make the right choice about their health care.

Health Literacy Continuum of Engagement

	Informed	Engaged	Empowered
Health Plans	Members receive information about their choices	Members understand differences between health plan choices	Members understand how different health plan choices impact what is important to them
Health Care	Patients receive information about a diagnosis	Patients are asked about their preferences in treatment plan	Treatment decisions are made based on patient preferences, medical evidence, and clinical judgment.

Health Affairs, February 2013 vol. 32 no. 2 223-231

HCA/PEBB Member Engagement Strategies



Physician Driven Strategies

- Required in the ACP plans
- Part of the Bree Collaborative criteria for total joint replacement bundles
- Required as part of TJR Bundle
- Shared Decision Making

Consumer/Member Driven Strategies

- SmartHealth
- Savvy Shopper, Choosing Wisely, Own Your Health
- Newsletter
- HCA/PEBB Program website redesign
- Training series – use of appropriate care - TBD
- Webinar series TBD
- Healthwise online
- Community Checkup (Washington Health Alliance)

Plan/Payer Driven Strategies

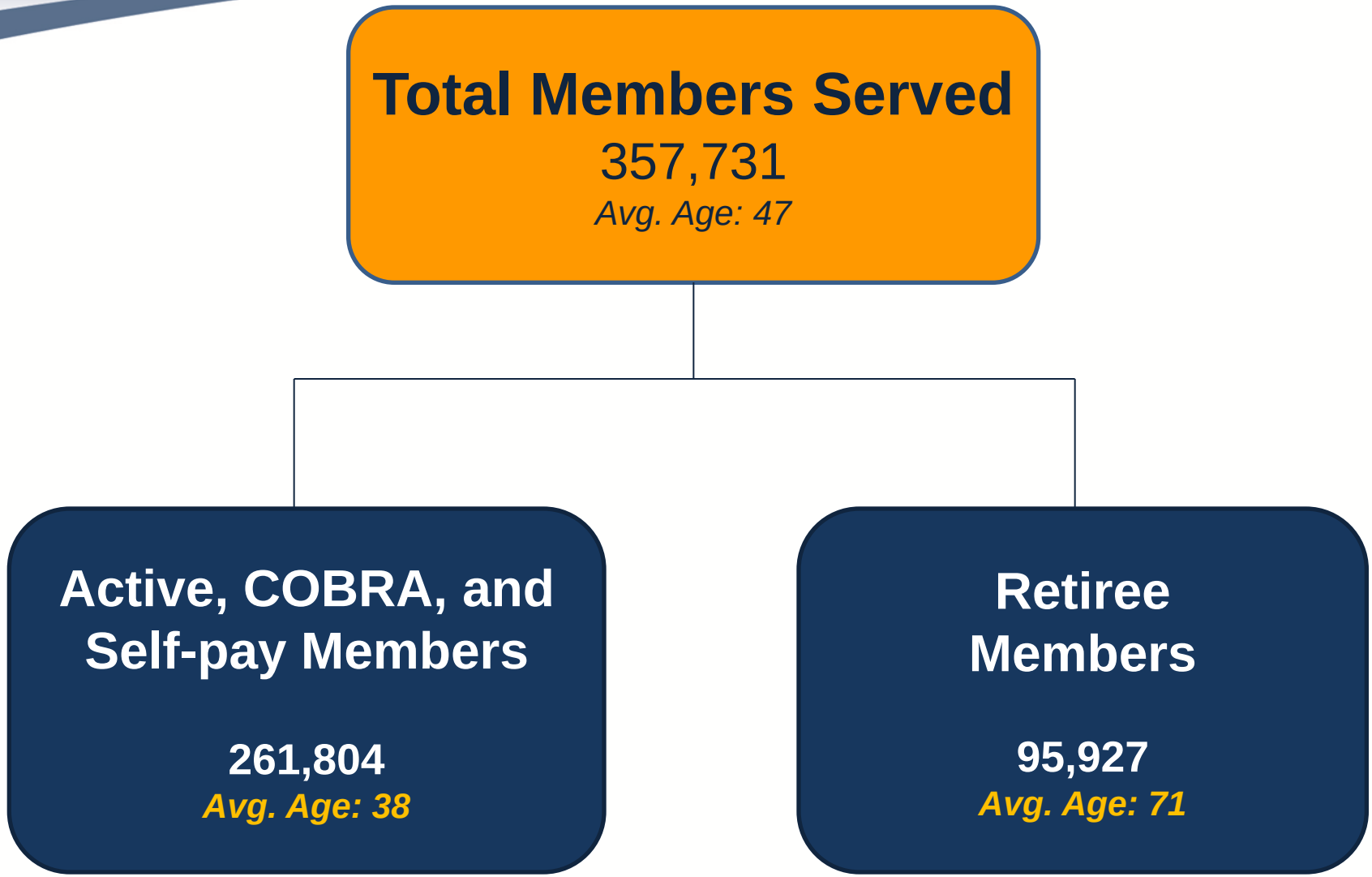
- Plan Online Tools
- Procurement for health literacy tools
- COC
- Screening reminders
- Online
  - Email with Provider
  - Rx refill
  - Test Results and Trending

Purchaser Driven Strategies

- SmartHealth
- Community Check-up
- Interactive Health Plan Selection tool
- PEBB Program website / mobile
- Kitchen table toolkits, newsletters
- Chronic Condition programs: DCP
- Risk Reduction programs: DPP, Tobacco Cessation

