AGENDA

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

June 12, 2018

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

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

II. *Approval of May Minutes*.....*Margo Bushmaier, Chair*

III. *Diabetes Analysis*.....*Mike Motley, Izzy Whittington, ACHI*

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

Upcoming Meetings

July 10, 2018, August 14, 2018, September 11, 2018

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
June 12, 2018

Date | *time* 6/12/2018 1:00 PM | *Meeting called to order by* Margo Bushmiaer, Chair

Attendance

Members Present	Members Absent
Michelle Murtha - Vice-Chair	Frazier Edwards
Cindy Gillespie - Teleconference	
Margo Bushmiaer - Chair	
Pam Brown	
Dr. Arlo Kahn	
Dr. Terry Fiddler	
Dr. John Vinson	
Dr. Namvar Zohoori	
Zinnia Clanton	
Melissa Moore	
Chris Howlett, EBD Executive Director, Employee Benefits Division	

Others Present:
Eric Gallo, Rhoda Classen, Jamie Levinsky, Adrea Walker, Shalada Y. Toles, Allie Barker, EBD; Dwight Davis, Micah Bard, UAMS; Mike Motley, Elizabeth Montgomery, ACHI; Sandra Wilson, AHM; Treg Long, ACS; Jessica Akins, Takisha Sanders, HA; Kristi Jackson, ComPsych; Ronda Walthall, ARDOT; Lindsey Bean, Kesha Walker, Novo Nordisk; Kyeshia Ward, Michael Rogers, APA; Karyn Langley, QCA

Approval of Minutes by: Margo Bushmiaer, Chair

Bushmiaer asked for a motion to approve the May 15, 2018 minutes. Brown motioned to approve the minutes. Murtha seconded. All were in favor.

Minutes Approved.

ACHI Updates by: Mike Motley, Elizabeth Montgomery, ACHI

Mike Motley and Elizabeth Montgomery presented a review of diabetes related questions from the previous meeting, an overview of healthcare plan quality measurement, review the quality of care indicators for EBD member, and plan management options for EBD members with diabetes.

Discussion:

Howlett asked if the total 30.3 million people that have diabetes is an aggregate for the undiagnosed? Howlett wanted to know if there were other factors to get to the 7.2 million of undiagnosed. Montgomery replied that these numbers are from CDC assessment.

Howlett asked if the retirees are on plan level, or is it Medicare eligible retirees (slide 13)? Motley said they were flagged as plan level retirees.

Zohoori asked if these are national levels, and we do not know the levels for Arkansas? Motley said they did not have access to the Arkansas numbers current enough to present. These numbers are from the national benchmarks on the HEDIS pages. Zohoori stated that we do not really know how we compare to national level, and Motley responded that is correct.

Howlett questioned if the all payer's claims data base was inconclusive to pull the data from, and Motley stated that would be a separate order of business.

Vinson asked if a third-party administrator would make information available to compare to our plan to other plans? Howlett stated that he would try another approach to contact the Department of Health to compare our plan to other plans in Arkansas and we will work on that.

Vinson asked to clarify on the statin therapy if it was one or continual, and Motley said that it is at least one. Motley said he will follow up on that. Vinson stated that it is a low threshold of use, and it may be that it was filled once. Montgomery responded that they will go back and look at the definition for that measure and follow up with the group.

Murtha questioned statin therapy, and how long has this been used. Dr. Kahn stated that for a number of years for anyone over the age of 40-75, if you give statins to patients that they will have less of a chance for cardiovascular disease. Vinson stated that it was 4 or 5 years ago, and that Dwight and Micah could make a presentation on this. There is a calculator to assess your risk of cardiovascular disease.

Murtha asked if these are all 50-75, and Motley said it is 40-75 for statin with Type 1 or 2 Diabetes. Also, Murtha asked about the ages for the HbA1c and eye exams. Motley responded 18-75.

Howlett stated that he will work with Dwight and Micah on freshening up this information relative to today's discussion.

Vinson stated that statins are very challenging because, they lower your chance of cardiovascular disease or heart attack, but they do not make you feel better. It is hard to get doctors to prescribe them, and it is very hard to get patients to fill them. We used to use a shared decision tool to talk to patients about how many people will have heart attacks on a percentage basis. A big piece is patient education.

Dr. Fiddler asked if you have a patient that takes a statin, and they do feel bad because of it, then do you change to a less pravastatin? Also, do you really know how many people take it and fill the

prescription. Do you see more compliance if you lower the statin? Vinson said some people cannot tolerate them at all, but that is a small percentage. Vinson stated there are a lot of statins to prescribe if someone has a side effect, but this is the top five if not number one prescribed drug. There are some that are hydrophilic as opposed to hydrophobic that help make it easier to tolerate if they have memory issues or muscle problems. There will be a small percentage that cannot tolerate statins at all.

