AGENDA

State and Public School Life and Health Insurance Board
Quality of Care Sub-Committee
Meeting

August 15, 2017

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

I. *Call to Order*.....*Margo Bushmaier, Chair*

II. *Approval of May 9, 2017 & June 13, 2017 Minutes*.....*Margo Bushmaier, Chair*

III. *ACHI Updates*.....*Mike Motley, Izzy Whittington, ACHI*

IV. *Wellness Option*..... *Dr. John Vinson*

V. *Director's Report*..... *Chris Howlett, EBD Executive Director*

Upcoming Meetings

September 11, 2017, October 10, 2017, November 14, 2017

NOTE: All material for this meeting will be available by electronic means only ASE-PSE BOARD@dfa.arkansas.gov. Please silence your cell phones. Keep your personal conversations to a minimum.

State and Public School Life and Health Insurance Board Quality of Care Sub-Committee
Minutes
August 15, 2017

Date | *time* 8/15/2017 1:00 PM | *Meeting called to order by* Margo Bushmiaer, Chair

Attendance

Members Present	Members Absent
Michelle Murtha – Vice-Chair	Frazier Edwards
Pam Brown (Proxy – Nikki Wallace)	Dr. Andrew Kumpuris
Zinnia Clanton	Dr. Joseph Thompson
Dr. Zohoori (Proxy – Dr. Bala)	
Don Hollingsworth	
Robert Boyd	
Margo Bushmiaer - Chair	
Dr. John Vinson	

Chris Howlett, EBD Executive Director, Employee Benefits Division

Others Present:
Geri Bemberg, Dwight Davis, UAMS; Gerren Crain, Eric Gallo, Matt Turner, Shalada Toles, Shanta Jones, Terri Freeman, Gretchen Baggett, EBD; Kristi Jackson, ComPsych; Marc Watts, ASEA; Karyn Langley, Qual Choice; Ronda Walthall, Wayne Whitley, ARDOT, Mike Motley, Elizabeth Whittington, Randy Loggins, Arlo Kahn, ACHI; Jessica Akins, Health Advantage; Nikki Wallace, AHA

Approval of Minutes by: Michelle Murtha, Vice-Chair

Bushmiaer asked for a motion to approve the May 9, 2017 minutes. Murtha motioned for approval of the minutes. Wallace seconded. All were in favor.
Motion Approved.

Bushmiaer then asked for a motion to approve the June 13, 2017 minutes. Murtha motioned for approval of the minutes. Wallace seconded. All were in favor.
Motion Approved.

ACHI Updates by: Mike Motley, Elizabeth Whittington, and Arlo Kahn, ACHI

Whittington reported on projects ACHI have been working on which include; setting up framework around Choosing Wisely, specifically the recommendation for low back imaging which, after doing analyses of the EBD population, was found that low back pain or back pain more broadly was a significant contributor to some spend within the population. Also provided updates on the 2016 Health Risk Assessment data, and a proposal that has come out of the wellness meeting.

Whittington reported on the concept of overuse. The institute of medicine defines overuse as the provision of health care services for which potential harms outweigh potential benefits. A study sited that estimated that between 10%-30% of all healthcare spending Is related to healthcare services overuse. Management of low back pain accounts for greater than $86 billion of unnecessary expenditures annually of the $300 billion.

Kahn reported, don't do imaging for low back pain within the first six weeks, unless red flags are present. Red flags include, but are not limited to:

- Severe or progressive neurological deficits or
- When serious underlying conditions such as osteomyelitis (infection in a bone) are suspected
- Trauma

Imaging of the lower spine before six weeks does not improve outcomes, but does increase costs and increases the likelihood of surgery. Low back pain can be addressed without imaging, instead with pain management and/or physical therapy as first courses of action.

Tests like CT scans expose patients to radiation and can lead to additional downstream testing (including unnecessary radiation exposure), which can also lead to unnecessary spinal interventions, such as surgery for a bulging disk that could have been managed through physical therapy.

Kahn noted that patients who received an MRI during the first month of diagnosis were eight times more likely to have surgery. It is a five-fold increase in medical expenses.

Boyd questioned if Choosing Wisely is an educational process to the participants, or is it something that the plan itself does in terms of limiting imaging?

Kahn replied saying that it is an educational effort, these recommendations serve as guidelines for those that do the various 450 services. It gives the doctors more assurance when they decide to wait on imaging because they are backed up by experts in the field.

Motley communicated about the methodology of the analysis. ACHI used national measure (HEDIS) to determine the rate of potentially wasteful lower back imaging within ASE/PSE members.

• Members (aged 18-64) with primary diagnosis of uncomplicated low back pain with an imaging event within first 4 weeks following diagnosis.

• Excluded members with "red flags" (history of diagnosis of cancer, neurologic impairment, trauma, etc.)

• 4,741 members were diagnosed with uncomplicated lower back pain within a one-year period. (October 2014—September 2015)

• 1,257 of those members had an imaging event within the first 4 weeks following diagnosis.

• 27% of members with uncomplicated low back pain received potentially wasteful imaging.

Cost Analysis

Using the same methodology as Washington state, Health Care Blue Book was used to determine cost estimates for each imaging type. "Fair Price" estimate comes from actual claims data which is defined as the price that consumers can reasonably expect a medical service to cost. Cost estimate of potentially wasteful imaging for this population for one year:

–X-Ray of Spine: $85 x 1,119 X-rays = $95,115

–CT Scan of Spine: $390 x 37 CTs = $14,430

–MRI of Spine: $642 x 288 MRIs = $184,896

–Total = $294,441

Howlett inquired if the numbers were unique to each set of scans or x-rays or if is there some bleed over where someone may have had an x-ray and also an MRI?

Motley replied that he believes them to be mutually exclusive based on the codes. Individuals could have had more than one test but each one would have been counted in its respective group.

Murtha inquired if ACHI had looked at any double studies (with or without contrast)?

Motley responded, yes, that was on the MRI. They used the without contrast number ($642) for the information given to differentiate the volume in the claims.

Murtha asked about the CT. They do a CT of the spine and do both with and without, or do a reconstruction?

Motley replied there were a few different codes within each of them. We can share those with you. For this purpose, we added them all up.

Murtha stated she is interested in knowing how many people are subject to more radiation than need be, because of with and without contrast and it is also costly for the plan.

Motley responded that ACHI can definitely provide that information.

Vinson inquired on how many MRI's have been done in EBD for the year.