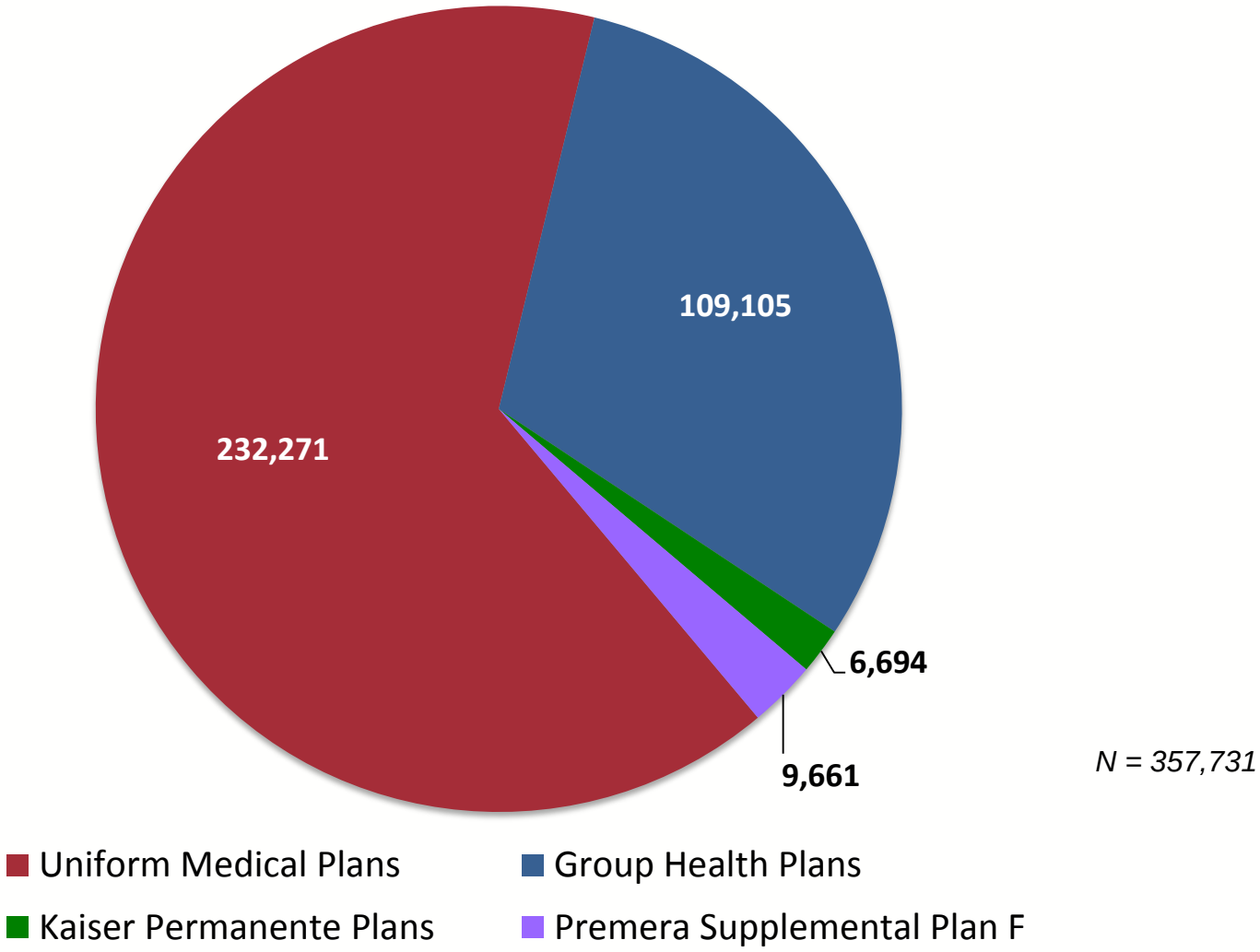
WHO WE ARE

Washington State Health Care Authority



Washington State Health Care Authority

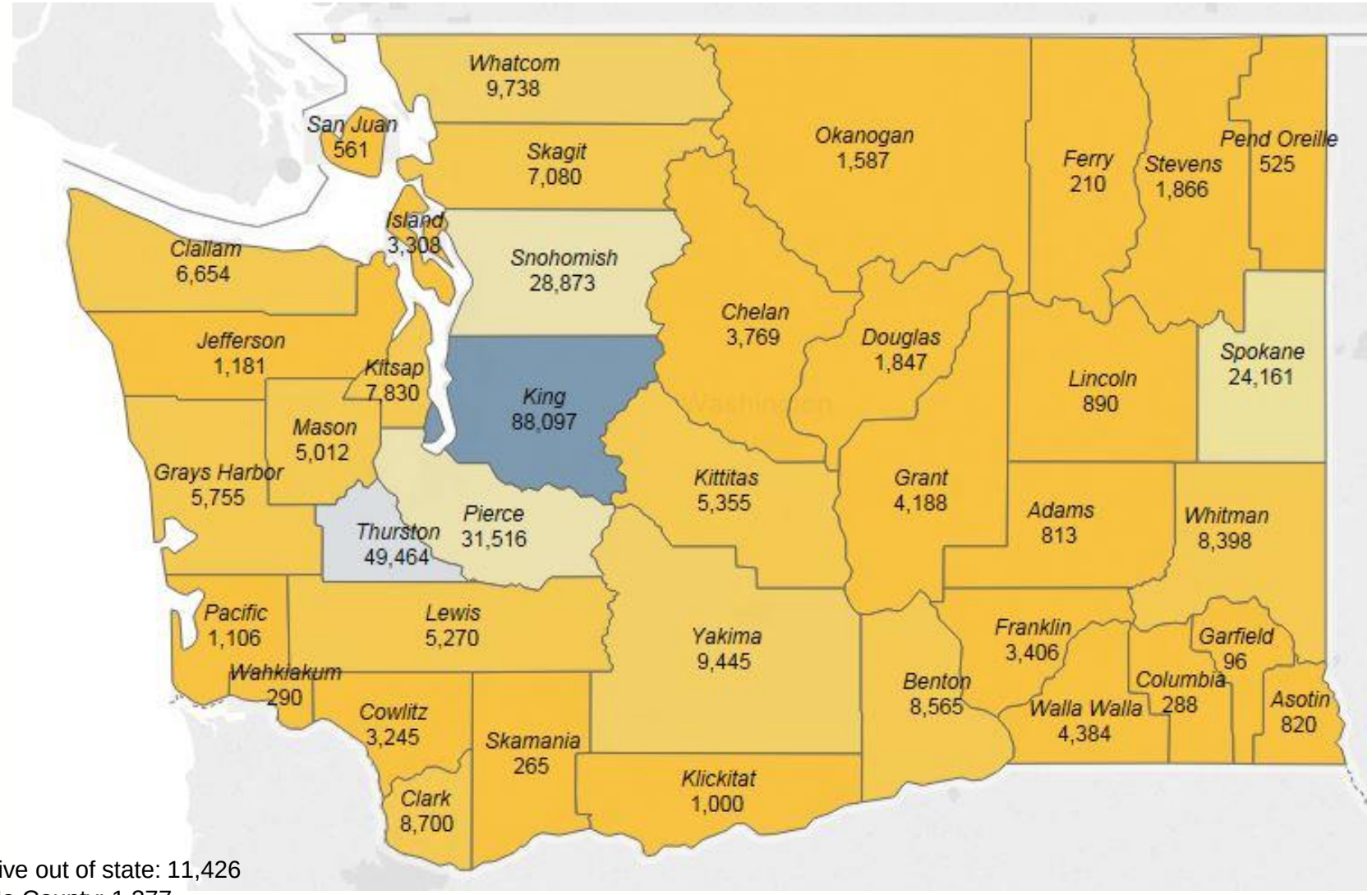
What plans are our members in?



N = 357,731

Washington State Health Care Authority

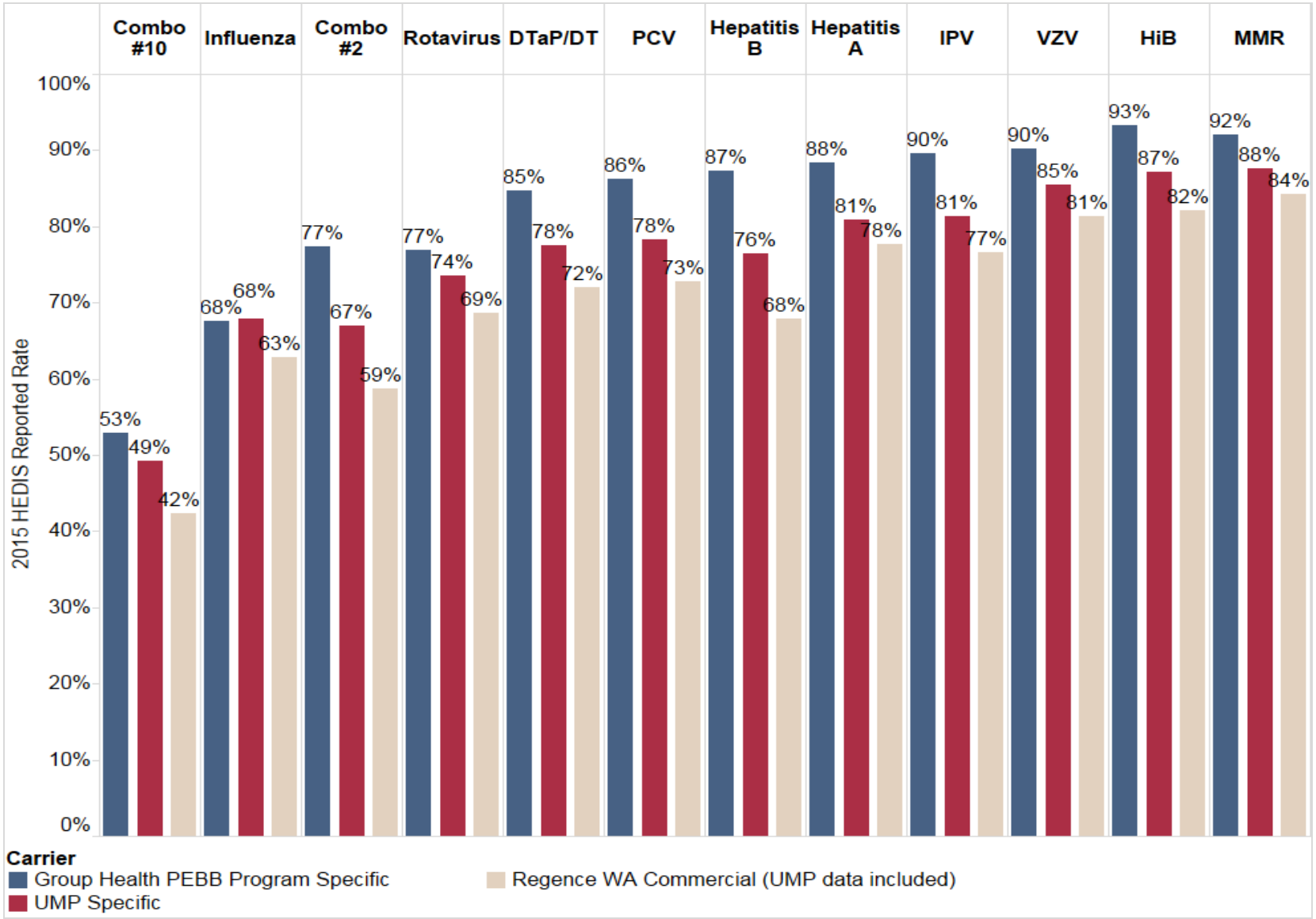
Where do our members live?