Dr. Fiddler said that he has patients that fill the prescription, but they do not know why they take it and do not take it because they felt bad once from taking it. What is the problem with cost to the plan when this is 10's of thousands of patients?

Dr. Kahn said compliance is a very complicated issue, and some people don't take the time to figure out the reason for non-compliance. There is no one that says they feel better from a statin, but they will prevent a heart attack down the road. Most people will comply with their medication if they understand the reason for the medication, so this is an issue of patient education.

Dr. Fiddler stated that is why you have assistants and nurses, and Dr. Kahn stated that is the whole idea of the patient centered medical home is everyone working at the top of their license.

Dr. Vinson stated that Medicare part D pays for certain conditions in certain high risk patients, and pharmacists to do a medication management review. Some plans around the country have something similar where pharmacists can intervene and make sure that people are taking the correct medications, and the pharmacist becomes part of the solution.

Howlett stated that part of the approach is that we are trying to align most of the sub-committees with the action items for the Board. Our clinical team here has been looking at the diabetic members of the plan and overall management, but I would like to get something comprehensive together for an overall approach to present before we vote on a motion. This way we can align it with the wellness benefit, such as BMI or obesity. We will also have the Naturally Slim program, and we will work with Motley, Montgomery, and Dr. Kahn to present to the Board. Howlett asked members to send him any requests on things to consider for the fall coming up.

Dr. Zohoori stated the management of patients is the biggest issue, and we have started using team based care at the ADH in different counties. There are community health workers to help patients overcome compliance barriers, and one issue is payment and compensation for their work. Medicaid does not offer that, but I think this is something to consider. There is evidence out there showing that these community health workers really help with compliance.

Howlett asked if the health department would have more state driven data to compare the plan to, and Zohoori stated that he can check with the ADH to see what data they have.

Zohoori was curious why foot exams were not included on this, and Dr. Kahn said he thinks it is because that would be coded as a wellness visit done by primary care physician. Montgomery responded that yes, this is tracked by claims data. Dr. Vinson said that this is tracked by NCQA, but it is hard to see on anything but your own paper chart.

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

Howlett provided a few recaps of the bariatric program that had some statutory changes starting this past January. Right now, there are 298 enrolled with 69 withdrawn with the top two reasons being, financial and no contact on the participants' side. There are 53 on the waiting list, and we have 16 confirmed surgeries for 2018.

Naturally Slim had 2,578 ASE and 1,951 PSE signed up in a little over 2 hours. The approved amount was 1,000 in each group, and Naturally Slim added an additional 200 spots for both ASE and PSE. We just started week three of that program, so I will try to have some data for us the next meeting.

For Catapult, just over 13,693 people have had screenings. We have over 11,000 appointments available with 486 clinics coming up, and 77 clinics are in pending status. The estimate is that we will have 38,000 completed screenings this year.

Dr. Fiddler made a motion to adjourn. Vinson seconded. All were in favor.

Meeting adjourned.

