TAKING ACTION ON OVERUSE

Overuse Case Scenarios: Summary of Findings

Engaging providers, patients and teams to reduce an overused, low-value service can be challenging. Compared to traditional quality improvement initiatives, it has been described as "swimming upstream.". Over the past three years MacColl/RWJF has developed and refined a model to help organizations tackle this issue, culminating in a 'capstone' meeting of participants and thought leaders in the field of reducing overuse to discuss lessons learned and plan for next steps. To further expand our understanding of HOW to address overuse within a health care setting, we conducted a workshop exercise around three "use case scenarios" submitted by meeting participants.

The workshop was conducted in two phases. In the first phase, participants were asked to plan and prepare for launching an overuse initiative by answering a series of questions:

1) Why are you addressing this specific service and what is the evidence for patient harm?
2) Does your data confirm that this is a commonly overused service?
3) Do others perceive it to be a problem and if so why or why not?
4) What are the important drivers of overuse and how will you address them?
5) How much support exists from leadership and who are the important stakeholders you will need to engage?

In the second phase, participants were asked to identify and sequence specific activities they could undertake to address this specific overused clinical service.

Here we describe the results of this workshop, discuss common themes that emerged across the three scenarios, and make a set of recommendations for those who plan to address an overused, low-value service.

Scenario 1: <u>Screening for Anemia in Children</u> offered by Eli Sprecher M.D., Assistant Director for Population Health & Value Based Care

> "In our clinic at Boston Children's Primary Care at Longwood, virtually all 2, 3, and 4 year-old-children are tested for iron deficiency anemia during their well-child visits. While children with iron deficiency anemia may be at risk for poorer developmental outcomes, data is lacking that addressing anemia improves neurodevelopment, especially for older children who did not have evidence of iron deficiency at 9-12 months of age. The American Academy of Pediatrics recommends screening for anemia between the ages of 9 to 12 months with additional screening at older ages only for children at increased risk (e.g., those with feeding problems, poor growth, or inadequate nutrition). My goal would be to decrease the rates of children who have had a normal hemoglobin and MCV at infancy (9-12 months) who have repeat labs at subsequent well child care visits."

<u>Planning and Preparation</u>:

An important early step is to gain leadership support for the initiative. In this case that would include the Chief Quality Officer, the Clinical Director and the Parent Advisory Group. In addition, the Evidence-based Guideline Implementation group, composed of two physician leaders, should visibly endorse the effort. To

build the case for change they should examine and present blood testing data from the last ten years to find the proportion of children with normal results at 1 year that also were normal in subsequent years. They also could build on their earlier success with deimplementation, such as an internal effort to decrease Albuterol and steroid administration for bronchiolitis. They need to make sure data systems are in place to track the conduct and impact of the initiative.

Implementation Plan & Activities:

Start by defining a subgroup (e.g. 4 year-olds) for initial reduction in testing and expand beyond that group over time. The topic should be a regular feature of the monthly QI docket, and they should determine what other venues are appropriate to discuss the project while it is underway. The project team could build knowledge, awareness and engagement in the project by:

- Emphasizing how this work aligns with recommendations from the US Preventive Services Task Force and/or other organizations;
- Organizing provider meetings and resident orientations that emphasize the cultural value of avoiding harm and not doing unnecessary testing;
- Sharing local stories that describe the potential consequences of unnecessary treatment as a result of over-testing;
- Communicating to providers about the lack of high-quality of evidence that a finding of iron deficiency leads to poor neurological outcomes;
- Creating scripts for providers to guide discussions with patients about anemia testing and nutrition;
- Establishing a consensus goal of replacing anemia screening with better nutritional screens and counseling;
- Building toward a common goal for providers, residents, clinical team members and finally patients for all to understand the harms of overuse; and
- Institutionalizing data capture and analysis for reporting and continue to improve use of monthly run charts and periodic reports on screening frequencies.

Continuation and Maintenance

Activities to continue and maintain the project include:

- Investigate resources and decisions needed to change order sets to remove CBC for ages 2, 3, and 4;
- Remove language from templates that indicate the need for such testing; and
- Remember to celebrate success and use it to build to the next improvement cycle.

Scenario 2: <u>Advanced Imaging for Lung Cancer</u> offered by Reshma Gupta, M.D., Medical Director for Quality and Value, UCLA Health

> "Advanced imaging (CT and MRI) is useful among patients with lung cancer for establishing the stage of the cancer at diagnosis, and for monitoring it progression and/or response to treatment. At UCLA, we noticed overuse in repeat (i.e. same modality and same body part) advanced imaging in short proximity (i.e. 2-4 weeks) among patients with a diagnosis of lung cancer. Preliminary investigation found no clear clinical or radiologic reason for this repeat testing. Our goal is to reduce overuse of CT and MRI among our lung cancer patients."

<u>Planning and Preparation</u>:

In this use case, there are multiple stakeholders. These include primary care (which has many levels of leadership that need to be engaged); overall organizational leadership/C suite; radiology; patients; oncologists; operations; informatics; care coordinators; payers and purchasers; utilization review; emergency department medical staff. To achieve shared prioritization of reducing unnecessary advanced imaging for people with lung cancer, all these stakeholders will need to be actively engaged.

Potential barriers to planning and engagement include incentives, as the organization works on a RVU model where more ordering is tied to higher reimbursement; ongoing issues with initiative fatigue; physician burnout; and a culture of blame where physicians may not feel safe admitting mistakes.

Potential facilitators to getting buy-in from stakeholders might include the prospect of an eased workflow; financial incentives for quality rather than volume; and a growing culture of a learning community within the organization and medical groups; and connection to the strategic priorities of the organization.

