

Resource Stewardship – Primary Care

Introduction to 2015 Dashboard



The Golden Mean

Aristotle's concept of the Golden Mean is "the ideal balance between two extremes, one of excess and the other of deficiency". The Golden Mean isn't the average between the two extremes, but the desirable middle that depends on the situation. For example, Aristotle wrote that courage is a virtue, but if taken to excess it would manifest as recklessness, and, in deficiency, cowardice.

In health care, we are constantly striving to find the golden mean. Every day we make tough choices about what tests and treatments our patients need. Finding the ideal balance of providing the right amount of care—not too little and not too much—is an ongoing challenge for all clinicians.

The purpose of this report is to help you understand how your use of new specialty visits, referrals, chem panels, and imaging compare with other providers in your clinic. The variation we see in use of these services can only be explained by clinician preferences for providing more or less care, or the "propensity to act". That variation drives unnecessary utilization and higher costs. The closer we get to achieving the right balance, the more our patients and Group Health benefit.

How to use the dashboard

We ask you to review these data and discuss them with your colleagues. Most of us are likely to see comparison data that make us uncomfortable. Our hope is that we will support and learn from each other to understand why we make the choices we do. In many ways, the conversation is more important than the data. Facing tough questions and wrestling with doing what's right is what makes up the fabric of our culture. We are each other's greatest resource.

What's new in this edition?

Chem panels replace lab tests in previous reports. Ordering only the needed individual tests is better for patient care than routinely ordering panels. Panels will often show abnormal results that are clinically insignificant, prompting unnecessary follow up.

Glargine prescribing patterns. The vast majority of patients with Type 2 diabetes who need basal insulin do just as well on NPH as on glargine. Glargine insulin is more than 10 times more expensive than NPH insulin, yet randomized trials comparing NPH and glargine show they have almost identical outcomes. Glargine has only been shown to be more effective in a few uncommon situations, such as patients with Type 1 diabetes or insulin deficient Type 2 diabetes who need both basal insulin and pre-meal rapid-acting insulin. In most cases, use of Glargine does not result in better outcomes, only a higher financial burden on our patients.

"Early" pap tests for cervical cancer screening, and antibiotic use for URI. We have achieved significant reductions in overuse in these areas and continue to improve. Under our Choosing Wisely® grant, we are collaborating with Swedish, WSMA and the WHA to help others in the state make similar improvements.

We welcome your feedback and suggestions. Please send them to:

Medical Director, Group Practice Division

Medical Director, Quality

Resource Stewardship

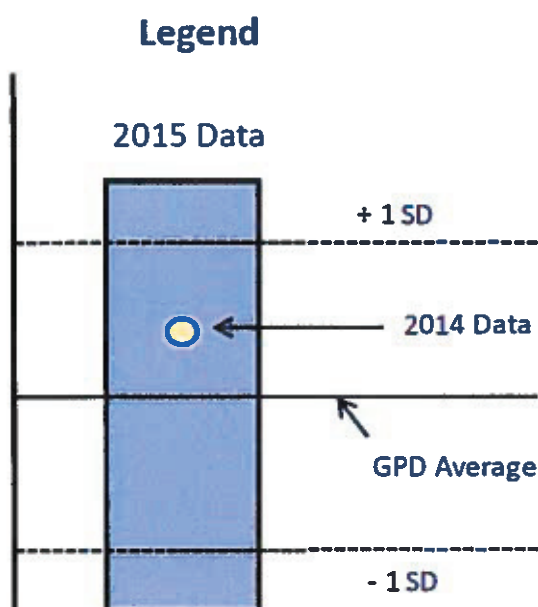
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GroupHealth.

Utilization and cost measures are adjusted imperfectly - utilization rates and costs use a denominator of DxCG adjusted panel size (per 1000 DxCG adjusted patients). We recognize that this does not capture all of the complexity between patients, but does present a good faith adjustment. We can never risk adjust perfectly.

In most clinics and measures, the variation in utilization and cost is great enough that it cannot be accounted for by differences in clinical circumstances or patients preferences. A significant factor in the variation is our differing practice patterns/styles. These data are presented to help prompt reflection and conversations on cost effective practice - we are each other's greatest resource.