EBD Quality of Care Subcommittee Presentation

Mike Motley, MPH
Assistant Health Policy Director

Elizabeth Whittington, MPA
Policy Analyst

ACHI
Arkansas Center for Health Improvement

June 2018

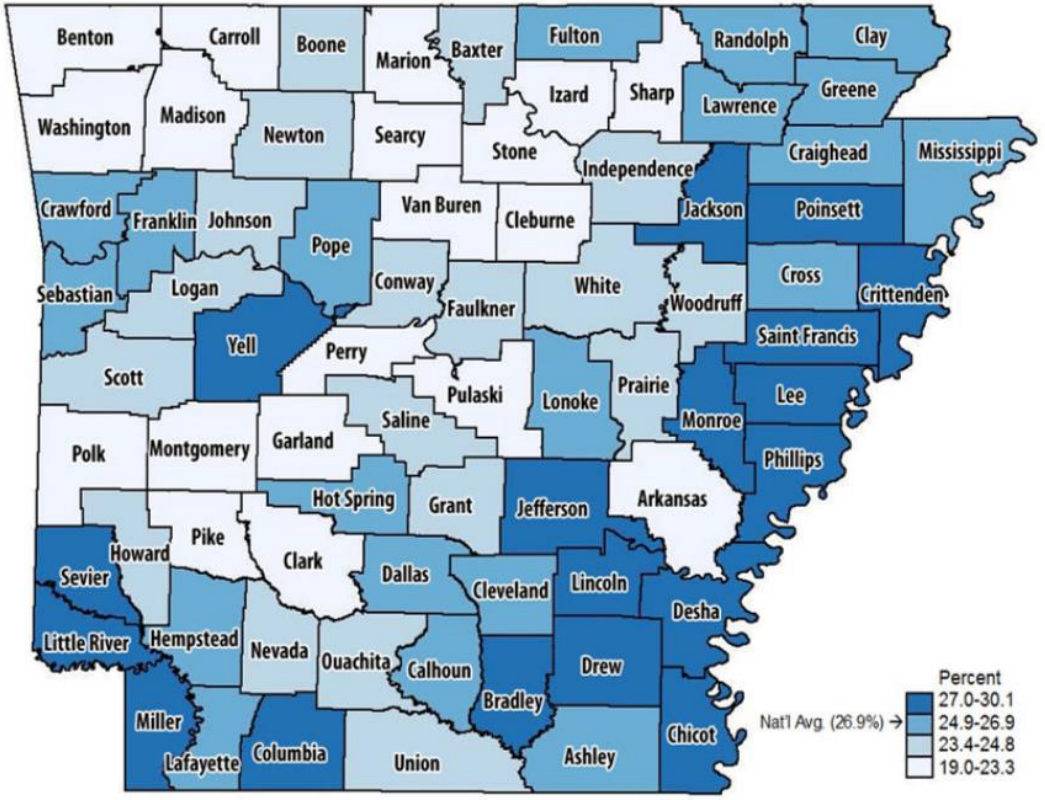
Objectives for Presentation

- Review diabetes related questions from previous Quality of Care meeting
- Provide overview of healthcare plan quality measurement
- Review quality of care for EBD members with diabetes
- Discuss plan management options for EBD members with diabetes

Follow Up

- **What is the rate of diabetes among Medicare beneficiaries in Arkansas?**

- **<u>Answer</u>:**
  - **–24.2% in 2013**



Source: Arkansas All Payer Claims Database, "Arkansas Medicare Chronic Conditions Report." July 1, 2016. Retrieved from https://www.arkansasapcd.net/Docs/165/

Follow Up

- **What is the rate of prediabetes among EBD members?**

- **<u>Answer</u>:**
  - **Limited availability to determine because of claims data; Clinical data needed**
  - **Prediabetes diagnosis code not always present in claims**
  - **Prediabetes rate in Arkansas is estimated to be 36.4% by the American Diabetes Association**

Source: American Diabetes Association, "The Burden of Diabetes in Arkansas." Retrieved from http://main.diabetes.org/dorg/PDFs/Advocacy/burden-of-diabetes/all-states.pdf

Follow Up

- **What are the best practices in identifying EBD members with potentially undiagnosed diabetes?**

- **<u>Answer</u>:**
  - **USPSTF recommends screening for abnormal blood glucose in adults aged 40 to 70 years who are overweight or obese (B recommendation)**
  - **Current plan efforts with biometric screening/ physician visit for wellness program provides opportunity to identify those with abnormal glucose levels**

Source: U.S. Preventive Services Task Force, "Final Recommendation Statement—Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening." Retrieved from https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/screening-for-abnormal-blood-glucose-and-type-2-diabetes

Diabetes Prevalence

- **National Prevalence Data:**
  - **Total: 30.3 million people have diabetes (9.4% of the US population)**
  - **Diagnosed: 23.1 million people**
  - **Undiagnosed: 7.2 million people (23.8% of people with diabetes are undiagnosed)**

Source: Centers for Disease Control and Prevention. National Diabetes Statistics Report, 2017. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2017. Retrieved from https://www.cdc.gov/diabetes/data/statistics/statistics-report.html

Diabetes Prevalence in Arkansas & EBD

- **Arkansas (Overall) = 13%**
  - **Highest rate = 17% in Izard, Mississippi, St. Francis, Monroe and Jefferson Counties**
  - **Lowest rate = 9% in Benton County**

- **EBD members with Type 2 diabetes (2016—2017):**
  - **11.2%**

Source: County Health Rankings & Roadmaps, "Arkansas 2018—Additional Measures: Diabetes Prevalence." Retrieved from http://www.countyhealthrankings.org/app/arkansas/2018/measure/outcomes/60/data?sort=sc-2

Purpose of Quality Measure Analysis

- **Provide comparison to regional and national quality benchmarks**
- **Serve as a resource for plan benefit and program design and modification**
- **Guide strategies for consumer and provider education**

Defining and Measuring Quality of Care

- **Quality often defined as appropriate, effective, and safe care**
- **National standards for evaluation have been developed by the Nation Committee for Quality Assurance (NCQA)**
- **Health Plan Employers Data and Information Set (HEDIS) Measures developed by NCQA**

Defining and Measuring Quality of Care

- Analysis requires member eligibility/ enrollment data; medical and pharmacy claims data
- From these data information on adherence to guidelines and service delivery can be obtained
- Quality of care measurement follows an established path of information collection

Defining and Measuring Quality of Care, Cont.