Live out of state: 11,426
No County: 1,377

HOW DO OUR PLANS MEASURE UP?

2015 HEDIS Report - Childhood Immunizations



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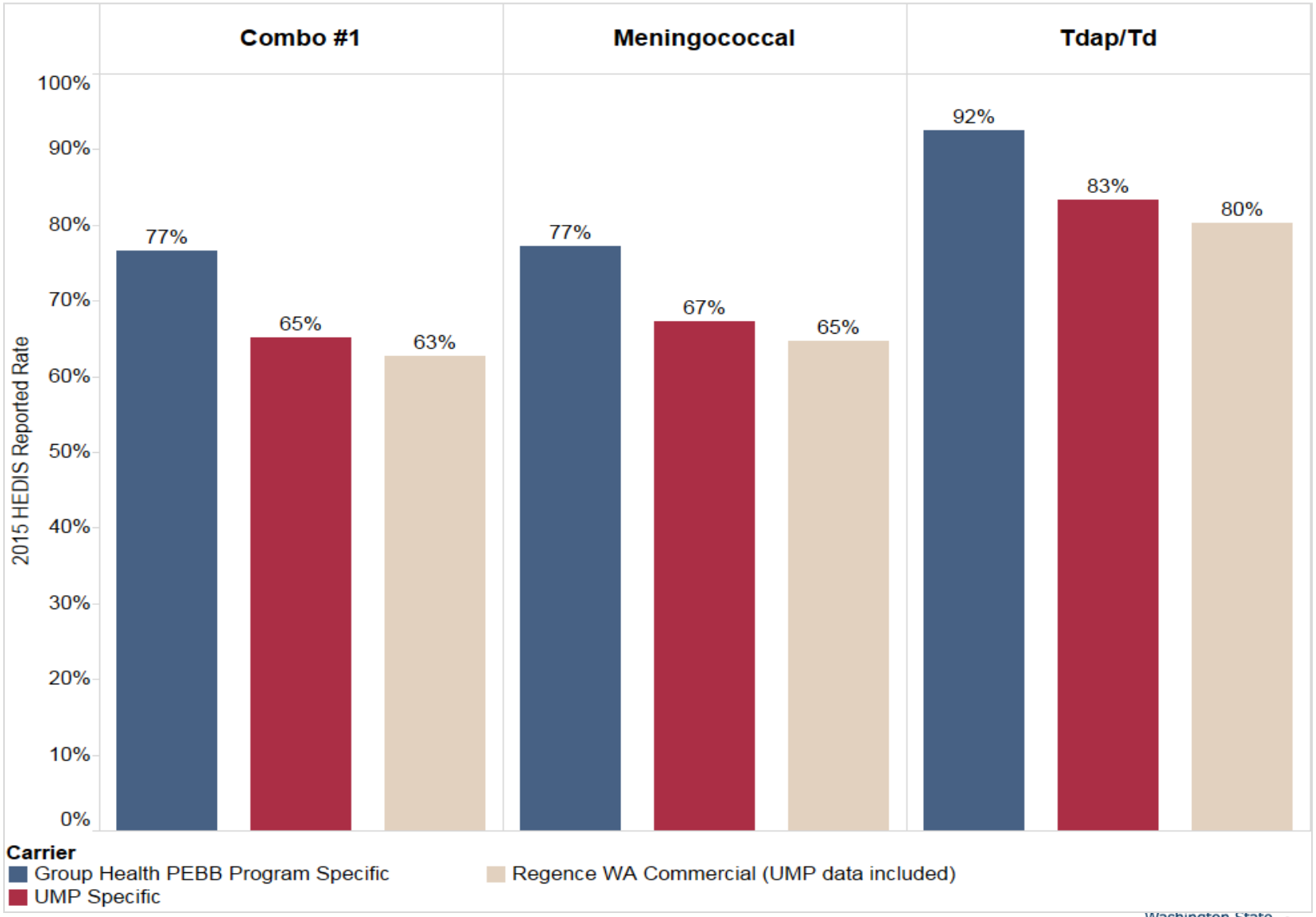
Adolescent Immunizations



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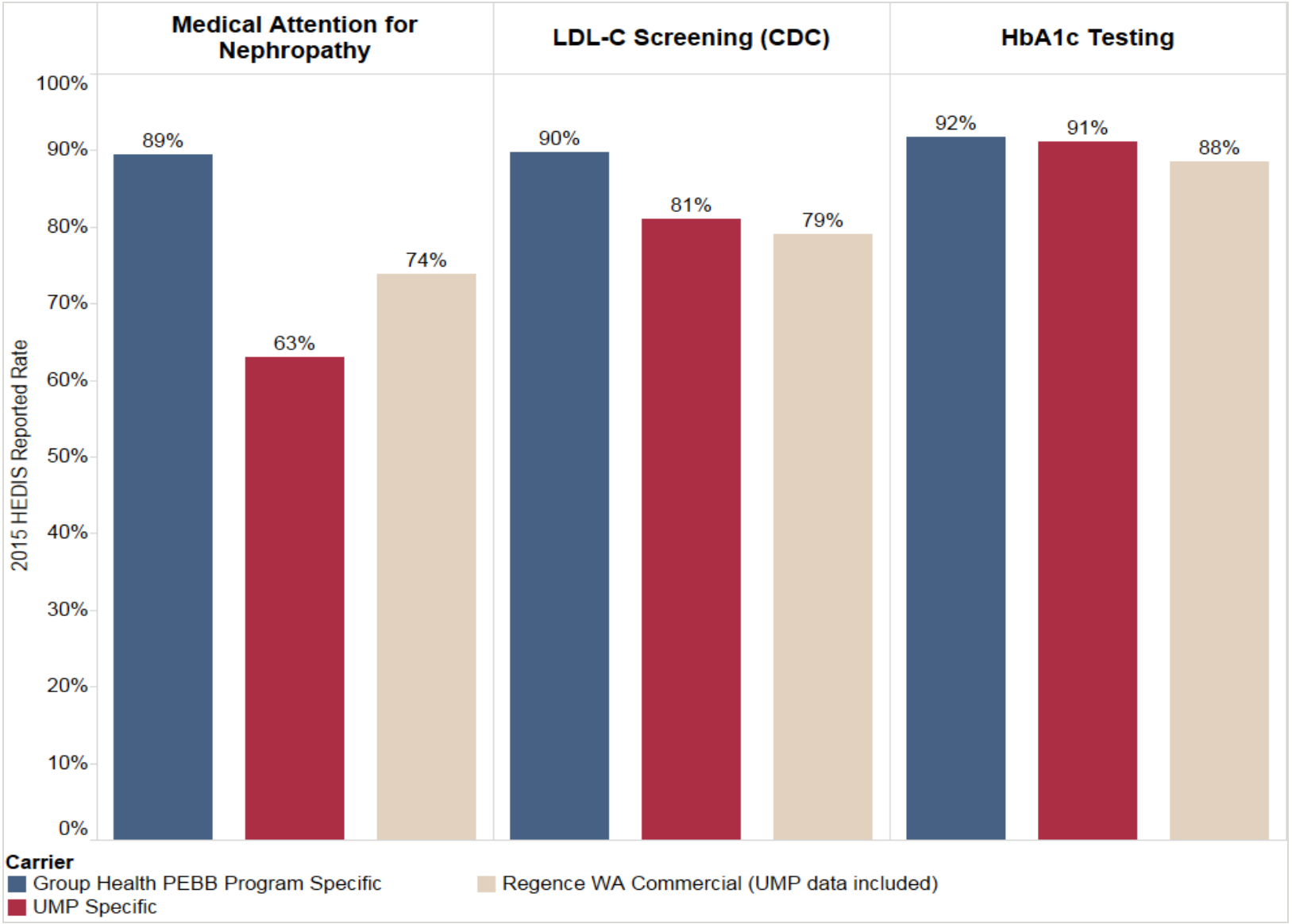
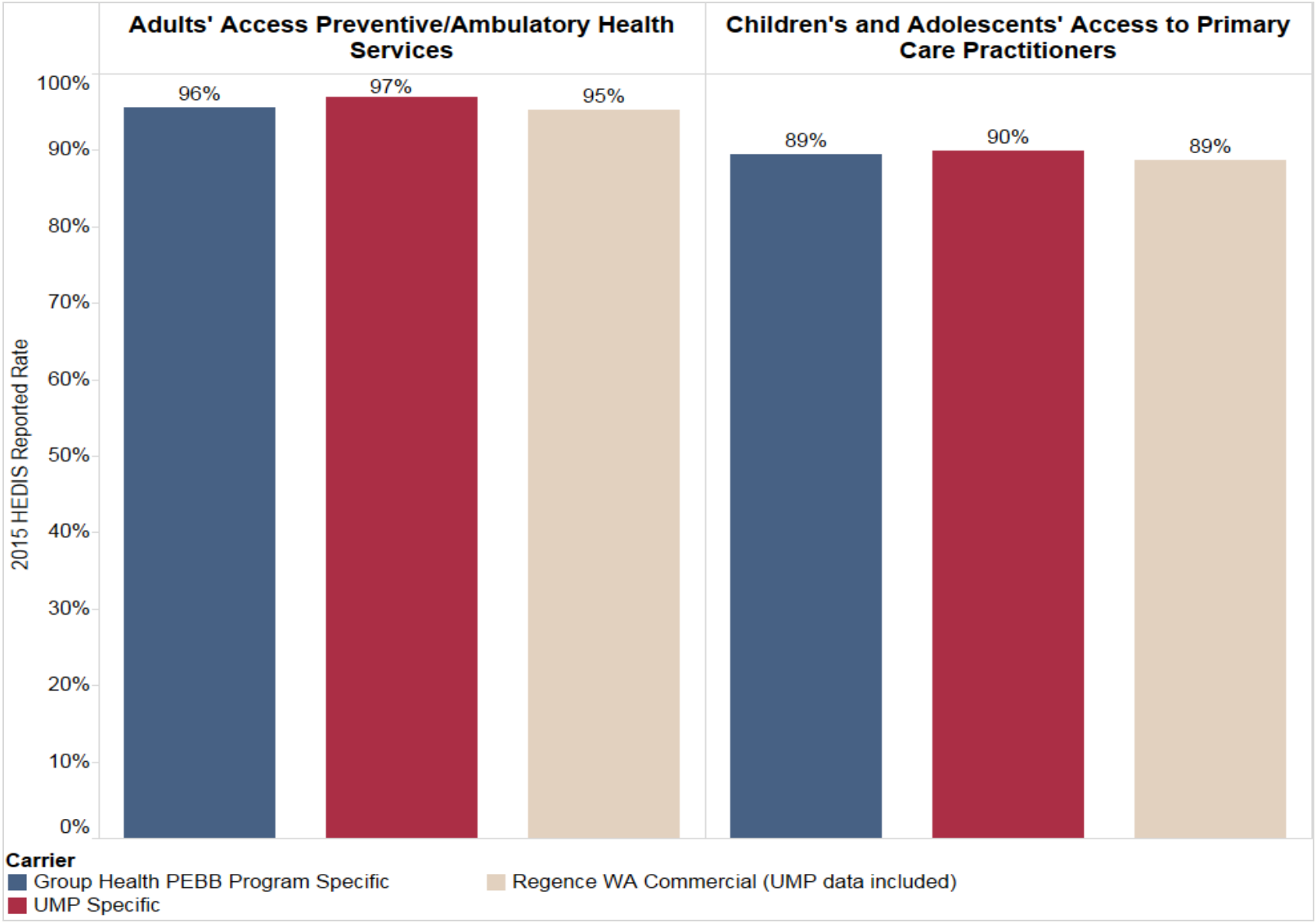
Comprehensive Diabetes Care