- DxCG is a tool for risk adjustment. For Resource Stewardship, we use a different version of DxCG than you generally see. The DxCG score used for panel size adjustment is a prospective score, which predicts future usage. The version of DxCG we use for Resource Stewardship is a concurrent score, which maps better to current utilization. As a result, the value you see for DxCG will likely be different than DxCG values you may have seen associated with your panel in other contexts.
- DxCG scores have a "floor" value of 1, so low scores (young healthy people) do not distort the data (we do not divide by a very low number, amplifying utilization). We applied this methodology to the 2014 and 2015 data.
- Note that variation in DxCG only accounts for about 40% of the variation in utilization and cost in a population.
- Data are not presented for clinicians with panel sizes smaller than 500.
- The clinic average is used for the referral comparison, not GPD average.
- If you don't have 2014 data reported, the following are the most likely reasons:
 - You are a new provider to GH as of 2015
 - Your 2014 panel size was less than 500

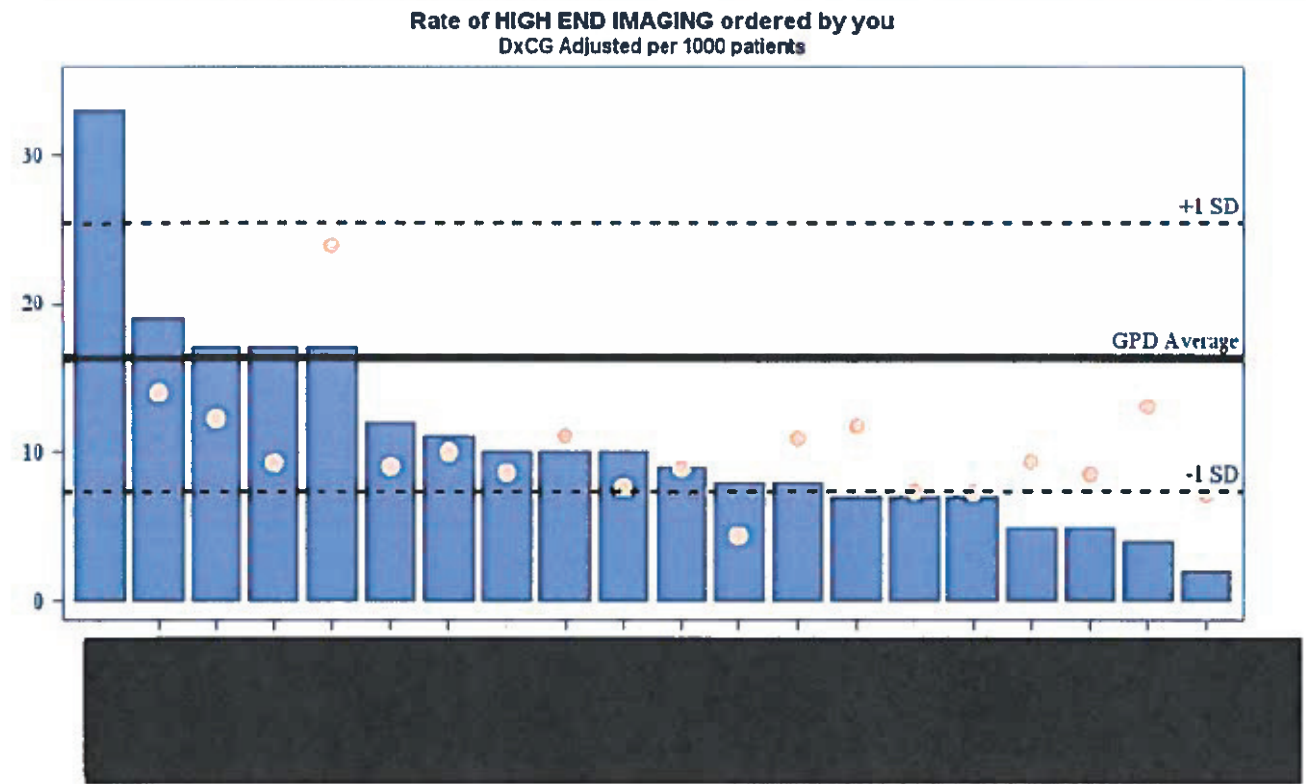
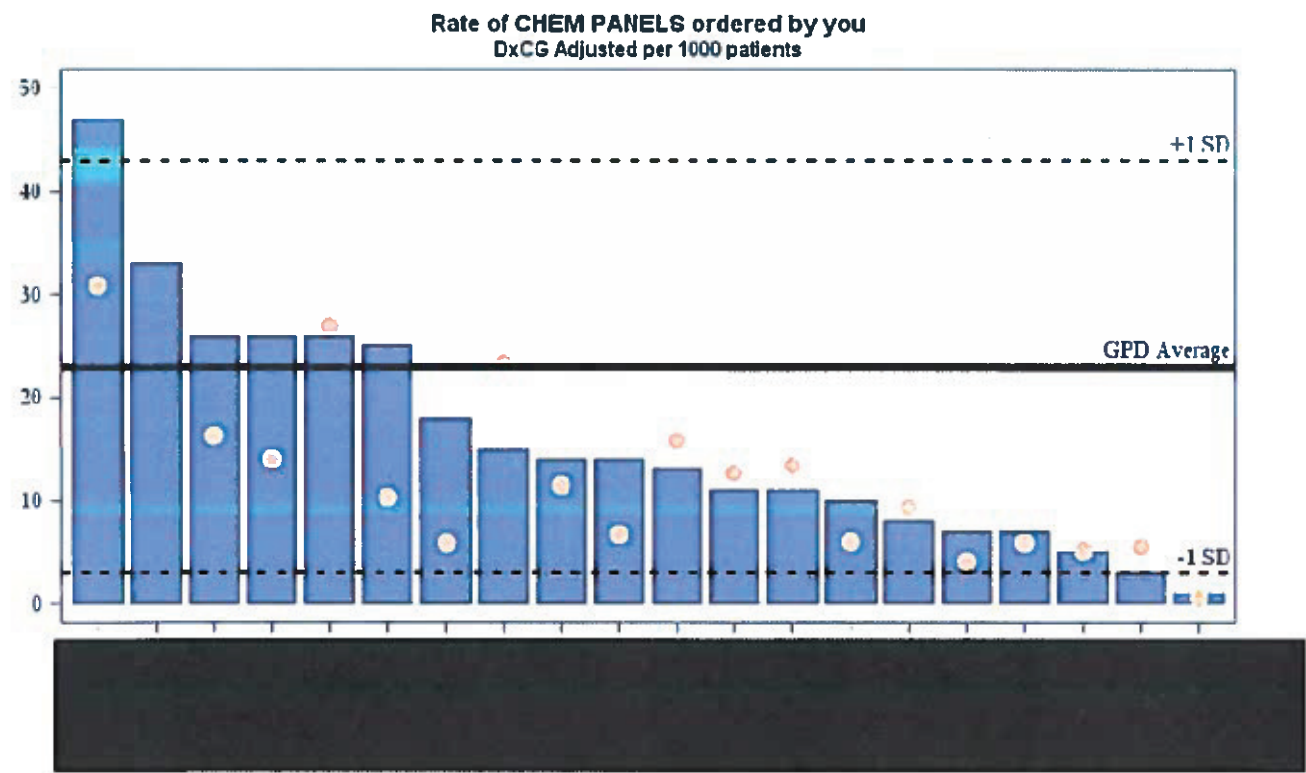
Clinic: _____

Rate of NEW SPECIALTY VISITS for your panel - measure of total impact of your panel in specialty (includes self-referral and referrals you and your partners made for your patients)
DxCG Adjusted per 1000 patients



Resource Stewardship Dashboard PRIMARY CARE FP-IM

Clinic: [REDACTED]



Resource Stewardship Dashboard PRIMARY CARE FP-IM

Clinic: [REDACTED]

Explanatory Note:

The numbers in the graphs are expressed per DxCG and per 1000 patients, with a floor DxCG of 1.0. To translate values shown in this table, first increase any DxCG < 1.0 up to 1.0, then divide by DxCG, then multiply by 1000 divided by Avg Raw Panel Size.

For example:

- If HEI is 80, DxCG is 2.0, and Panel Size is 800, then $80/2 * 1000/800 = 50$
- If Pharmacy Rx is 12,000, DxCG is 0.7 (rounded up to 1.0 remember!), and Panel Size is 1200, then $12000/1.0 * 1000/1200 = 10,000$

Data sources:

New Specialty Visits: Cost Management Database (CMD), Claims

Specialty Referrals: Referrals System, [REDACTED]

High-End Imaging: Epic

Chem Panels: Lab Systems, [REDACTED]