At this stage, a more in-depth analysis is needed to fully understand the scope of this type of overuse in this organization. The team plans to conduct a root cause analysis to try and more fully document the extent of overuse of advanced imaging in lung cancer patients and where and why the problem is occurring. Possible causes could include lack of documentation in the EHR, lack of communication between specialties, physician desire to reassure patients, or individual providers or specialties tending to order, or other unknown causes. Further, they plan to develop a measure of overuse of advanced imaging in lung cancer and build dashboards so they can track progress over time and conduct real-time monitoring.

The team noted that largest the investment of time and resource would be during the planning period, to gather data, engage patients and other stakeholders, and to develop the measures and dashboards. The project will take place under the auspices of the organization's quality improvement program, which has dedicated resources and a process for determining allocation of those resources to various initiatives.

In this case, it is likely that the replacement test would in many cases be reassurance to the patient.

The team plans to use patient stories at all stakeholder engagement sessions and also within the project team. These will include, at the start, of real stories of patient harm from overuse of imaging, including patient time, anxiety and financial burden.

<u>Implementation Plan & Activities</u>:

Since the team had not yet completed their planning and engagement work, they were not in an active implementation phase. However, the team brainstormed a variety of ideas that might be possible once an implementation time was ready. These include:

- Establishing a dedicated project team to this improvement effort
- Use "prizes" and tie them into existing financial incentive programs
- Present to primary care and specialty groups, sharing both data and stories of overuse of lung cancer imaging
- Empower staff to initiate conversations or identify overuse in the clinical setting.
- Building in time to office visit to conduct shared decision making about the potential overuse of imaging
- Advocate and educate on the use of empathic communication styles for clinician-patient conversations.
- Ongoing positive reinforcement celebrating progress in reducing overuse
- Share and use patient stories over the course of the project, not just in the initial stakeholder engagement phase. Hopefully the stories would change as the project progresses to include stories of avoided unnecessary imaging. This was thought to have the potential to also keep the project team engaged throughout the project.

Scenario 3: <u>Overtreatment of Diabetes</u> offered by Jeff Kullgren, MD, VA Ann Arbor Healthcare System and University of Michigan Medical School

> "A prime example of overtreatment is using blood glucose-lowering medications to achieve a hemoglobin A1c (HbA1c) < 7% among older Veterans with type 2 diabetes mellitus (T2DM), for whom such tight glycemic control has few benefits and can lead to serious harms from hypoglycemia such as confusion and falls. Despite efforts like the VA Hypoglycemia Safety Initiative (HSI) and *Choosing Wisely®* which aim to raise awareness of overtreatment of T2DM among older adults, nearly 1 in 5 older Veterans with T2DM are overtreated and very few of these at-risk patients have their T2DM medications de-intensified. Our goal is to reduce the use of insulin and oral hypoglycemic medications among older veterans with an HbA1c < 7%."

<u>Planning and Preparation:</u>

The evidence of harm from overuse of hypoglycemic medications in elderly patients is well established, both within published literature and within the VA. In addition, VA data clearly demonstrate that hypoglycemic medications are often overused among older Veterans and are rarely de-intensified.

Much of the discussion was spent on understanding the organizational priorities in the VA, understanding roles and responsibilities of individuals within primary care teams who could be engaged in overuse reduction efforts, and drivers of overuse in the VA. Issues surrounding access to care are currently high priorities for VA leadership, which may limit attention and resources for efforts to reduce overuse.

There is some potential within Patient Aligned Care Teams (PACT), the VA's medical home model, and for others on the team besides the prescriber, such as nurse care managers and pharmacists, to play an important role in addressing this issue.

However, there are no point-of-care tools to support de-prescribing, no clear accountability for who is responsible, and insufficient time for patient conversations during visits. Finally, with regards to drivers of overuse, primary care providers both within and outside of VA are typically subject to quality measures that target underuse but not overuse.

<u>Implementation Plan & Activities</u>:

A central theme of planned activities was the need to involve patients, especially a patient who experienced a hypoglycemic event, in planning activities to better engage providers and teams in reducing the use of hypoglycemic medications. At the very least, eliciting patient stories of harm from within each specific VA Center are needed. A specific activity was to present these stories at monthly medical staff meetings and morning huddles within PACT teams.

The group struggled with activities to engage leadership when the current highest priority is access. Meeting with academic endocrinologists who support care of patients with diabetes to solicit their support and ideas for how they can support efforts was an early first step.

Providers need patient-facing educational materials to help patients understand the need to decrease their medications and reassure them that tight diabetes control may not be best for them. Involving patients in developing these materials and pre-testing them with patients was a specific activity.

Dedicating analyst/programmer support to pro-actively identify patients who meet criteria for de-intensification and sharing those lists of patients with PACT teams at regular intervals was discussed. Finally, meeting with individual PACT teams and identifying who within the team can work together to address this area was discussed.

Summary

- Start with “low-hanging fruit” where consensus is easiest to achieve among providers and where overuse is common.
- Confirm and present evidence about the prevalence of overuse of the clinical test or service within the health care setting.
- A great deal of work is needed in early phases of the project: engaging leadership, obtaining buy-in from clinical experts within the organization, confirming that the overused service is commonly overused, etc.
- Explicitly align the work with strategic priorities of the organization is important for both engaging leadership, but also providers and members of the care team.
- Engage patients in the work early and share patient stores of harm, or potential harm to engage both leadership and providers. In addition, conversations about the potential for patient harm are important throughout all phases of the project, not just initially.
- Don’t leave providers empty-handed, even if replacement service is scripts about how to have conversations with patients, accompanied by patient-facing resources and educational material, replacement services are important.