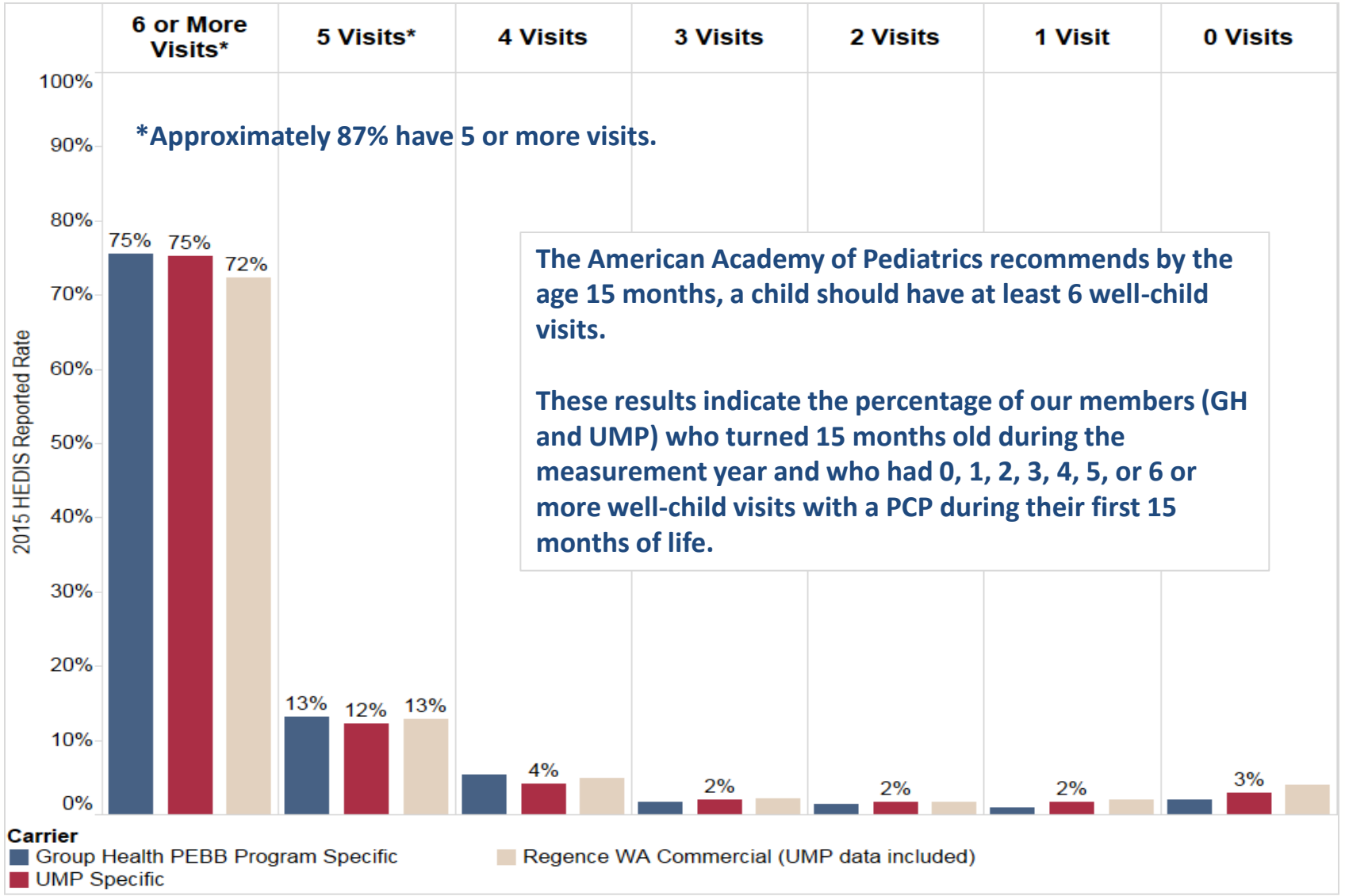
Washington State Health Care Authority

Access to Care: Adults and Children



Washington State Health Care Authority

Well-Child Visits First 15 Months of Life

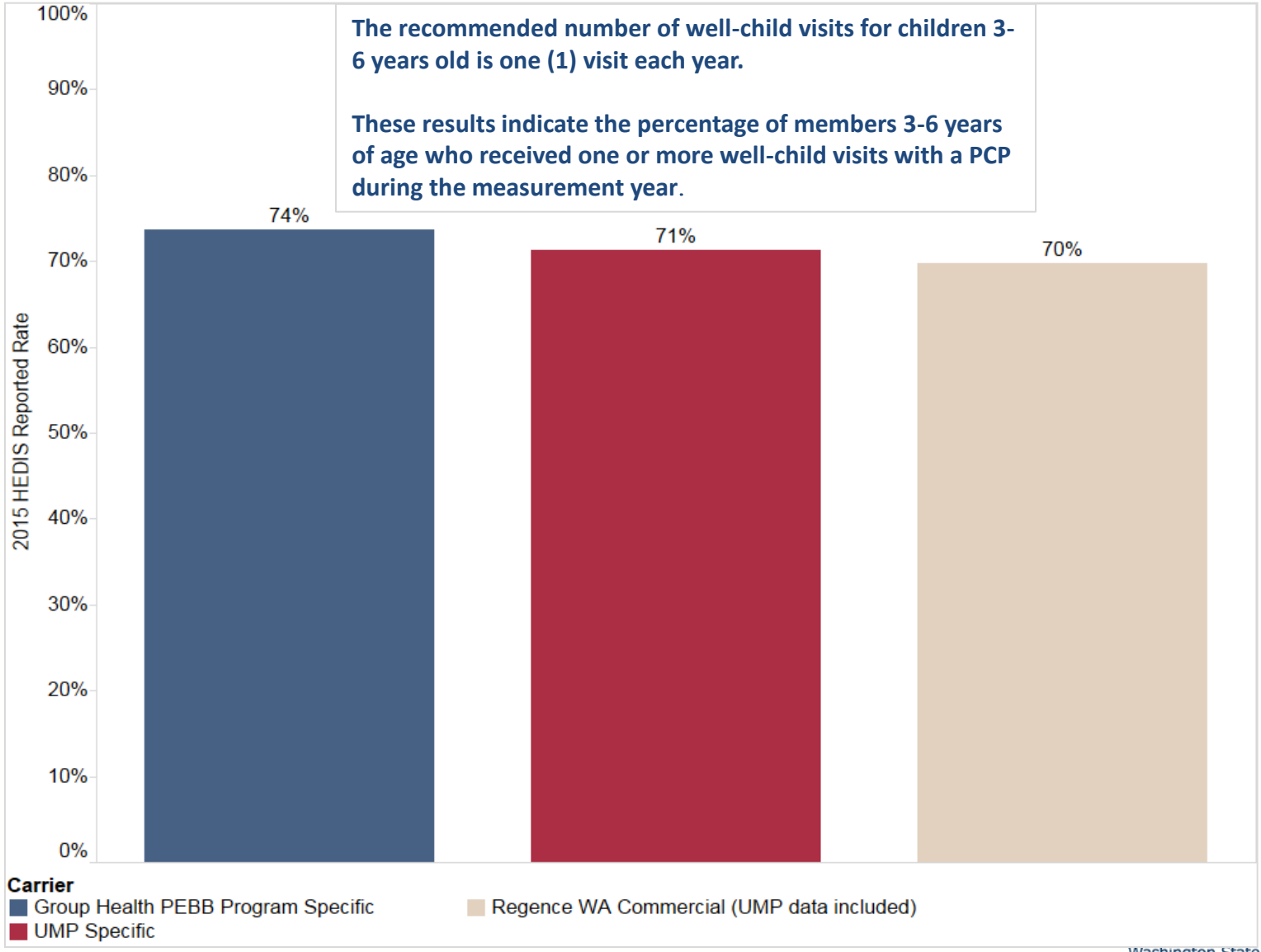


The American Academy of Pediatrics recommends by the age 15 months, a child should have at least 6 well-child visits.

These results indicate the percentage of our members (GH and UMP) who turned 15 months old during the measurement year and who had 0, 1, 2, 3, 4, 5, or 6 or more well-child visits with a PCP during their first 15 months of life.