Motley responded that we don't have that information right now. It would require a pretty broad look at the information. We could pull total volume.

Murtha asked Dr. Kahn if the Choosing Wisely recommends doing an MRI over CT?

Kahn responded that they do. It is phrased when MRI is available don't do CT on this image.

Provider Analysis

Motley stated on the provider side, there were 469 providers included in the analysis, 176 providers had at least six patients with uncomplicated low back pain within that year.

Howlett inquired if there was a graph where ACHI has charted for contrast what the numbers would look like if we adopted the Choosing Wisely, and how that graph would shift?

Motley replies that we would have to consider some other interventions that have been done. It would be kind of difficult to know what individual behavior would occur.

Vinson inquired if there are benchmarks such as what is 90% of excellence in the nation or, what you would strive to be if you were as good as the best state or the best plan?

Motley responded that we would have to come back to you on that.

Boyd asked if we have something for the board to adopt?

Howlett stated that there are things that have come up through this committee and to the board that this would be an additional item. ACHI are presenting plan numbers for us to be considered as well

as potential pros and cons for consideration that we could potentially implement, but that charge still lies with this committee as to how that would look from a recommendation stand point.

Vinson would like to clarify if all the MRI's and CT's were approved through the PA process?

Howlett responded that if they didn't meet the PA criteria it would be denied. ACHI can come back with their data and can come back through the vendor. We can go back and try to calculate that for you.

Howlett inquired if we ever did a cross check between the different providers and the range of cost based on provider offering service?

Motley stated that it has been a while, but we can look back into it and pull the information.

Opportunities for Improvement

•Contact providers with high rate of potentially wasteful imaging to discuss practice patterns and clinical guidelines.

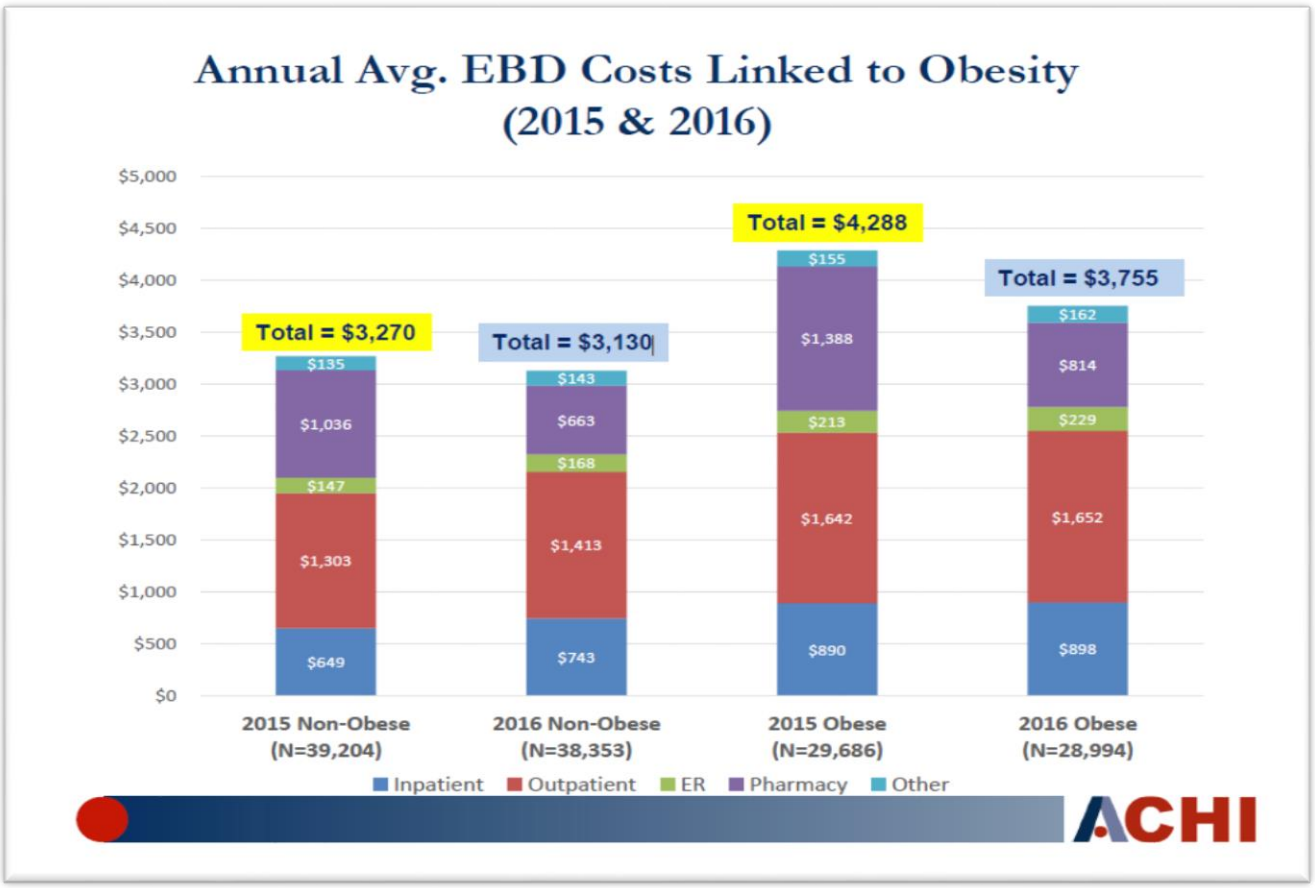
• Disseminate further patient education materials about potential harms/risks of over-testing.

• Tier co-payments based on value to increase patient accountability on those demanding unnecessary imaging services.

• Utilize prior authorization controls for outpatient MRI/CT scans that limit coverage of lower back imaging within 6 weeks of diagnosis.

• Apply global payment arrangements that reduce incentives for physicians to over-test.

