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Session: De-Implementing Low Value Health Services

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Dr. Paul Barnett: Welcome everybody, I am Paul Barnett, I am the Instigator of the presentation today about De-Implementing Low Value Health Services. I would like to first introduce my co-panelists: David Au who is Director of the HSR&D COIN Program in Seattle and Eve Kerr Director of the HSR&D COIN Program in Ann Arbor.

What we are going to talk about today, I am briefly going to give an overview of the problem of unneeded care and what we mean by a low value service that we might want to de-implement. I will talk very briefly about some of the different lists and catalogs of low value services and then turn to David and then Eve to describe their current work de-implementing low value services and I will briefly describe some work that I am doing. Then I want to save some time at the end to talk about how do we choose among all the areas for de-implementation and sort of from the perspective if you are an HSR&D researcher or perhaps a manager and wants to know where to get started on this question and think through. There are many topics and how do you choose among them, many types of unneeded care.

So the problem of unneeded is that thirty percent of U.S. healthcare spending is wasted according to the Institute of Medicine. Largest component of that is unneeded services which it estimated to be about two hundred and ten billion dollars a year. Just to put this in perspective, thirty percent of US healthcare spending is about four to five percent of U.S. Gross Domestic Product (GDP), that is approximately one dollar out of every twenty in the U.S. economy is wasted healthcare spending. One to two percent of GDP is a good estimate of what the unneeded services component of that waste is. It is obviously a very significant problem.

What do we mean by low value care? Obviously it is care that is not effective and certainly care that causes more harm than benefit. It also consists of another category and this may be the biggest part, care that yields too little benefit to justify its cost. Cost effectiveness analysis allows us to come up with a formal definition, which is – the alternative to the care is dominant. That is the alternative is as effective and less costly or more effective and no more costly. In the absence of dominance, we have to consider about whether that benefit is sufficient to justify the cost. This is a situation that the care or the alternative is more effective and more costly and so we look at the incremental cost effectiveness to ratio.

This is comparing our innovation to standard care both cost divided by qualities and this is a way to come up with how much does this innovation yield. What does it cost to yield an additional quality adjustment here? And we often use the threshold – how low this ratio has to be is not that well defined, but we often say that anything that costs more than a hundred thousand dollars to generate a QALY is really too expensive in U.S. healthcare.

I want to talk briefly about the fact that there are many catalogs of services that have been identified as low value, things we should stop doing. Originally by the Rand Corporation, in the UK National Institute for on Clinical Effectiveness has its catalog, many, many catalogues that have been generated. I have pushed some slides describing these to the end of the slide deck that you can look on your own. There are references and links to all of these.

I wanted to mention two in particular because I think they are very important. First is the Oregon Health Services Commission has created its own ranking of services by value. The significance of this list is I think it is the only example in this country where a list has been used to define the scope of coverage. That is pretty noteworthy. Another list that I wanted to be sure to mention is the Choosing Wisely Initiative which is the most recent effort in the U.S. Its involved seventy medical specialty societies, they have been identified by four hundred examples of low value care. We have a Committee in the VA to implement some of these choosing wisely identified low value services.

The Dartmouth Health Atlas Group estimated among those four hundred they looked at the impact of eleven of those services on the Medicare program two of them they found would have very big impact: the anti-psychotics in dementia, unneeded Vitamin D screenings, but most of the services that they looked at the savings were quite small, less than ten million dollars. To say that all things on the list are not equal in terms of their at least financial impact.

The lists have some limitations; some of these are just based on a single study the strength of evidence is not always very clear in them. Often the thing that we are talking about de-implementing is a particular care for a particular subgroup of patients. That subgroup of patients may be difficult to define and there are some equity questions especially when crossing the threshold between being in the group or out of the group is hard to distinguish. It is clear the list being so long, many of the lists have hundreds of items. There needs to be some sort of prioritization about what we do first. That I want to get to at the end of the call.

What I would like to do is turn over now to the other panelists to describe the work that they are doing on the de-implementation and examples of how HSR&D service is addressing this. David if you would start that would be great.

Dr. David Au: Sure I would be happy to do that, let me load my slides here quickly. I assume everyone can see them okay.

What I would like to do is talk a little bit about one of our projects within a broader QUERI Program that really focused on improving safety and quality through evidence based de-implementation.

What we really tried to do is to think about practices that are being performed relatively common within VA where there is actually a safety risk or at least where the safety benefit ratio is probably are not favorable for patients. I am a lung doctor by profession and so I have been interested this COPD and so we have been focusing on de-implementation of inhaled corticosteroids in a project we call DISCUSS. [Let me see I am trying to advance slides here.]