Washington State Health Care Authority

Well-Child Visits 3-6 years of age

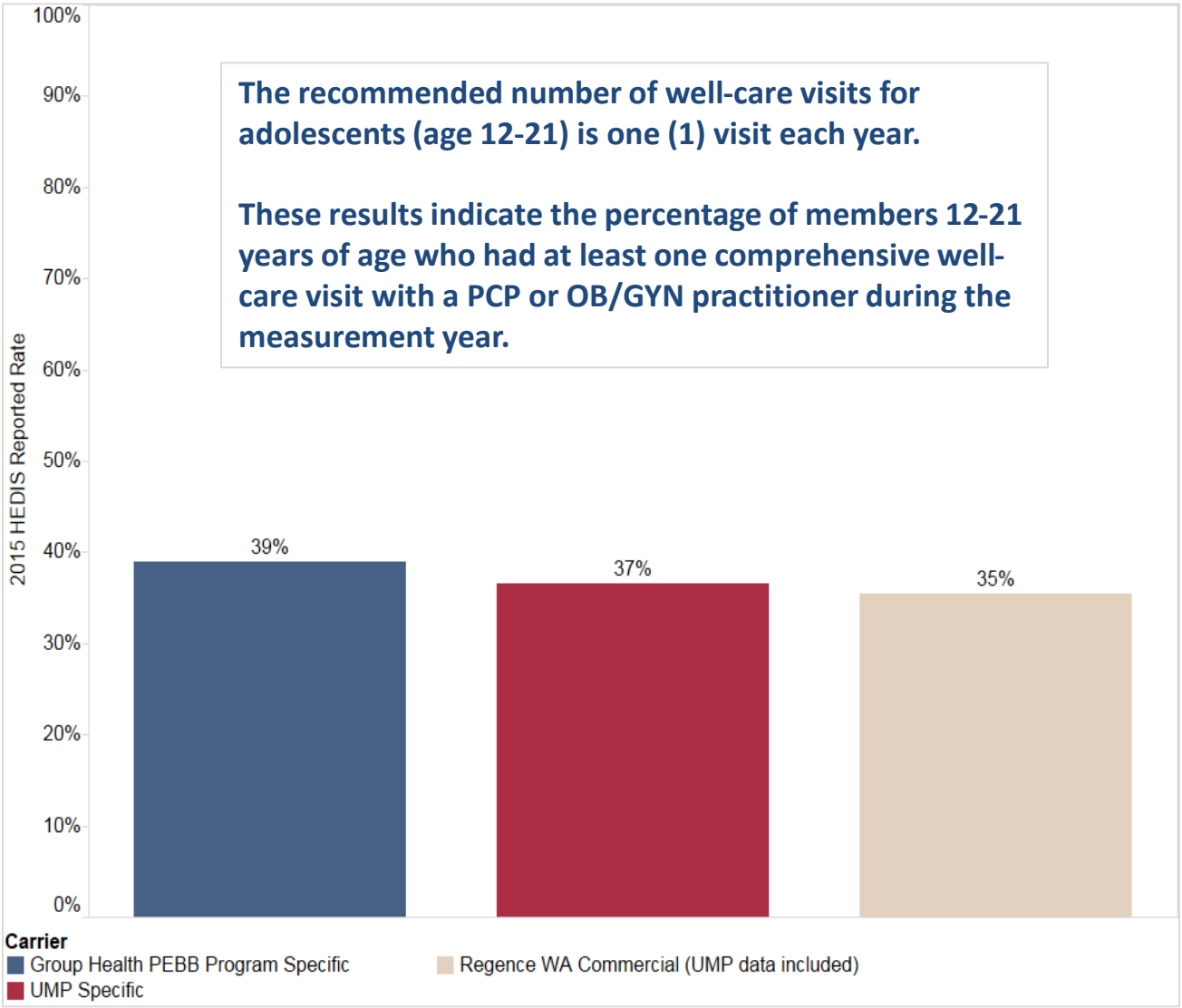


Washington State Health Care Authority

Well-Care Visits for Adolescents

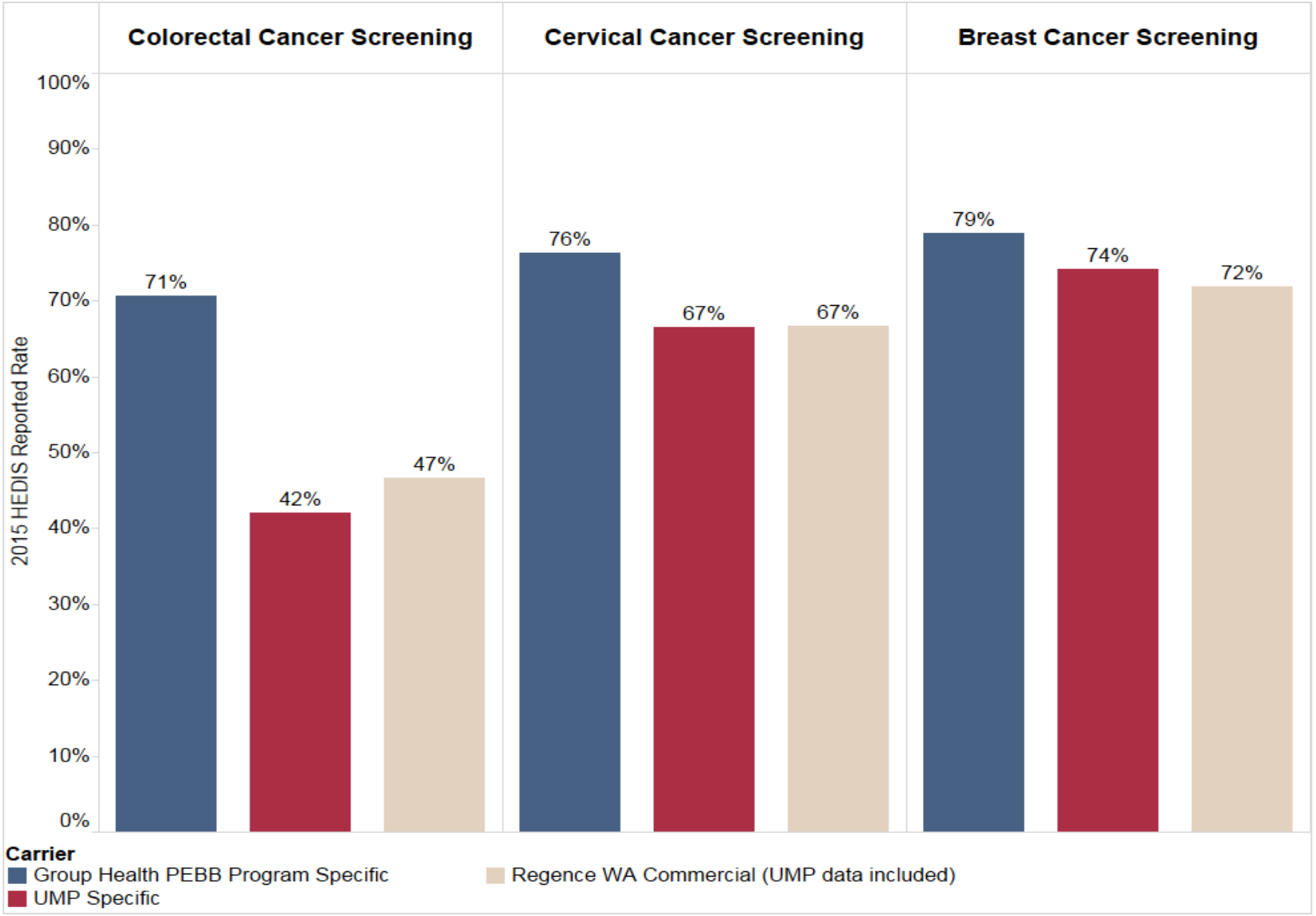
The recommended number of well-care visits for adolescents (age 12-21) is one (1) visit each year.

These results indicate the percentage of members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.