2016 Health Risk Assessment Analysis



•Smoking rate from 2015 HRA: 9.4%

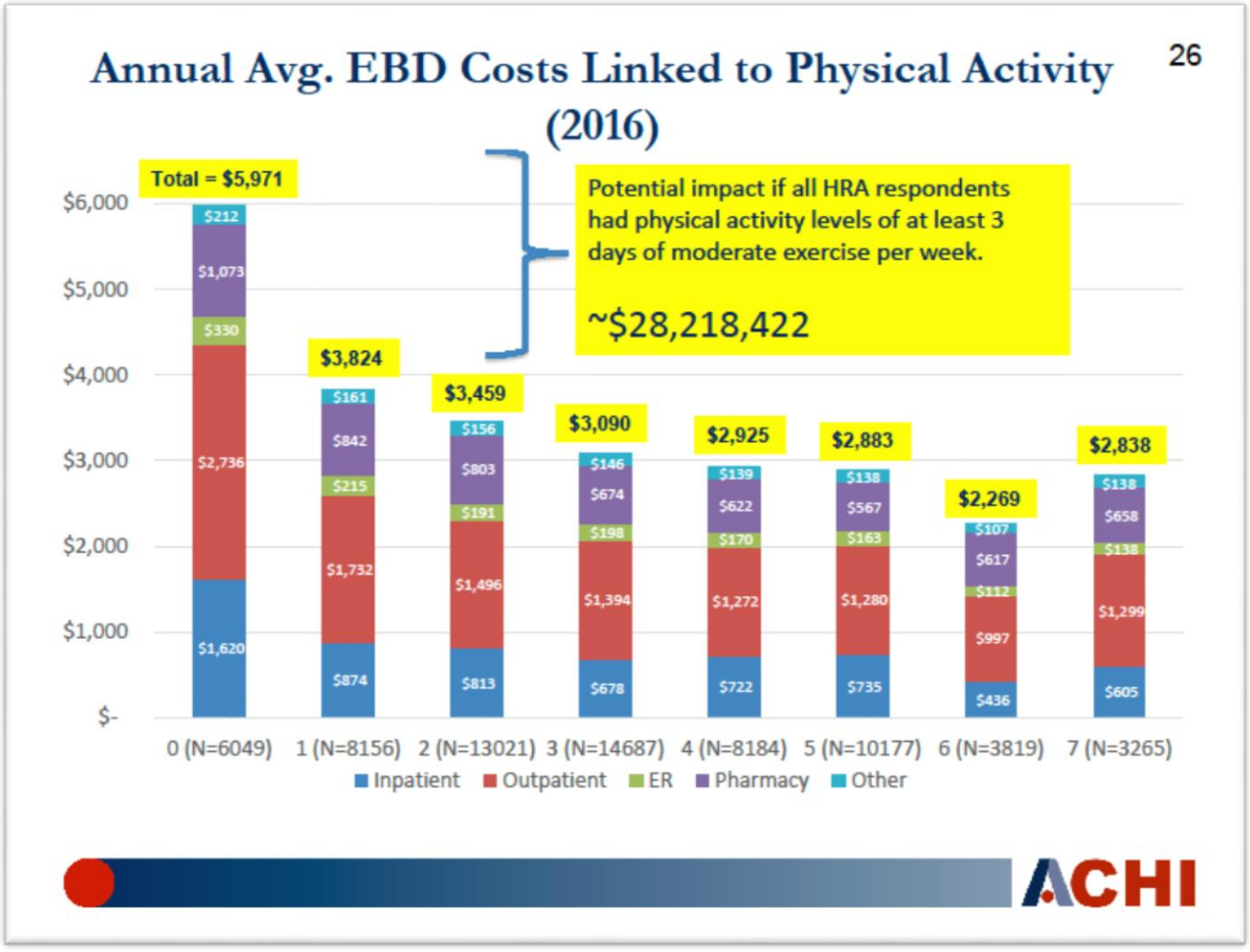
•Smoking rate from 2016 HRA: 8.9%

•Arkansas Current Smoker Statistics (2015):

- 24.9% of adults (18+) current smoke cigarettes
- Ranked 49th among the states

Boyd inquired if this is self-reported?

Whittington responded that yes it is.



Whittington discussed, the next steps are to continue further exploration of the 2016 HRA analysis and look at some of these risk factors broken out by age group particularly for the physical activity component. We also have some take-ways related to the lower back imaging. Also, maybe looking into new recommendations to look at for this group as far as Choosing Wisely.

Wellness Option by: Dr. John Vinson

Recommendation from Wellness Subcommittee:

1. To be eligible for a premium incentive amount (to be determined by the Board), member's will be required to complete the following:

    a. Undergo annual biometric screening and completion of health risk assessment (HRA):

i. Modify the HRA questionnaire to ensure that information captured in the biometric screening is not duplicated in the HRA
ii. Revise the HRA to include educational components to alert members about EBD resources/covered benefits

b. All components of biometric screening must be completed by the member in order to receive the premium incentive, inclusive of:
    i. Annual nicotine screening, with requirement that member be nicotine free to be eligible for incentive (with exemptions for members who are actively enrolled in EBD's tobacco cessation program)
    ii. Annual height/weight measure to derive BMI
    iii. Annual blood pressure measurement
    iv. Collection of cholesterol and blood glucose in 2018 for 2019 incentive credit

c. Flu shot requirement; HRA would include a self-attestation that the member intends to receive a flu shot or has already received a flu shot for the current year flu season

2. Based on outcomes and data from initial year of implementation, the Board will consider, for 2019 activities and 2020 incentive determination, required enrollment in tobacco cessation for members who test positive for nicotine, and enrollment in weight management or obesity counseling for members whose BMI is over 40.

*The goal of the Wellness Committee is for primary members and spouses both to be required to complete activities for incentives; however, the Board will make the final determination

Bushmiaer inquired if the plan will still require the annual physical?

Vinson responded that it does not require a visit to the physician to be eligible, however we hope that all patients that need to go see their physicians based on their results would see their physician. We hope that the HRA and screenings would be done and drive patients to their physicians for appropriate management of conditions around wellness.

Howlett provided some additional information. The plan dealing with wellness spends on average about $83-$86 million a year. In that process we typically receive under 10% of the information from the employee or physician back to the plan. We need data back to the plan to engage the membership to address and treat conditions and engage the population. We can't modify for plan year 2018 so what is in place this year will go through next year. So the ultimate goal for us today and through the fall is to be able to pull together and make a recommendation to the Board. Operationally we need to have something in place to operationalize by the end of October. There are some operational complexities with the flu shot implementation that we still have to discuss. Dealing with the nicotine specifically we are shooting around the $20 range. We should be able to positively operationalize this in 2019 instead of 2020. Administration of the biometric screening as well as the physical has not been operationalized. There are a few different options to look at and help meet the requirement. Dr. Bemberg explained that from the current products that are offered on the pharmacy side as well as what we are trying to operationalize here that there shouldn't be any disconnect.

Dr. Bala stated that this is a great first step due to having unreliable information in the past.