COPD guidelines are pretty explicit that inhaled corticosteroids are generally limited and we saw people with COPD to patients with severe to very severed disease or patients who had frequent exacerbations and that we should not be providing them to patients who have mild to moderate disease who do not have obstructive lung disease at all which is pretty actually quite common. Mainly is one they are not effective and two they actually do increase the risk of pneumonia by twelve percent that is probably among adverse events. But also includes things like oropharyngeal candidiasis and skin bruising, osteopenia.

If you look at the use of inhaled corticosteroids and the appropriateness, these graphs represent the number of people who may actually be receiving inappropriate inhaled corticosteroids. So what we see here on this graph is the number of medical centers and the proportion of patients who carry a diagnosis of COPD and really do not have any other indications for it, who may be receiving inhaled corticosteroids inappropriately. It is a huge range; it goes from about a quarter up to as high as close to a hundred percent. A lot of it is because we actually we do not get spirometric results or these patients have no evidence of spirometry which is a necessary test to make a diagnosis of COPD. In this graph over here of the country it basically shows there is a geographic variation of inappropriate prescribing. So here in Seattle it is actually pretty high relative to other parts of the country.

The reason why we are focusing on this in particular is because there are actually alternate approaches that are actually safer. This is a study that was just published in the *New England Journal* called “The Flame Trial”. Basically what it shows that in comparison to a group of what we call LABA/LAMA’s this combination of inhaled corticosteroids and LABA actually had more risk of harm and had actually less benefit in terms of exacerbation risk. If you look down here they actually had a higher risk of pneumonia and confirming what we expected for a long period of time. This kind of shown actually at least the pneumonia risk has been shown now for at least ten if not fifteen years’ worth of clinical trials and data and there is more evidence behind it.

This is observational data from Sammy Suissa that basically shows that once you discontinue an inhaled corticosteroid your risk of pneumonia actually falls pretty precipitously over the first ninety days and then kind of flattens out with an adjusted risk ratio of about .060. So real effects when you discontinue the therapy.

There are broader issues though about how you go about implementing the discontinuation of inhaled corticosteroids within the VA. Honestly for COPD I always called COPD the Rodney Dangerfield of chronic diseases because there is not a lot of organizational emphasis that is placed on it.

So the question is – how do you go about decreasing the use of an inappropriate inhaled corticosteroid and is there a roll for specialists like myself in the population management level. Our interests are not to try to improve delivery and safety of care. At the same time we do not want to be intrusive, I think primary care providers have a pretty tough existence right now so the last thing we want to do is actually create more work. In fact what we want to do is try to move the bar in a different direction where we take some responsibility and we seek the advice and concurrence of primary care to do so.

The aims of this particular project which is actually a quality improving initiative is to decrease the low value ICS use among patients with mild to moderate disease and really to try to get pulmonary specialists to engage in the population. Our secondary aims are to assess the acceptability of the intervention to primary care providers as well to Veterans. We will measure the rate of pneumonia as well as COPD exacerbations. And then we are going to do a budget impact analysis on the implementation costs. The overall design is reminding that this is a quality improvement project; we are actually using a clustered randomized trial where primary care providers, the PACT team is the unit of randomization. The intervention and targeting the primary care provider and their patient.

These are kind of the anticipated patients. This study is actually going on in two sites; it is going on at Puget Sound and all our CBOC’s as well as the Bedford VA and all their CBOC’s. We have kind of identified the number of patients in our population who have COPD and this kind of shows how these people kind of drop off. Among patients with diagnosis of COPD who have an inhaled corticosteroid prescription there are roughly three thousand five hundred patients who actually PFT’s which suggests that sixty-three percent of patients who are receiving inhaled corticosteroids actually do not have a PFT that we can document.

This basically just kind of shows the flow, but what we are really looking at is to really target this group of patients where are just trying to get rid of all the potential indications for inhaled corticosteroids.