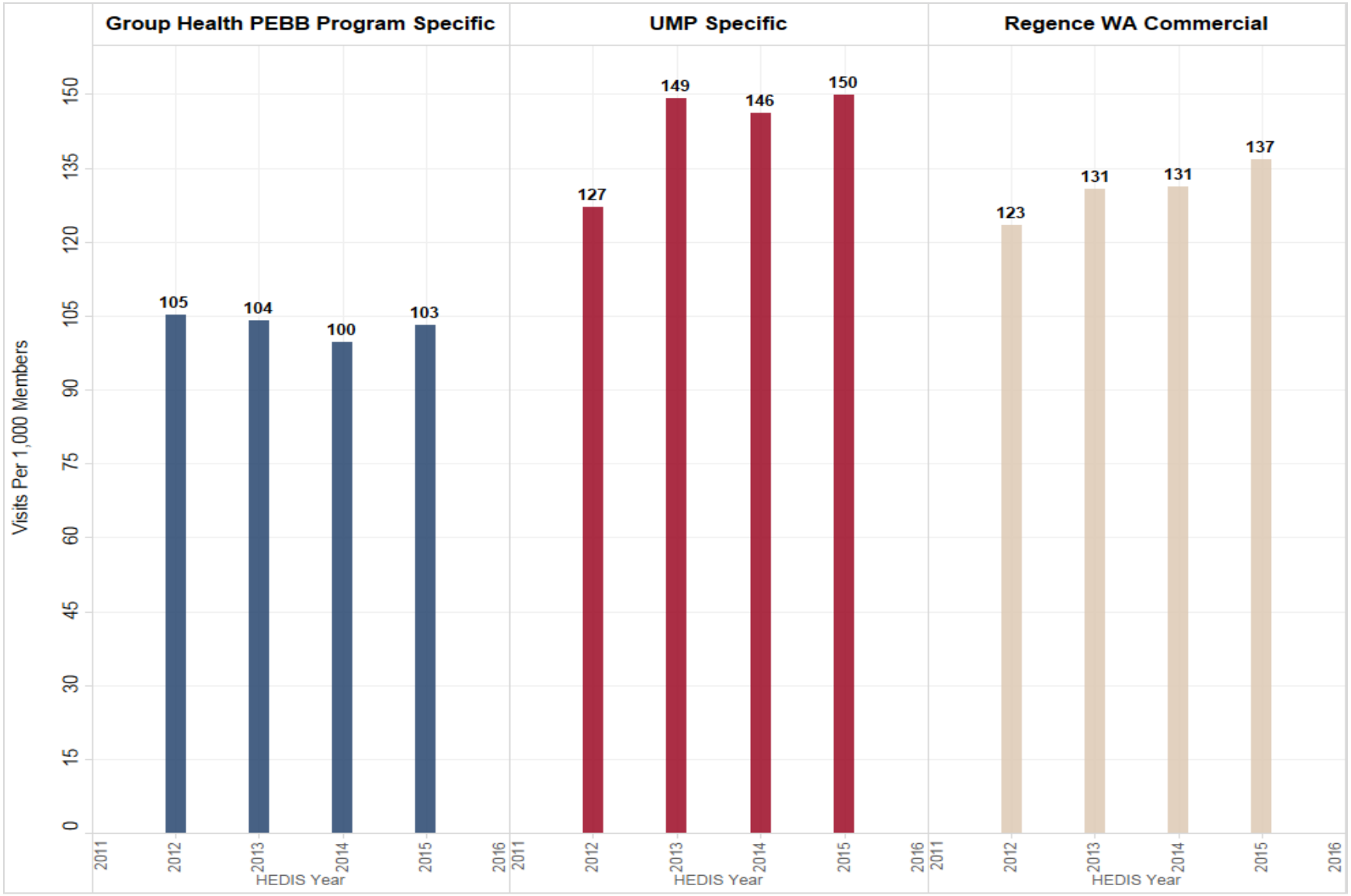
Washington State Health Care Authority

Cancer Screenings



Washington State Health Care Authority

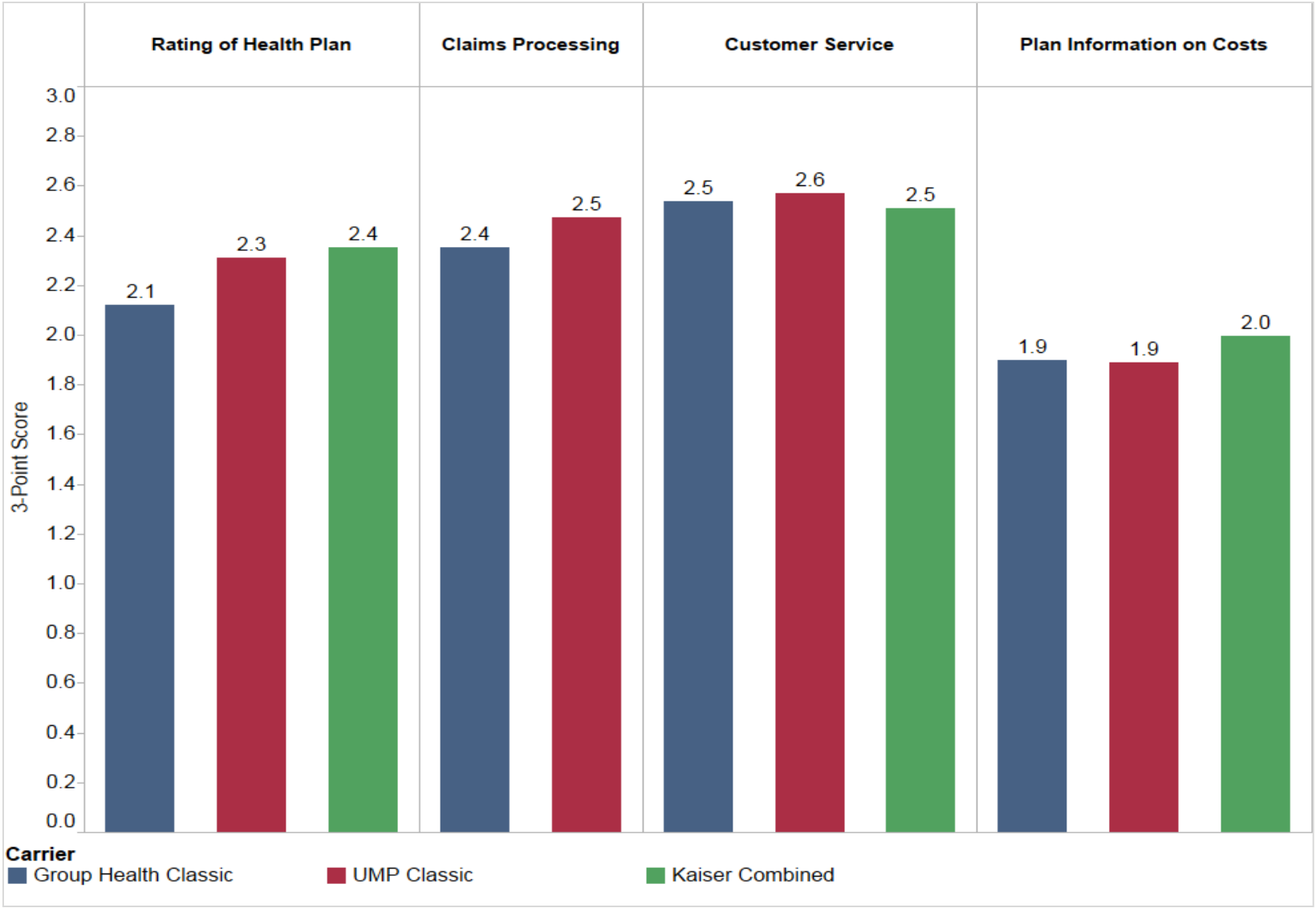
Outpatient Use: Emergency Department