Vinson clarified that the wellness committee on the flu shot requirement did take a position that it would only allow for medical exemptions. If it's philosophical or religious, it would not count towards the incentive.

Howlett stated on the tobacco cessation piece that if they enroll in the program then they will be covered while they are working through that addiction.

Bushmiaer asked if the committee was ready to make a decision or if more information was needed?

Hollingsworth made a motion to approve the recommendations from the Wellness Sub-committee with the one modification.

Boyd Seconded.

Motion Approved.

Director's Report by: Chris Howlett, EBD Executive Director

Howlett stated that if anything is tweaked or adjusted from the wellness recommendations, some of the wellness things may come back to this committee and the Benefits Sub-Committee for a stamp of approval.

The emerging therapies statute went into effect on 8/1/17. With that, the Quality of Care and Benefits Sub-Committee will be receiving presentations the remainder of this year for any potential emerging therapy for this plan to be considerate of. That's originally dealing with regenerative medicine or stem cell based treatments. The statute reads that between now and the end of the year any of the approval of those therapies by the full board (the recommendation will come from this committee and/or the Benefits Sub-Committee combined). If any are approved, we have from January 1 through the end of June of next year to operationalize those into a pilot program and take effect on 7/1/18.

Murtha motioned to adjourn. Vinson seconded. All were in favor.

Meeting adjourned.

EBD Quality of Care Subcommittee Updates

Mike Motley, MPH
Assistant Health Policy Director

Elizabeth Whittington, MPA
Policy Analyst

Arlo Kahn, MD
Senior Policy Advisor

ACHI
Arkansas Center for Health Improvement

August 2017

Objectives for Presentation:

- **To review background on health care services overuse and impacts on lower back pain management**
- **To assess preliminary analytic outputs related to lower back imaging and Choosing Wisely recommendation**
- **To review 2016 health risk assessment data and discuss next steps for analysis**

Cost Impact of Overuse

- **Health care services overuse contributes to between 10 and 30 percent of all total health care spending ($300 billion annually)**

- **Management of low back pain accounts for >$86 billion of unnecessary expenditures annually**

Source: Shrank, W., Keyser, D., & Delitto, A., "Professional Athletes and Back Surgery: A Teachable Moment on Overuse in Health Care?" *Health Affairs Blog*, August 1, 2017.

Top 20 ASE/PSE Diagnoses: Potential to Impact Through Intervention 2016

Clinical Classification Category	Total Plan Paid	Unique Patients
Spondylosis; intervertebral disc disorders; other back problems	$14,694,262	16,614
Medical examination/evaluation	$14,383,565	75,200
Maintenance chemotherapy; radiotherapy	$12,005,758	731
Osteoarthritis	$9,859,450	7,026
Other screening for suspected conditions (not mental disorders or infectious disease)	$8,581,436	40,557
Coronary atherosclerosis and other heart disease	$8,278,458	6,724
Cancer of breast	$8,137,618	2,156
Other connective tissue disease	$5,624,911	16,647
Cardiac dysrhythmias	$5,590,183	6,877
Chronic kidney disease	$5,550,786	1,758
Residual codes; unclassified	$5,539,904	13,476
Septicemia (except in labor)	$5,486,604	656
Leukemia	$5,312,409	257
Immunizations and screening for infectious disease	$5,275,877	39,770
Complication of device; implant or graft	$5,208,682	1,268
Nonspecific chest pain	$5,148,580	8,580
Other nervous system disorders	$4,746,518	7,712
Diabetes mellitus with complications	$4,176,209	5,912
Other ear and sense organ disorders	$4,130,922	6,037

Choosing Wisely Recommendation/Defining Overuse

Choosing Wisely Recommendation-Nonspecific Low Back Pain (AAFP)

- **Don't do imaging for low back pain within the first six weeks, unless red flags are present**

- **Red flags include, but are not limited to:**
  - **Severe or progressive neurological deficits**
  - **When serious underlying conditions such as osteomyelitis (infection in a bone) are suspected**
  - **Trauma**

Source: American Academy of Family Physicians, Choosing Wisely Recommendation-Lower Back Imaging.

Choosing Wisely Recommendations- Nonspecific Low Back Pain

- **Rationale: Imaging of the lower spine before six weeks does not improve outcomes, but does increase costs and increases the likelihood of surgery**

- **Low back pain can be addressed without imaging through pain management and/or physical therapy as first courses of action**

Source: Redd, S. Institute for Clinical and Economic Review Baseline Report-Choosing Wisely Recommendation Analysis: Prioritizing Opportunities for Reducing Inappropriate Care-Imaging for Nonspecific Low Back Pain.

Background on Health Care Testing

- **Tests can be done for many reasons, including screening, diagnosing a disorder, determining the severity of a disorder, or monitoring response to treatment**

- **Every test carries some level of risk, including potential injury during a test, need for further testing, or unnecessary treatment**

- **Physicians must weigh risks of testing against usefulness of information**

Source: Merck Manual Consumer Version, "Common Medical Tests." Retrieved from http://www.merckmanuals.com/home/appendixes/common-medical-tests/common-medical-tests