- **Denominator = Evidence-based need for procedure/treatment**
- **Numerator = Procedure/treatment of interest & documentation of procedure/treatment**

- **<u>Example: Screening for Colorectal Cancer</u>**
  - **Numerator = Adults screened for colorectal cancer**
  - **Denominator = Adults 50-75**

EBD Diabetes Quality Measures

- **Analysis includes 3 HEDIS measures:**
  - **Hemoglobin A1c (HbA1c) testing**
  - **Eye exam**
  - **Statin medication use**

- **These three measures were selected as they comprise key indicators used to determine the quality of care provided to diabetics**

HbA1c Testing

Outcomes:

2016 EBD	Numerator	Denominator	Rate
HbA1c - Active	8,599	10,974	78.4%
HbA1c - Retirees	409	808	50.6%
HbA1c - Overall	9,008	11,782	76.5%

National (2016)

Commercial		Medicaid	Medicare	
HMO	PPO	HMO	HMO	PPO
90.6%	89.3%	86.7%	93.5%	93.6%

Arkansas Medicaid PCMH Target (2018): >=78%

Eye Exam

Outcomes:

2016 EBD	Numerator	Denominator	Rate
Eye Exam - Active	7,388	10,974	67.3%
Eye Exam - Retirees	320	808	39.6%
Eye Exam - Overall	7,708	11,782	65.4%

National (2016)

Commercial		Medicaid	Medicare	
HMO	PPO	HMO	HMO	PPO
53.6%	47.5%	54.9%	70.4%	69.6%

Arkansas Medicaid PCMH Target (2018): >=65%

Statin Medication

Outcomes:

2016 EBD	Numerator	Denominator	Rate
Statin Therapy – Active	3,885	8,048	48.3%
Statin Therapy - Retirees	308	575	53.6%
Statin Therapy - Overall	4,139	8,623	48.0%

National (2016)

Commercial		Medicaid	Medicare	
HMO	PPO	HMO	HMO	PPO
60.2	58.9	60.2	70.7	67.8

Arkansas Medicaid PCMH Target (2018): >=51%

Recommendations for EBD Member Diabetes Management

- **Conduct provider and patient outreach regarding eye exams and statins for diabetic members**

- **Use results from biometric screenings panel for targeted case management**

- **Assess provider variation in quality measures; medication therapies, etc.**

Recommendations for EBD Member Diabetes Management

- **Support opportunities for intensive weight counseling (e.g. Medicare Diabetes Prevention Program-like framework)**
- **Encourage agency/school district participation in AHELP and CHELP**
- **Bariatric program—Continue monitoring and evaluation**
- **Naturally Slim program—Conduct monitoring and evaluation**

Appendix: HbA1c Testing Methodology

Denominator: Adults 18-75 with any of the following:

- **Diabetes (type 1 and type 2) identified as having either two outpatient, ER, non-acute inpatient or observation stays with a diabetes related diagnoses**
- **1 acute IP stay with a diabetes diagnosis**
- **Filled prescriptions of insulin or hypoglycemic/anti-hyperglycemics on an ambulatory basis**

Numerator:

- **Individuals with an HbA1c screening during the measurement year**

Appendix: Eye Exam Methodology

Denominator: Adults 18-75 with any of the following:

- **Diabetes (type 1 and type 2) identified as having either two outpatient, ER, non-acute inpatient or observation stays with a diabetes related diagnoses**
- **1 acute IP stay with a diabetes diagnosis**
- **Filled prescriptions of insulin or hypoglycemic/anti-hyperglycemics on an ambulatory basis**

Numerator:

- **A retinal or dilated eye exam by an eye care professional in the measurement year**
- **A negative retinal or dilated eye exam by an eye care professional in either the prior year or the measurement year**

Appendix: Statin Medication

Denominator: Adults 40-75 with any of the following:

- Diabetes (type 1 and type 2) identified as having either two outpatient, ER, non-acute IP or observation stays with a diabetes related diagnoses
- 1 acute IP stay with a diabetes diagnosis
- Filled prescriptions of insulin or hypoglycemic/anti-hyperglycemics on an ambulatory basis
- Exclude those with ASCVD

Numerator:

- Individuals who received statin therapy