This is our basic design where we identify patients who may be inappropriately receiving inhaled corticosteroids. We actually identify a primary care visit that is coming up and we do a chart review, the team of two pulmonologists at Seattle and two pulmonologists at Bedford. About one week prior to the primary care visit we kind of meet and we look at the primary care notes and try to develop recommendations. From there we put a functionally an e-consult into the intervention group that kind of documents our rationale. Then rather than just say primary care should do this or primary care should that, we actually anything that we make a formal recommendation to we actually complete the order on behalf of primary care. Then we sign off on the note, we send the note to the primary care provider probably about a day or two hopefully before the patient shows up in clinic with the rationale. And then we also complete any orders that we have recommended and send it to the primary care provider to endorse. If they want to accept the recommendation all they have do is sign it, they can spunk which is perfectly fine by us, they can discontinue it. But it keeps primary care in the loop. Now if they happen to have a pulmonologist who is actually part of this patient’s team, we also ‘cc’ the pulmonologist to let them know that we have been in their chart making recommendations as well. Then what we will do is look about two weeks afterwards and send both patients and providers surveys to find out how intrusive or how we are doing with the intervention and then approximately six months later we are actually recommending long term outcomes.

This is an example of what we are doing, just to give you a highlight; this is obviously a test patient. It just says we have this quality improvement initiatives and that we have a team in Seattle as well as Bedford and that we have entered any recommendations.

This might be an example of recommendations – tapering and discontinuing inhaled corticosteroids as follows. Then we make pretty explicit I think recommendations about initiating olodaterol or initiating mometasone for one month and then discontinuing it thereafter. We also provide a little bit of the rationale behind it and then we provide some references as well at the end. Hopefully all in all it is designed to be kind of collaborative in nature and really designed to not be intrusive and try to really unload work from people while still trying to make care safer.

I will stop with that and maybe I can transition the talk over to Eve at this point.

Dr. Eve Kerr: I am pulling my screen up. Thank you David that was a great example, actually a great segue for my talk and once I see my screen I will be happy to start talking but I do not see my screen.

Moderator: We can see your screen right now; we just need to have your slides up. Right now we can see your email and calendar.

Dr. Paul Barnett: And it is a busy calendar.

Dr. Eve Kerr: So you just want me to put my slides up, I thought you were controlling, I thought you were putting up the slides.

Moderator: No and I tried to relay through your assistant earlier that you needed to have your slides up on your screen, we display them right from your screen.

Dr. Eve Kerr: I did not understand that I am sorry.

Dr. Paul Barnett: Heidi I have four slides about my project, maybe we can do that while Eve is getting her slides up.

Moderator: Okay sounds good.

Dr. Paul Barnett: Just briefly, this is Paul again; describe projects that we have done here in Palo Alto. One project had to do with routine CD-4 testing. The new guidelines say that in patients who have HIV who have good viral control, routine CD-4 testing is no longer needed so there is an area for economy, care that is not needed. We studied this and we found that VA providers even before the guidelines came out had begun to reduce their testing. And that VA could reduce the testing further, but really the total value of this is less than a million dollars for the whole system. It is obviously not something where we want to spend a lot of de-implementation resources. We looked at it, published it but not going to follow up.

The other thing that we have been working on is inappropriate MRI of the lumbar spine. This is one of the items on the Choosing Wisely list. There is a great deal of evidence that says in the cases of new onset, uncomplicated low back pain, an MRI is not needed. We first studied VA data on this and somewhere between one-third and sixty percent of the lumbar spine MRI orders are not appropriate in the VA system. The low end is based on administrative review; the high end is based on medical record, but a very small number of records of the latter.

I think most interestingly we found that it was eleven percent of the ordering providers that accounted for half of the inappropriate scans. The idea that we do something that would affect all providers did seem appropriate. We need to understand why these eleven percent is ordering these scans. What we have underway right now is a mixed methods study where we are identifying providers of new onset, uncomplicated low back pain and looking at what distinguishes those primary care providers who do a lot of imaging from those who do not. So by interviewing them, talking about what is the support services they receive, what sort of referrals, what is happening in the clinic, what is their view of guidelines and they feel it is the patients that are driving this. In order to build a definition we need, excuse me an intervention, we need to understand what is wrong.

Then we have a quantitative study to look at the downstream effect of the inappropriate scans on surgery related, patient pain, pain medications and cost. The reason we think these downstream effects are important is because the value of the scan is not so much, it is about twenty or thirty million dollars a year. They could be driving a lot of downstream costs so that study is on the way.

If Eve is ready now, we can switch to her.

Dr. Eve Kerr: That sounds good Paul; I have the slides up so hopefully you can see them now.

Dr. Paul Barnett: We are flexible, we can work around it.

Moderator: Eve once you click on that button to Show My Screen we should be able to see your slides.

Dr. Eve Kerr: Click on it, can you see my slides? Yes?

Dr. Paul Barnett: We can see your desktop – now we see your slides, great.