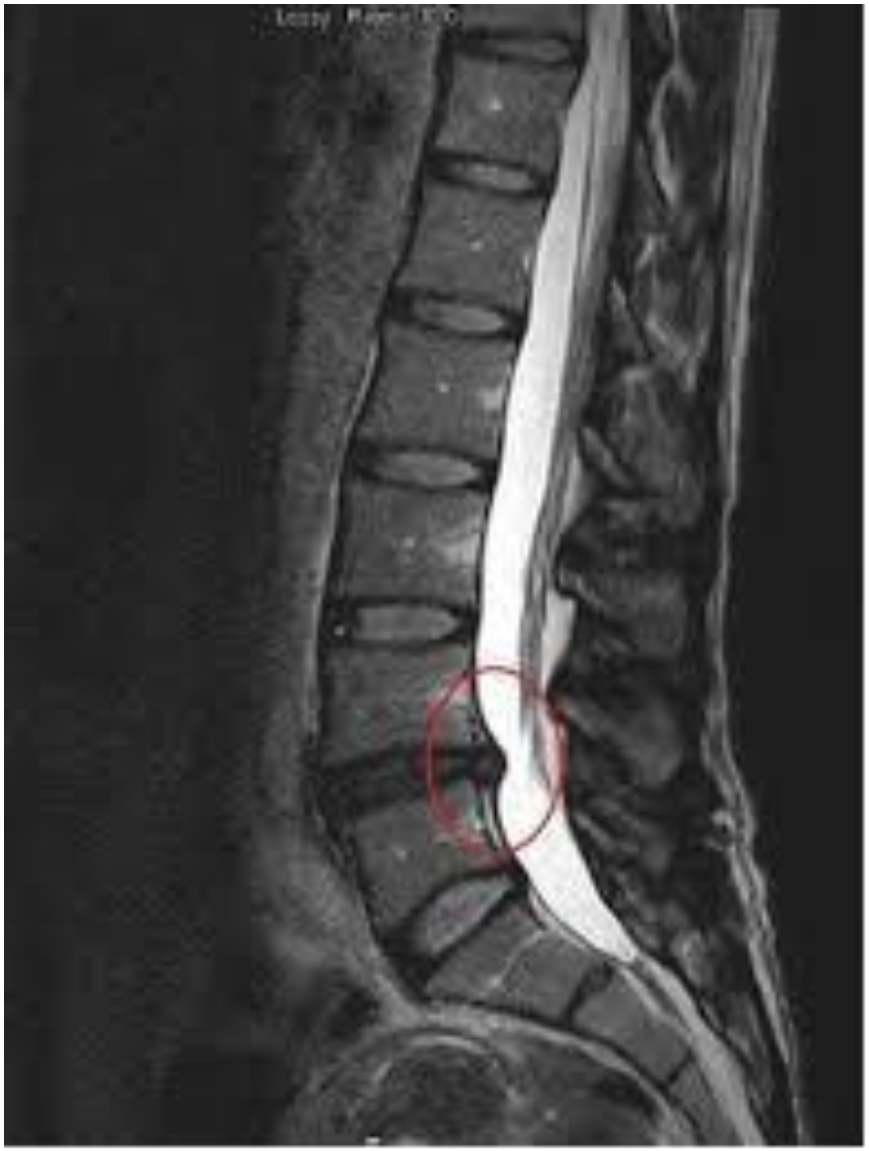
Risks of Unnecessary Imaging

- **When patients receive unnecessary imaging, they are at an increased exposure for harms**
- **Tests like CT scans expose patients to radiation and can lead to additional downstream testing (including unnecessary radiation exposure)**
- **Can lead to unnecessary spinal interventions, such as surgery for a bulging disk that could have been managed through physical therapy**

Source: University of Michigan Health System, "Why Doctors Order Scans for Low Back Pain When They Probably Won't Help." October 28, 2016.

Spine Image Example

Spine MRI Example



Downstream Risks of Overuse

- **As noted in a recent *Health Affairs* article, Tiger Woods is still not playing golf after four back surgeries**

Source: Shrank, W., Keyser, D., & Delitto, A., "Professional Athletes and Back Surgery: A Teachable Moment on Overuse in Health Care?" *Health Affairs Blog*, August 1, 2017.

Overuse Consequences

- **Patients who received an MRI during the first month of diagnosis were eight times more likely to have surgery**
- **Five-fold increase in medical expenses**
- **No observed gains in recovery time as compared to patients undergoing no imaging**

Source: Webster, B., & Cifuentes, M., "Relationship of Early Magnetic Resonance Imaging for Work-Related Acute Low Back Pain with Disability and Medical Utilization Outcomes." *Journal of Occupational and Environmental Medicine*. 52(9):900-907, September 2010.

ASE/PSE Lower Back Imaging Analysis

Methodology

- **National measure (HEDIS) to determine rate of potentially wasteful lower back imaging within ASE/PSE members**
- **Members (aged 18-64) with primary diagnosis of uncomplicated low back pain with an imaging event within first 4 weeks following diagnosis**
- **Excluded members with “red flags” (history of diagnosis of cancer, neurologic impairment, trauma, etc.)**

Utilization Analysis

- **4,741 members were diagnosed with uncomplicated lower back pain within a one year period (October 2014—September 2015)**

- **1,257 of those members had an imaging event within the first 4 weeks following diagnosis**

- **27% of members with uncomplicated low back pain received potentially wasteful imaging**

Cost Analysis

- **Using the same methodology as Washington state, Health Care Blue Book was used to determine cost estimates for each imaging type**

- **"Fair Price" estimate comes from actual claims data**
  - **Defined as the price that consumers can reasonably expect a medical service to cost**