Washington State Health Care Authority

Health Plan Related Measures

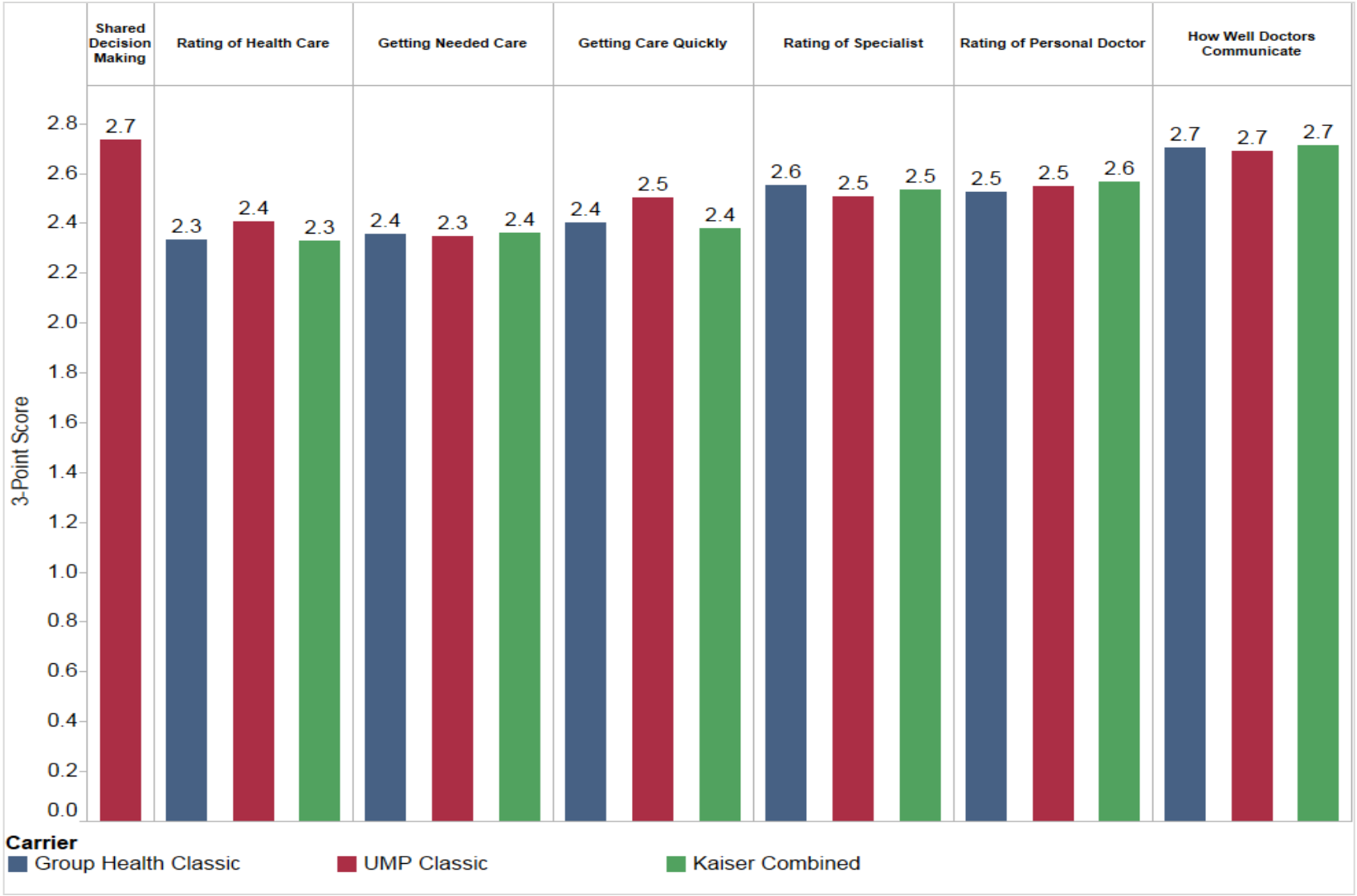
2015 Consumer Assessment of Healthcare Providers & Systems (CAHPS) Results