Dr. Eve Kerr: Perfect great, okay. Sorry about that that was my misunderstanding I have not used this new method it was always somebody else driving the slides. Those are both great examples for the need for de-implementation and I think that I will lend another example for an approach that we are using kind of in a very similar vein to David’s example as well. We have a project that is funded by HSR&D that is called the ASSURES Study or Assessing when to Stop or Scale Back Unnecessary Routine Services.

Tim Hofer and I recently wrote an editorial for *JAMA Internal Medicine* where we really focused on the fact that de-intensification which we define as the process of “stopping or scaling back the intensity or frequency of medical interventions that are currently part of a patient’s ongoing management.” We consider that the next frontier for improving care quality. And certainly the example that David gave is a great project to show that a lot of routine things we are doing like using inhaled steroids, we really need to think and stop doing some of the things are routinely ingrained in us in medical practice.

I see a lot of patients like this, a seventy-seven year old man, diabetes, chronic kidney disease. He has been coming to the VA a long time; he takes all the medications that he is supposed to be taking to prevent complications from diabetes and cardiovascular disease. For his diabetes he is on two oral medications and in fact he has very tightly controlled blood pressure and a very tightly controlled hemoglobin A1C of 6.5%. For those of you who know about diabetes, a lot of times we shoot for very tight control especially in younger patients. But when patients get older that kind of tight control, the low sugar, can actually lead to a lot of complications including loss of consciousness, memory impairment, falls and untoward outcomes.

Nonetheless he has probably been taking medications like this for twenty years. In fact, we did a study that Dr. Jeremy Sussman led a few years ago that looked systematically at how often we are stopping medications, de-intensifying medications for patients with low hemoglobin A1C. Even for patients with very low, this is kind of super tightly controlled, we are stopping medications only around twenty-five percent of the time. As you can see we kind of stratified that by life expectancy and even for patients with very low life expectancy which is that white bar, they are only being stopped around thirty percent of the time. Just as remarkably you will see that for patients with not as tight controls, greater than 6.5% the differences between stopping those medications is not huge. So there is some baseline change of medications and if you think about that that delta between greater than 6.5% and less than 6% is even more remarkable because a lot of that the medication is not being stopped due to troger of low sugar. It is probably just a lot of baseline change in medication.

We really wanted to understand in this particular instance the kind of exemplifying the whole issue of de-intensification. Why aren’t providers stopping medications? So we did a survey study that actually asked providers about what they think about de-intensification for a patient just like Mr. H’s scenario based. Actually about forty percent of providers said this is all VA PCP’s so nationally representative survey of VA primary care providers that they thought the patent would benefit if his A1C is maintained at a low level which is not according to the guidelines. About a quarter felt that they would worry about his diabetes medications would be vulnerable to future malpractice claims if they stopped or reduced his diabetes medication though no evidence of that that has occurred. Then about forty percent worried that reducing his diabetes medication would lead to an A1C that falls outside of the current performance measures. In fact, the VA has never had performance measures around tight glycemic controls. There is a lot of unfounded beliefs around reducing medications in this case in particular for diabetes.

We were really interested in doing a study that had as a focus the intensification. The first aim of our study is actually to identify and validate clinical indications for de-intensification in primary care. We all have examples from our clinical practices and our specialties but we wanted to develop a systematic method and I will show you what that looks like to actually identify those indications. It does not have to be just around medication and de-intensification; it can also be around procedures or testing.

We wanted to assess prevalence and reliability of measures of de-intensification and then very importantly to develop multi-component strategies to disseminate and implement de-intensification measures.

The first part of our study are aim one was actually to develop this system to identify clinical indications for de-intensification. We started with an environmental scan and that was of the literature and tried to then kind of prioritize within that what we found. After the environmental scan that actually led to two separate parts of our method. The first is we took the prioritized indications and we did a rapid evidence synthesis and we are actually in the process of doing these, we are collaborating with the Portland Evidence Synthesis Program at the VA and the University of Oregon. We are also doing rapid opportunity estimates in the VA to understand how often de-intensification is not occurring so the extent of the problem. Once we get through those steps we are actually going to have modified Delphi expert panel so that experts not involved in the prior processes will be able to rate the de-intensification indications by priority.