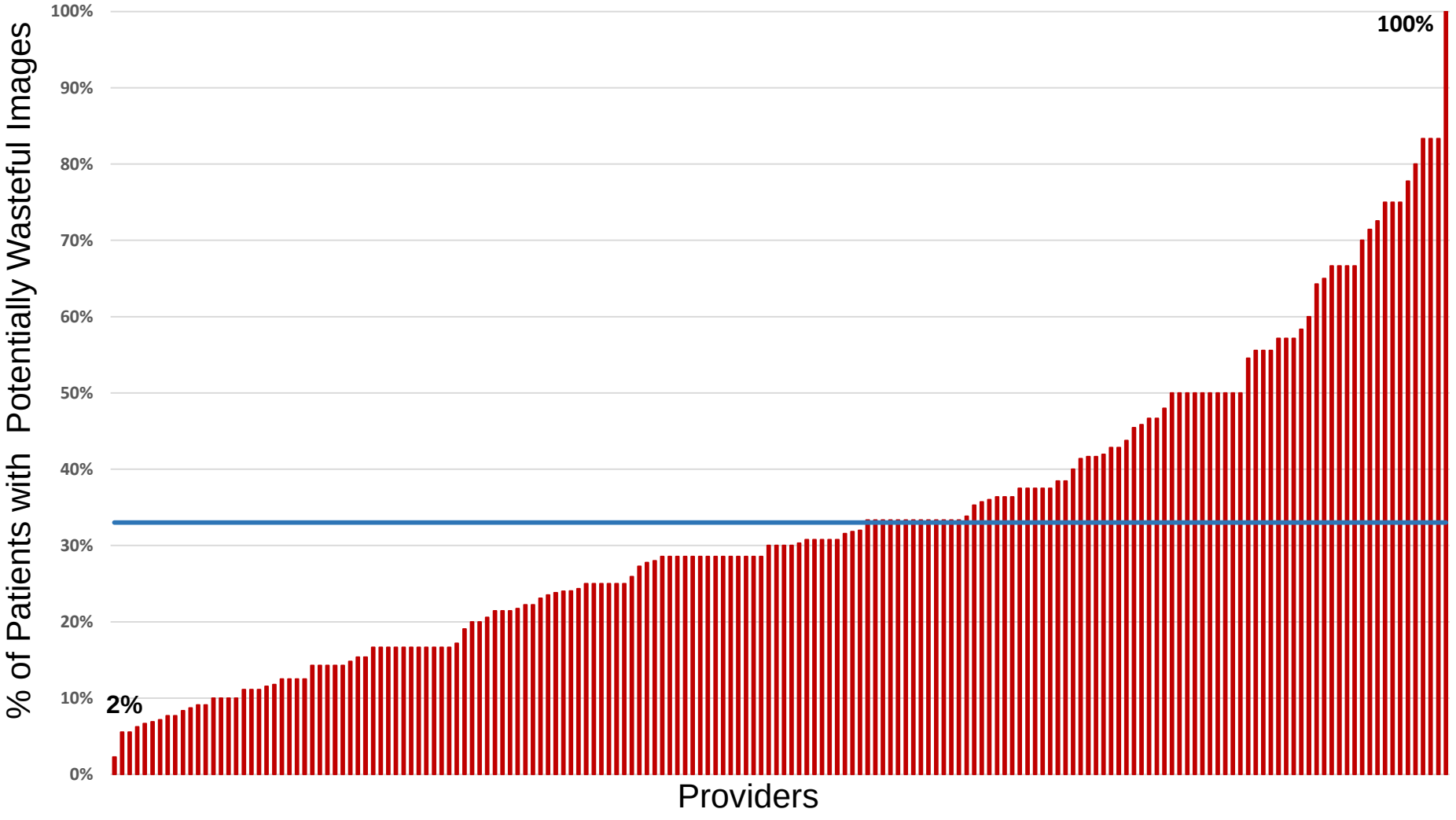
Cost Analysis

- **Cost estimate of potentially wasteful imaging for this population for one year:**
  - **X-Ray of Spine: $85 x 1,119 X-rays = $95,115**
  - **CT Scan of Spine: $390 x 37 CTs = $14,430**
  - **MRI of Spine: $642 x 288 MRIs = $184,896**
  - **Total = $294,441**

Provider Analysis

- **469 providers were included in this analysis (individuals or groups)**
- **176 providers had at least 6 patients with uncomplicated low back pain within that year**
- **Following slide shows distribution of patients with potentially wasteful imaging**

Potentially Wasteful Images by Providers (2014-2015)



Provider	# of Patients with Uncomplicated Low Back Pain	# of Patients with Potentially Wasteful Images	% of Patients with Potentially Wasteful Images
Provider A	125	40	32%
Provider B	104	25	24%
Provider C	99	22	22%
Provider D	68	14	21%
Provider E	65	22	34%
Provider F	64	11	17%
Provider G	60	28	47%
Provider H	56	12	21%
Provider I	51	37	73%
Provider J	48	16	34%
Provider K	44	1	2%
Provider L	39	12	31%
Provider M	37	9	24%

Opportunities for Improvement

- **Contact providers with high rate of potentially wasteful imaging to discuss practice patterns and clinical guidelines**

- **Disseminate further patient education materials about potential harms/risks of over-testing**

- **Tier co-payments based on value to increase patient accountability on those demanding unnecessary imaging services**

Source: Redd, S. ICER Baseline Report-Choosing Wisely Recommendation Analysis: Prioritizing Opportunities for Reducing Inappropriate Care-Imaging for Nonspecific Low Back Pain.

Opportunities for Improvement

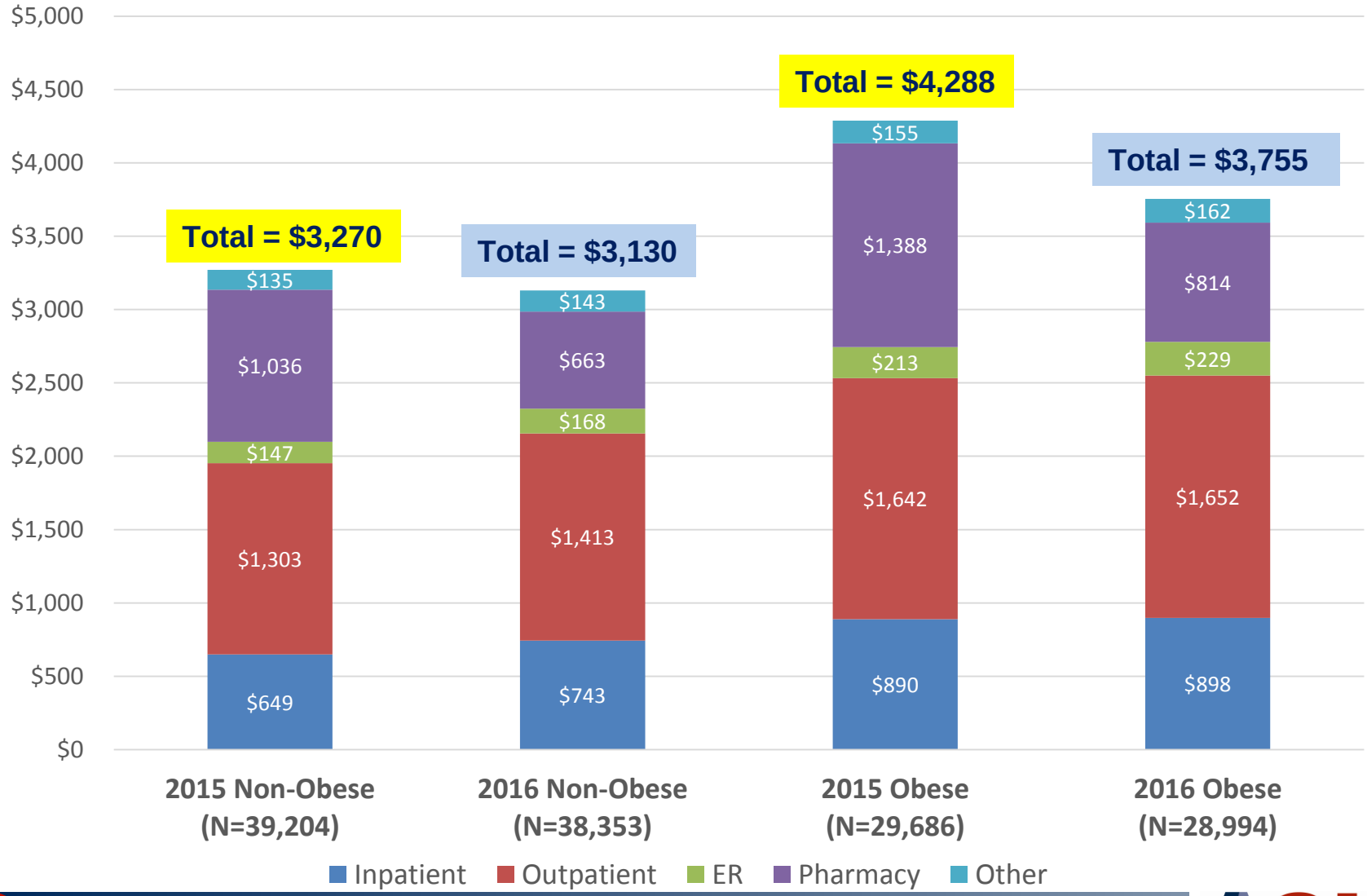
- **Utilize prior authorization controls for outpatient MRI/CT scans that limit coverage of lower back imaging within 6 weeks of diagnosis**