Washington State Health Care Authority

Health Care Related Measures

2015 Consumer Assessment of Healthcare Providers & Systems (CAHPS) Results



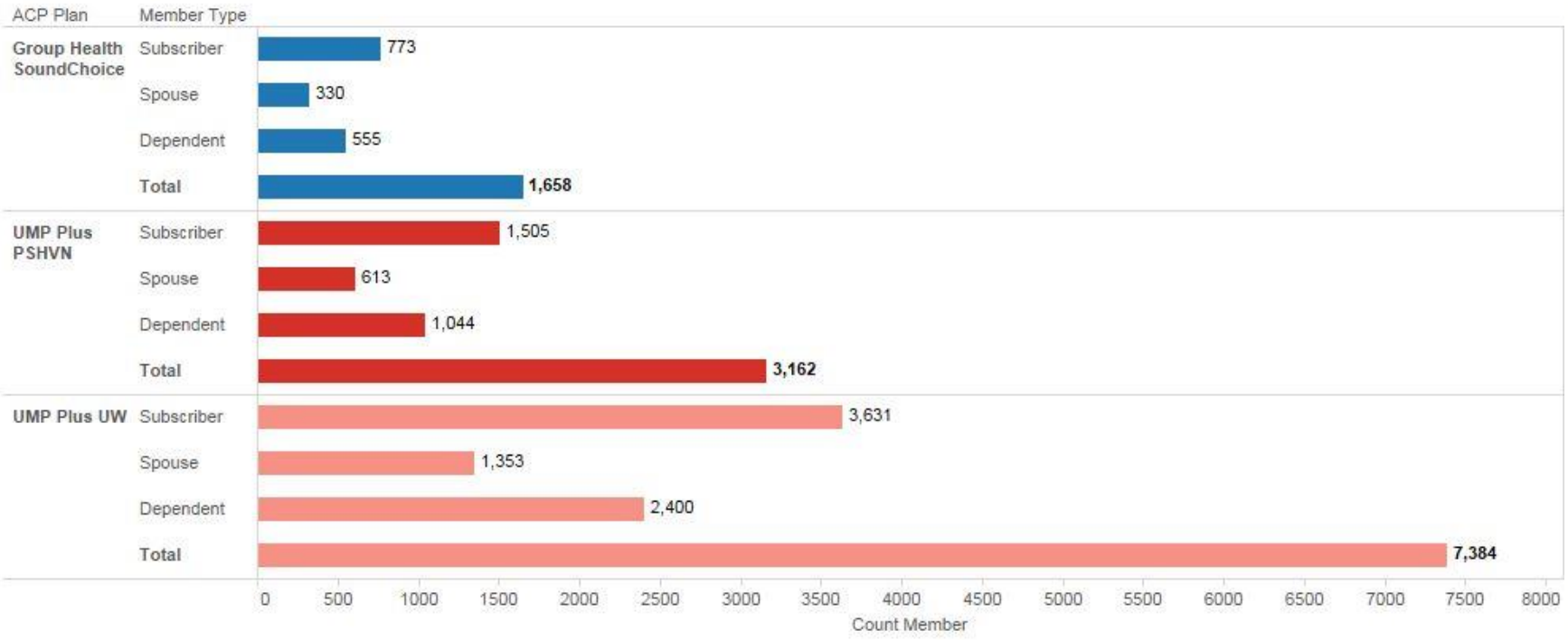
Washington State Health Care Authority

TAB 5

VALUE-BASED PURCHASING: NEW PLAN ENROLLMENT RESULTS

Washington State Health Care Authority

12,000 Enrolled in New Plans for 2016



Washington State Health Care Authority

New Plan Enrollment for 2016

- Demographics:
  - Average age of ~33 years old
  - 45% Female, 55% Male
- The vast majority of members in UMP Plus came from UMP Classic or UMP CDHP
  - 1,195/1,494 for PSHVN
  - 2,943/3,606 for UWMedACN
- Almost all GH SoundChoice members came from other GH plans (680/765)

Open Enrollment Survey Results

- What do PEBB Program members want from their plan?

Washington State Health Care Authority

Open Enrollment Survey Results

- What do members want who enrolled in new plans?

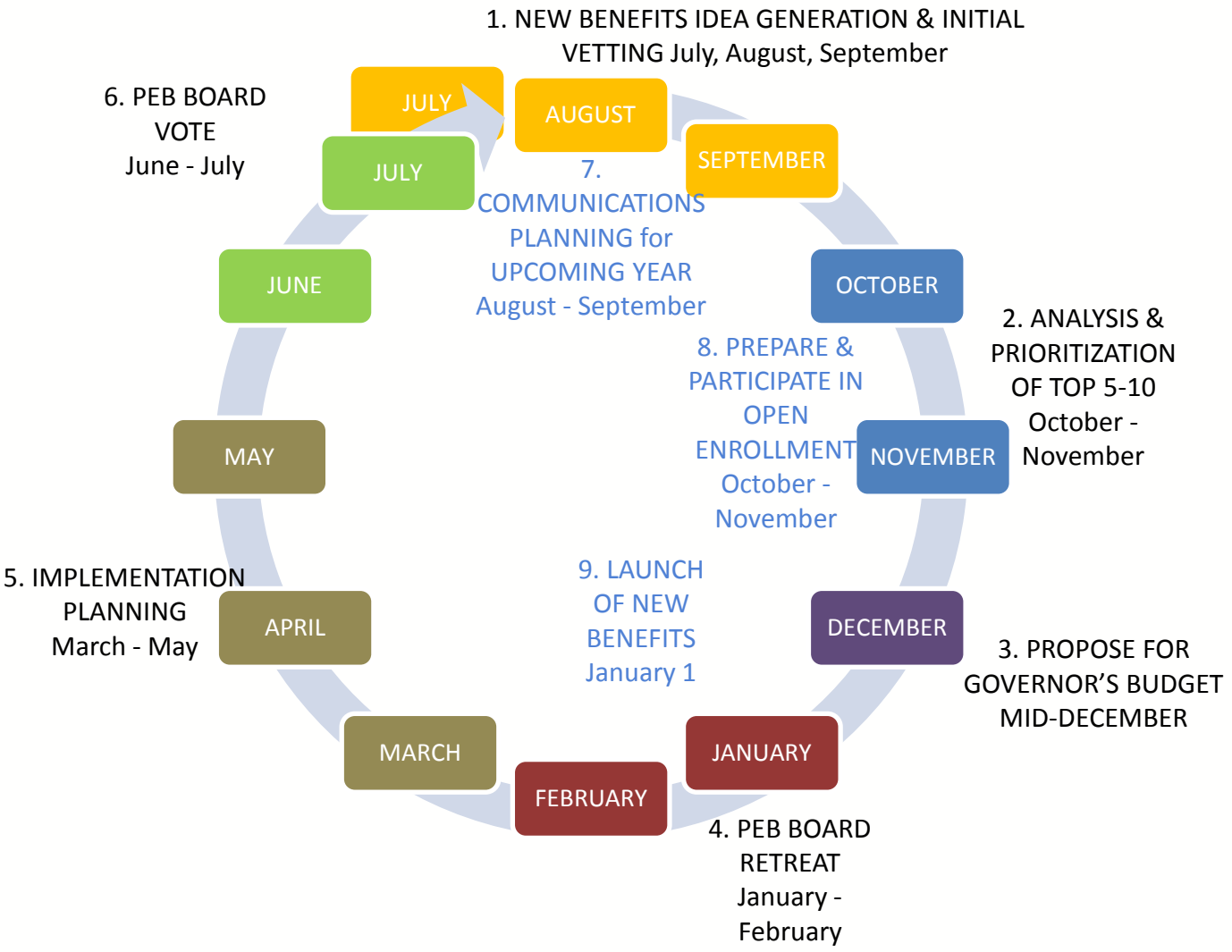
Washington State Health Care Authority

TAB 6

LOOKING AHEAD TO 2017

Washington State Health Care Authority

PEB BENEFIT PLANNING & IMPLEMENTATION CALENDAR



Washington State Health Care Authority

HCA PEBB Program Strategic Priorities Roadmap 2016 - 2018

Our Mission:	*Provide high quality health care through innovative health policies and purchasing strategies*
Our Vision:	*A healthier Washington*
Our Values:	*People First, Respect, Leadership, Public Service, Innovation, Collaboration, Service Excellence, Stewardship*
The Triple Aim:	*Better health, Better care, and Lower costs for Washington residents*
2019 Goal:	*80 percent of state-purchased health care will be value-based*

Initiative	2016	2017	2018
MEMBER ENGAGEMENT	• Define Scope • Create Plan	• Implement	• Implement
ACP EXPANSION	• Define Scope • Plan • Contract	• Implement	
REPLACE PAY1			
RE-PROCURE UMP TPA	• Prepare RFP	• Issue RFP • Select Apparent Successful Bidder	
ENHANCE PEB DATA ANALYTICS			
DEVELOP BUNDLED EPISODES	• Negotiations • Contracts	• Implement TJR and TPA contracts • Prepare next bundle?	
RE-PROCURE LIFE INSURANCE	• RFP • Negotiations • Contract	• Implement	
CADILLAC TAX	• Identify	• Implement	
EMPLOYER SHARED RESPONSIBILITY	• Implement	• Implement changes/additions	
UW WORKDAY IMPLEMENTATION	• Production • Implementation	• Stabilization • Implement additional processes	

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2017 Proposed Benefit Changes

Driven by…

- Legislature
- Constituent requests
- Plan recommendations
- Industry trends
- Board recommendations

Prioritized List

- 100% coverage for male sterilization
- Remove dental restriction
- Increase nutritional counseling visits
- Site of care for medical drugs
- Redesign long-term disability benefit
- Centers of Excellence for Total Joint replacement