So just very quickly when we did that environmental scan, we actually found seven hundred and sixty-eight recommendations that met our inclusion criteria and I should say this is all in primary care, all part of routine care and met inclusions for possibilities for de-intensification. In doing further review, we identified four hundred and nineteen as potentially important in the VA, valid and feasible to measure. Then we grouped similar recommendations you will find because we reviewed so many different kinds that there is a lot of repetition. Then we prioritized those for prioritization to our Internal Advisory Council, which I made up of VHA leaders and partners. The Advisory Council prioritized thirty-two of those that are going now for rapid evidence synthesis and opportunity estimates.

That is Aim 1 we are right in the process of Aim 1 and Aim 2 we are actually going to construct the measures. Those first three bullets say – we are going to take those de-intensification recommendations that are then rated as valid by the expert panel and we are going to generate measures in the VHA and we are going to examine the reliability of them, variation and de-intensification rate across sites for those. And also predictors of de-intensification both organizational and patient level.

Then what I am really excited about in Aim 3 is now we are going to say – we have these measures, we have certain indications, how are we going to implement them into practice. We are going to conduct collaborative decision-making sessions with patients and providers to identify both gaps in understanding and potential barriers to deploying the de-intensification measures. Then to develop consensus strategies for addressing patient provider motivational and organizational challenges to implementing de-intensification. Our product we hope will then be to synthesize all those findings into practical intervention strategies, which hopefully we and others can test in the future.

Again, we do feel that this area of de-intensification is particularly tricky because it does often deal with things that we have been doing for a long time and sometimes stopping things that are routine is the most difficult. But we do feel it is really important that we find ways to de-intensify treatments when they are no longer useful or potentially harmful and that we do so in a manner that is respectful to the patient/physician relationship; promote shared decision-making and doing so we think is really the next frontier for improving care quality.

That is it, thank you.

Dr. Paul Barnett: Great, that is wonderful Eve. We are going to in a little bit try to get some feedback from our students. Think through this idea, I think that your discussion of how you are setting priorities for a de-implementation is a very interesting one. It is a little bit of a black box to us. I want to focus the rest of the talk here, the rest of the seminar here on how do we prioritize among all of the different things that are possible to de-implement. You alluded to it being tricky to stop stuff, first get some thoughts about if you are presented with these hypothetical alternatives, which would you de-implement first. We are going to run a poll here after I explain what these alternatives are. The idea is would you choose to de-implement first a harmful service; one that is ineffective and more widely used; or low value service that is quite widely used.

The scenarios here are a harmful service, it is causing the loss of a hundred QALY’s in the healthcare system, but the costs are relatively modest at twenty million dollars. The ineffective service is not benefitting anyone and costs a hundred million dollars. The low value service is actually benefitting people, it is generating a thousand QALY’s but it is very expensive, very widely used. You do the math; you see this is about six hundred thousand dollars for QALY so way out of the range of what is regarded as sufficient value. Heidi if we can run the polls and ask people to choose between scenario one, two and three these are just completely hypothetical – harmful; ineffective or low value service.

Moderator: Okay the poll is up on people’s screen, we will give everyone a few minutes to respond and we will close this out and go through the results. Responses are coming in but we will give everyone just a few more moments. There was no great way to put write this poll question, I am sorry, it is a little disjointed between the screen that Paul was talking to and this one. Hopefully you are able to gather from the last one what we were doing here. It looks like we have slowed down so I am going to close this out. What we are seeing is – seventy percent the first option; twenty-two percent the second option; and nine percent the third option. Thank you everyone.

Dr. Paul Barnett: That is very interesting. I would not have expected such a strong result. If we were to take a shear cost effectiveness analysis perspective and we re-invested the savings in healthcare at the rate of two hundred thousand dollars per QALY, we would actually prefer number three, strongly over number two and then number one. Because if you just look at the gain in quality adjusted life years, is much greater by addressing that six hundred thousand dollars and reusing it somewhere else in the healthcare system.

This is a little bit arbitrary, the numbers are totally arbitrary. I think the issue is just to illustrate the difference between cost savings and what is happening with the QALY’s benefit. By the way, if you use a different number, a hundred thousand dollars for quality and two hundred thousand dollars for quality whatever for how you would use the savings, the rankings are unaffected by this.

This raises a question about how to set priorities. There is an interesting paper by Elshaug and about proposing a program for Australia on how to identify and prioritize things that we might want to de-implement. It goes beyond just the shear efficiency, which I showed in that prior slide. Elshaug says that we should be using the same criteria that have been developed for technology assessment. So not just cost and quality just the life years, the strength of the evidence and some concern about equity. I think this is why the poll came out the way it is concerned about not doing harm. Also the availability is there a cost effective alternative for this disease; how do we affect patient subgroups; what is the disease burden in the affected patients.