- **Apply global payment arrangements that reduce incentives for physicians to over-test**

Source: Redd, S. ICER Baseline Report-Choosing Wisely Recommendation Analysis: Prioritizing Opportunities for Reducing Inappropriate Care-Imaging for Nonspecific Low Back Pain.

2016 Health Risk Assessment (HRA) Analysis

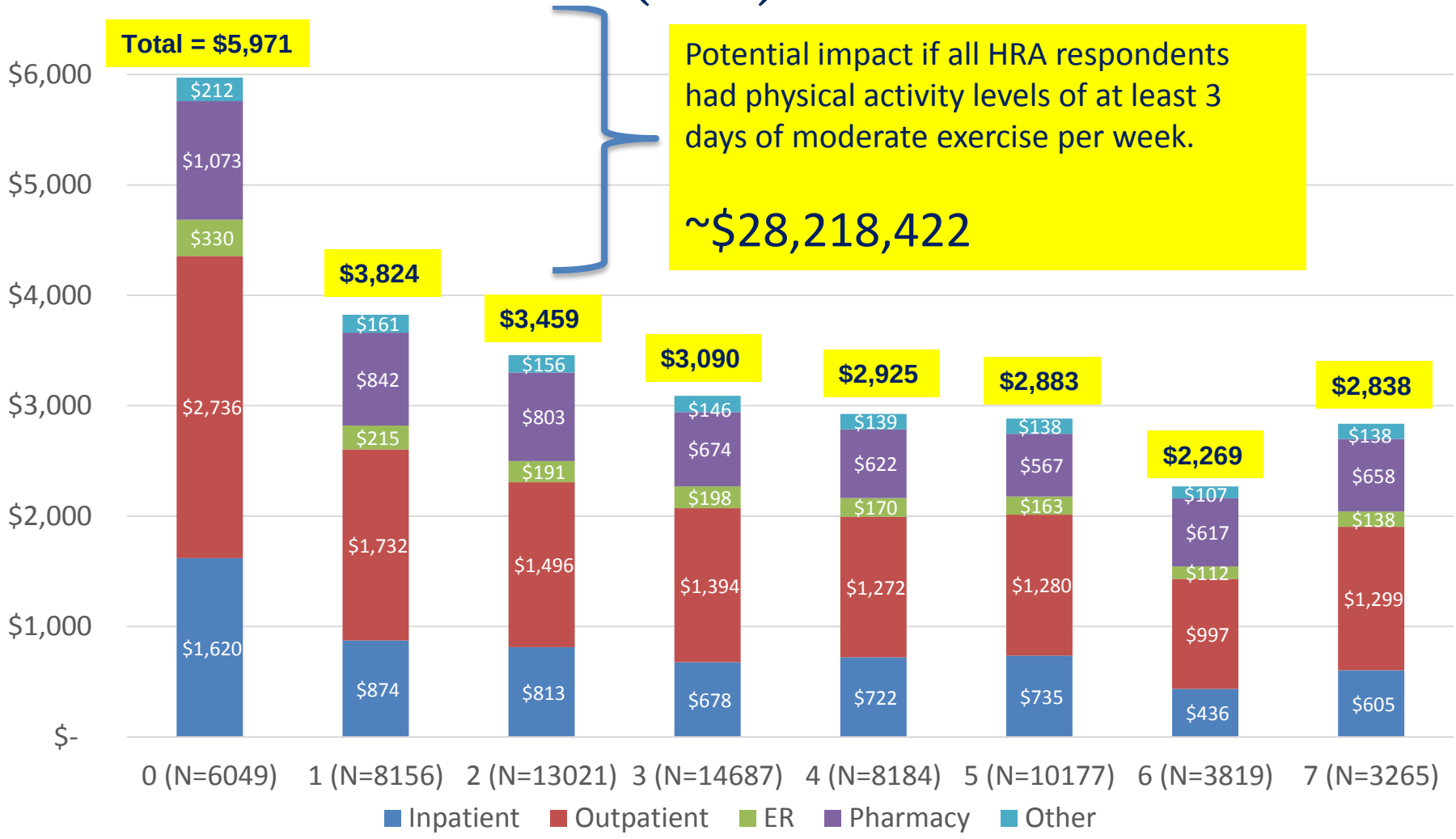
Annual Avg. EBD Costs Linked to Obesity (2015 & 2016)



EBD Rates of Smoking from HRA Data

- **Smoking rate from 2015 HRA: 9.4%**
- **Smoking rate from 2016 HRA: 8.9%**
- **Arkansas Current Smoker Statistics (2015):**
  - **–24.9% of adults (18+) current smoke cigarettes**
  - **–Ranked 49th among the states**

Annual Avg. EBD Costs Linked to Physical Activity (2016)



ACHI Next Steps

- **Further exploration of 2016 HRA analysis**

- **Select next Choosing Wisely recommendation for analysis based on EBD claims spend**

Health Affairs Blog

Professional Athletes And Back Surgery: A Teachable Moment On Overuse In Health Care?

William Shrank, Donna Keyser, and Anthony Delitto

August 1, 2017

After four back surgeries, Tiger Woods still is not back on the golf course. Steve Kerr, the coach of the Golden State Warriors, missed most of last season and even much of this year's playoffs with headaches and recurrent pain after back surgery. These two high-profile patients, and their very public surgery results, should encourage us all to ask whether "more is always better" in health care.