I think these are all important questions. I would like to open the discussion just to ask David and Eve, David how did you arrive working on this particular area. Why did you decide to make that a priority?

Dr. David Au: I think when we were making these decisions we were trying to think about things that you could implement which are the most common things. At the same time we were trying to balance things, decisions around de-implementation. The issue around de-implementation I think also has to do with a little bit of politics of life. One of the concerns frankly we had was removing services that might have some marginal value to some individual patients or providers. Then be in a position where we were being perceived as over regulating or intruding into very individual decisions.

So we were very concerned about the so-called Debt Panel or anything along that line. But in our discussions with numerous groups, it sounds very similar to Eve’s environmental scans; we found that practices that were potentially harmful were ripe targets for de-implementation because they think we inherently have this idea of doing no harm. If we are doing harm that we actually do not realize we are doing it and it is more acceptable to the providers. That is where we started in the larger QUERI Programs to focus on actions that we know actually will lead to harm but are being done widely within the organization. It was both harm as well as the prevalence of the practice.

Dr. Paul Barnett: That is great; I will just mention that someone is added to the discussion. I encourage people who are on the seminar to please use the Question feature to ask questions or even post comments. This comment is - the poll question grossly simplifies the situation by assuming the same effort and same success rates in de-implementing a twenty million dollar program, number one versus a six hundred million dollar program, number three which is probably not true. I think that is a point well taken, we have not factored in the cost of the implementation and that certainly affects our judgment about where to start.

Eve you mentioned that it was tricky to stop doing things that we are used to doing. I wonder if you want to elaborate a little bit on that.

Dr. Eve Kerr: Sure. I agree strongly with some of David’s comments about where do you start. I think if you had worded the question differently, what would you de-implement first. I think that when people are thinking about that question, they are weighing not only QALY’s but what can they accomplish given today’s culture. I think that that is part of the as David said, everybody can get around doing no harm. That is why I think we gravitate to those things first. One of the things that we were really interested in is how many recommendations are there out there, strong recommendations about stopping care. A lot of times the recommendations that we found were not explicitly about stopping care, but it was about lack of benefits for continuing care or providing care, which you then of course can reverse code if you are held to stopping care. Even though we found a lot of recommendations not all of them were explicit about stopping care.

I think we have a lot of work to do in this kind of prioritization space because there is not that much literature about harm and about unnecessary care in terms of strong recommendations and things that are well assessed. That is part of the tricky part about prioritization I think.

Dr. Paul Barnett: For my part I think the reason we were attracted to the low back pain imaging question is, well partly everybody says there is all this imaging going on, we are finding stuff that we were never even looking for. The strength of the evidence is quite strong about the low back pain guidelines; the imaging is not yielding any useful actionable information. There is this possibility of downstream effects that we want to look at. In the case of the low back pain, the question is – there is probably not any harm, but we are not certain that there is no harm. There is certainly not any benefit there, there is some modest cost and that is why we got it. The main priority was the strength of the evidence that was the main thing that drove our decision to work in the area.

Any other questions from our audience? Not yet. David one of the things I listed was from the Dartmouth Group from Kerry Polo’s work was the antipsychotics in dementia was a big ticket item for Medicare and I know that is one of your QUERI, I believe that is one of your QUERI projects, right.

Dr. David Au: That is correct. I mean we know, that is a project being led out of Bedford Group by Tina Harmon. We know that antipsychotics are very commonly used within nursing home settings really for behavior change. We know that there are alternative therapies that are available, behavioral based or otherwise that are actually much safer.

I think that does raise one of the issues we thought a fair amount of the idea that you are stopping something have the kind of behavioral economics where we field a lot of stopping therapy. So what all of our interventions actually have an alternate that is safer to use. In the CPC study we are recommending LABA/LAMA combinations, which are safer. In the antipsychotic therapy trial we are recommending behavioral based interventions that have been shown to be equally effective. The offset of course that some of those things actually take more time, more energy. It is pretty easy to write a prescription and then have it happen. But we know that it is common, we know that it increases mortality.

The other point I want to make briefly is that as go and have discussions with BRUTE [ph], not necessarily just within VA but outside VA about things that you might consider to be the low value practice in general and I will use opioids as an example. I think people are a little more sensitive to the question of value and are now thinking about value in terms of rationing care as well. We are also very sensitive to that concept even though we are really trying to promote practices that we think are best and have a consensus that our best practices I think outside of VA and possibly even within VA there are still perceptions that we are trying to ration care which is really not the emphasis of what we are trying to do at all.