The Institute of Medicine National Roundtable on Health Care Quality coined the term "overuse" to describe the provision of health care services for which potential harms outweigh potential benefits. Overuse in health care comes in many forms, including unnecessary or risky diagnostic and screening tests, use of therapeutic procedures that are not needed or introduce unnecessary risk, and the inappropriate use of medications. Unnecessary expenditures for health care overuse in the United States are estimated to range from 10 percent to 30 percent of total health care spending or, at a minimum, $300 billion a year. Although no medical specialty is immune from practices that lead to overuse, opportunities to improve quality of care for low back pain, while also reducing costs, are particularly apparent.

The management of low back pain accounts for more than $86 billion in health-related expenditures annually, rivaling cancer and heart disease as the most expensive diagnosis treated in the United States. Since the early 1990s, overuse of high-cost procedures for low back pain has contributed to a steady rise in these costs but has done little to improve outcomes. This overuse directly contradicts longstanding clinical practice guidelines that promote the use of non-opioid analgesics, avoidance of imaging tests, use of physical therapy-based exercises, and primary care for patients

with low back pain. Early and aggressive exercise-based interventions during the acute phase of pain more effectively return patients to previous levels of activity than other treatments, and physical therapy early after an episode of acute pain lowers the risk of subsequent medical procedures more than therapy at later times. Nonetheless, during the 12-year period between 1999 and 2010, there was a 50.8 percent increase in use of narcotics, a 56.9 percent increase in the use of advanced imaging, and a 106.0 percent increase in the number of referrals to other physicians, some presumably for surgery.

Given the persistently low rate of guideline adherence (50 percent at best), complaints abound regarding the failure of the US health care system to effectively treat low back pain with too much money wasted on non-beneficial and non-proven treatments. Diagnostic imaging is an especially significant driver of back pain-related costs because it can lead to additional tests, follow up, and referrals that result in invasive procedures with limited to no benefit. In fact, the rise of outpatient surgeries for low back pain coincides with the rise in diagnostic imaging. While everyone agrees that, in certain instances, back surgery is absolutely necessary and can be lifesaving, rapidly rising rates of surgical back procedures, wide variations in their use, and high rates of reoperation and complications all point to its overuse. Not even the advent of new spine surgery technology, such as spinal fusion surgery or disc replacement surgery, has reduced rates of repeat surgery. Most recently, some of the largest increases in back pain-related expenditures have been for the newer prescription narcotics, despite their many potential side effects and ongoing controversy around their use for chronic pain.

Overuse is caused by both supply and demand. Many patients are dissatisfied with “wait and see” approaches; they want a clear diagnosis of the cause of their pain, information and instructions, and immediate pain relief. Some overtly avoid physical activity during an acute episode of back pain because they are afraid of aggravating their condition. These fears are only made worse when providers use diagnoses that “medicalize” the condition and further discourage patient activation (that is, a patient’s engagement in his or her own health care). In fact, certain changes in the spine, such as intervertebral disc degeneration, along with many other imaging findings, are common among aging patients and not necessarily correlated with low back pain symptoms.

Physician reimbursement methods and member insurance benefits can also incentivize overuse. For providers, retrospective payment for services may encourage the provision of more tests and procedures than is actually necessary to achieve better patient outcomes and upcoding for the maximum expected return per-patient visit, instead of adherence to evidence-based practices. In the physical therapy environment, interventions and procedures that have little or no support in the clinical literature typically have higher reimbursement rates than interventions that have been shown to be beneficial. Patients may also be incentivized to seek any medical service for their back pain, instead of considering those options that might be more effective or cost efficient. Many publicly insured patients are shielded from paying (cost sharing) for back pain treatment, and those who are privately insured have per-visit copayment responsibilities that fail to support interest and engagement in optimal physical therapy treatment.

Should the experience of Tiger Woods and Steve Kerr help others make decisions about surgery? We imagine that they both received care from the most highly esteemed professionals, that cost was not an obstacle, and that their care was attentive. Presumably, their results did not meet expectations discussed with their providers. Steve Kerr has sought to share his experience with others and advised during an April 23 press conference, “I can tell you if you’re listening out there, if you have a back problem, stay away from surgery. I can say that from the bottom of my heart. Rehab, rehab, rehab. Don’t let anybody get in there.” Recent media reports indicate that Tiger Woods not only continues to experience back pain that is impeding his play, but additional consequences include side effects associated with opiate pain relievers.

We hope these high-profile experiences will promote more dialogue about the risks of overuse. Overuse in health care is pervasive, costly, and causes harm to patients, yet it has been remarkably difficult to get the medical profession, health care industry, and general public to acknowledge the

scope of the problem or take steps to reduce it. Sometimes, an influential story can be more impactful in changing public opinion than a mound of evidence. We should take this opportunity to discuss these important lessons about the risks of surgery, the downside of too much care, and the fact that spending more on health care does not necessarily deliver the best outcomes.

ASSOCIATED TOPICS: COSTS AND SPENDING, PAYMENT POLICY, QUALITY
TAGS: CHRONIC PAIN

7/19/2017

Recommendation from Wellness Subcommittee:

1. To be eligible for a premium incentive amount (to be determined by the Board), member's will be required to complete the following:

    a. Undergo annual biometric screening and completion of health risk assessment (HRA):
        i. Modify the HRA questionnaire to ensure that information captured in the biometric screening is not duplicated in the HRA
        ii. Revise the HRA to include educational components to alert members about EBD resources/covered benefits

    b. All components of biometric screening must be completed by the member in order to receive the premium incentive, inclusive of:
        i. Annual nicotine screening, with requirement that member be nicotine free to be eligible for incentive (with exemptions for members who are actively enrolled in EBD's tobacco cessation program)
        ii. Annual height/weight measure to derive BMI
        iii. Annual blood pressure measurement
        iv. Collection of cholesterol and blood glucose in 2018 for 2019 incentive credit

    c. Flu shot requirement; HRA would include a self-attestation that the member intends to receive a flu shot or has already received a flu shot for the current year flu season

2. Based on outcomes and data from initial year of implementation, the Board will consider, for 2019 activities and 2020 incentive determination, required enrollment in tobacco cessation for members who test positive for nicotine, and enrollment in weight management or obesity counseling for members whose BMI is over 40

*The goal of the Wellness Committee is for primary members and spouses both to be required to complete activities for incentives; however the Board will make the final determination