Dr. Paul Barnett: There are some additional questions and Heidi I am having trouble getting the screen to expand so I can read them. I was wondering if you could read them.

Moderator: Okay certainly I will stop from the…

Dr. David Au: I sent an email out earlier….

Moderator: The first question that I have here something that Eve mentioned. How does the shared decision model work when a physician is resistant to discontinuing an unnecessary or harmful service?

Dr. Eve Kerr: I am happy to take a stab at that David may have comments as well. I think for shared decision-making or collaborative decision-making obviously the discussion has to be with the physician and the patient. That being said I do not think any of these programs can or will make a physician not prescribe something or stop prescribing something. As a physician for example strongly believes in inhaled steroids, whether or not the patient has asthma reactive airway disease or if they strongly believe in very tight glucose control for older patients or similarly, they are not going to stop those medications. These efforts really have to be multi-pronged in order to get both clinicians to buy into what you are trying to do. Also inform patients on their own because sometimes patients can bring these things up – hey I am taking a medication, I may not need or maybe harmful. Then the physicians need the tools to have those conversations. I do not think there is going to be a single solution necessarily, but one of the things that we found and we are trying to tackle in other projects as well, is getting patients much more involved in these discussions. Because all our efforts so far have focused on clinicians and we need to engage patients more as well.

Dr. Paul Barnett: That is the next question – how do you get patients to accept treatment changes they might worry about adverse events?

Dr. David Au: I will take a stab at that. In my discussions with patients, I think some of this data on inhaled corticosteroids use is fairly recent and I just have a candid conversation with them. I tell them that there are competing risks functionally to therapy and that we may have some safer alternatives. Most of the time when you frame it in the context of having of an alternate, safer that is at least equally effective just not more effective than patients are generally quite willing to accept those recommendations. I think for the primary care providers at least for us, we are very sensitive to the perception as well as the reality of having another pulmonologist come in and intervene on a patient that they actually do not know. We did this through medical record review and so we are quite \_\_\_\_\_ [00:48:41] by the fact that this is based on medical record review and that the ultimate point of decision is really left to the primary care provider in discussion with the patient. That is why we time it the way we do.

The other thing that I will say is that what we try to do is we try to make this an intellectual exercise for the primary care provider to think through their patient a little bit in terms of it but not really have to increase their workload in the sense of having to fill out all these additional orders. We try to take that and if they agree with our recommendations then they can sign off and if they do not then all they have to do is discontinue it. So we try to make it easy as well as be sensitive to the demands of primary care.

Dr. Paul Barnett: So David your comment really is a great segue for the next question. It says that at dissemination and implementation conference we heard that most primary care physicians cannot keep up with all the evidence about what works and what does not. Dr. Au’s project includes facilitated chart review recommendations, any chance that can be automated?

Dr. David Au: Actually we are working on that. It turns out that it is more complicated than we even though because there are a lot of penalties in the record that are certainly not apparent through ICD-9 coding or ICD-10 coding. The issues around do they have asthma is really an important issue to us because we do not want to discontinue someone who might have the possibility of asthma or who may getting inhaled corticosteroids for other indications. That said, we are actually thinking about all things, machine language learning through some of these notes to see whether or not we can actually at least call the herd of potential notes to a more tenable number.

I think also it is how you approach it; I do not think the pulmonologists would have the bandwidth to take everything on all at once. But they probably would have the bandwidth to take on a certain number per week over time. One of the questions we are asking is once we intervene on a patient the number of times will primary care providers actually intervene upon their own accord or will they still require a little bit of prompting from us. I do think it is reasonable if you added incremental amount of work to the pulmonologist life it will be incremental. I mean that is one of our approaches is to see whether or not we can do this so that we affect the larger population over a broader period of time not necessarily trying to target everything all at once.

Dr. Paul Barnett: I have maybe a small point to contribute on this with regard to the lumbar spine pain project. We were looking for evidence of whether the imaging was appropriate or not and we did it two ways, one which was an automated way just using standard diagnosis codes to identify people who had criteria that would suggest a scan was appropriate. Then we did the same thing with chart review, the chart review is very small number of cases. It took us less time to do the hundred thousand by an automated method; it took us less time to do a hundred thousand when it took us to do a hundred and fifty at our site by a chart review. Just the order of magnitude of why automation might be a good idea. So our priors were that once we opened up the chart we would actually find a lot of these that were regarded as inappropriate by the automated method that actually turned out to be appropriate when we got into the nuances of what was in the chart.

The converse was true, we found higher rates of inappropriateness by chart review because when we delved into it we really found out that those problems that were identified had been resolved or they were not really an indication for a scan after all. That was quite surprising to us that the chart review was actually revealing higher rates of inappropriateness. If you have any comment on this Eve, about your work.

Dr. Eve Kerr: I mean that is a little surprising I guess. The work that we are planning to do now we are going to be constructing measures and collecting medical record information about that but also doing some validation for certain measures with the medical record reviews. We are going to be using EHR data, administrative, VISTA data but also doing some medical record reviews. It will be interesting to see the different kinds of measures if we have similar results to you. The other issue I think that David was commenting on with respect to saturation, a primary care provider and how much being a primary care provider that resonates with me. But also how much needs to be done to in the IT environment with reminders and templates and everything else and how much can be done in other ways. I mean this is one reason to get patients more involved in their care. We have been experimenting with behavioral economics approaches that are much more light touch using pre-commitment devices and other things. I think this is why we want to do the provider and patient deliberative sessions about what is going to work. Because I think we have to think beyond just the medical record to get these things done because one more reminder that is not necessarily the right way to do it all the time for everything. I like David’s suggestion that maybe some of these things can extinguish after a while because we see that the provider has just taken this off and then therefore the reminder goes away. That is going to take smarter systems than we have right now but that is certainly something that is possible for the future.

Dr. Paul Barnett: This is something with the imaging study, we are mindful that a lot of the standard response to excess imaging order is to put in new order sets that require the clinician to jump through some hoops to get there imaging orders processed. The consensus in the literature is that these efforts have not accomplished much just on the margin two or three percent of the orders are affected. One of our primary care leaders hear at Palo Also said to me – you need to give people alternatives, give them something else to do instead. Do not tell them do not order this, tell them to do this. That is what are at a little bit of trying to figure out exactly what it is. Is it that it is hard to get a patients referred to physical therapy? Is it the only place to send them to the orthopedics clinic and they need to get a scan? We do not really understand exactly what is wrong with the process and we should not have a major reaction to what our response should be. Certainly the knee jerk reaction should not be to add the burdens of the primary care physicians most of whom are doing just fine.

Any insights about the distribution among providers? David I see you have medical center level data. We did not find such a strong effect at the medical center level but we did find it at the provider’s office.

Dr. David Au: I think any time you look at practice variation you see kind of that general distribution. I was surprised, I think a lot on that one particular curve shown by medical center I think a lot of that is being driven by the fact that there are some facilities that actually do not obtain spirometer at all. We know from many previous studies that when you do not use spirometry you get the diagnosis wrong about fifty percent of the time. There is a strong, those numbers I think are being driven strongly by the use of spirometry in general. It is not surprising also for me because unlike many other disease like diabetes or heart failure or hypertension there is really no driving organizational force within the organization to actually improve delivery of care or to even raise it as an issue. It does not really surprise me to be quite frank so we are relaying on just the usual medical community standards to help.

I can tell you although those numbers look that way in VA I can tell you that practice at the University of Washington at least is exactly the same, as the practice in the VA in general. I do not think it is a VA only issue.

Dr. Paul Barnett: There is one last comment; we are at the top of the hour. Someone said – for clinicians when you take oath “Do no harm” no amount of dollar value is justifiable if we are harming people. That might be the possible reason for the strongly tool in the poll result.

Any last comments David or Eve before we turn it back to Heidi and she is going to do another little poll to see how people give any feedback on the presentation.

Dr. David Au: Nope, thank you.

Dr. Eve Kerr: No thank you it was great thank you Paul.

Dr. Paul Barnett: Thank you so much for your contributions, very interesting work you are doing, good to learn about it and we will look for some published results here. Heidi thank you so much for helping us with technology here and coordinating this in three different parts of the country.

Moderator: I am always happy to help out with that, not a problem. For our presenters I also want to repeat, Paul thank you so much for taking the time to present here at today’s session, we really do appreciate it.

To the audience I am going to close the meeting out in just a moment. When I do you will be prompted with a feedback form, please take a few moments to fill that out, we really do read through all of your feedback.

I want to thank everyone for joining us for today’s HSR&D cyberseminar and we look forward to seeing you at a future session. Thank you.

Dr. David Au: Thank you.

Dr. Paul Barnett: Thank you Eve, Dave and Heidi.

Moderator: Thank you.

Dr. David Au: Bye now.