



AGENDA

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

November 13, 2018

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

- I. Call to Order.....Margo Bushmaier, Chair*
- II. Approval of August Minutes.....Margo Bushmaier, Chair*
- III. Choosing Wisely Analysis..... Mike Motley, Izzy Montgomery, ACHI*
- IV. Director’s Report..... Chris Howlett, EBD Executive Director*

Upcoming Meetings

December 11, 2018, January 15, 2019, February 12, 2019

NOTE: All material for this meeting will be available by electronic means only [ASE-PSE BOARD@dfa.arkansas.gov](mailto:ASE-PSEBOARD@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

November 13, 2018

Date | time 11/13/2018 1:00 PM | Meeting called to order by Margo Bushmiaer, Chair

Attendance

Members Present

Michelle Murtha - Vice-Chair

Dr. John Vinson

Margo Bushmiaer - Chair

Dr. Arlo Kahn

Dr. Terry Fiddler

Melissa Moore - Teleconference

Chris Howlett, EBD Executive Director, Employee Benefits Division

Members Absent

Cindy Gillespie

Pam Brown

Dr. Namvar Zohoori

Zinnia Clanton

Others Present:

Eric Gallo, Rhoda Classen, Shalada Toles, Renee Brown, Ellen Justus, Torie Wooley, Jennifer Landers, Terica Crossley, Boyd Schaefer, EBD; Mike Motley, Elizabeth Montgomery, ACHI; Sandra Wilson, AHM; Jessica Akins, HA; Kristi Jackson, ComPsych; Ronda Walthall, ARDOT; Stephen Carroll, AllCare Specialty, Mitchell Strack

Approval of Minutes by: Margo Bushmiaer, Chair

MOTION by Dr. Fiddler

I motion to approve the September 11, 2018 minutes.

Dr. Kahn seconded. All were in favor.

Minutes Approved.

ACHI Updates by: Mike Motley, Elizabeth Montgomery, ACHI

Mike Motley and Elizabeth Montgomery presented updates using the updated Health Waste Calculator output, follow-up analyses from previous meeting, three additional low-value services, and they discussed next steps for analyses and recommendation. Potential considerations to address overuse are tailored member education, provider education, review of prior authorization criteria or medical management utilization management practices, provider-level assessment of variation, and the review of value-based payment models.

Discussion:

Dr. Fiddler: Do we have this data from '14, '15, and '16?

- Motley: For provider variation, we would have to generate it, but that is something that we could do.
- Dr. Fiddler: If we know the providers with the highest variation for low-value services, I'm curious to know if they are the same providers doing the same procedures each year. Also, are they just being more precise or are they doing it just because it is available.
- Motley: We can look a few years back. This just shows the volume of what this analysis has deemed low-value services.
- Howlett: We are missing part of the equation. It is 800 out of how many? We would almost have to do a place of service indicator on the claim to quantify how many EBD members went to that physician/physician group. I would be interested to see those numbers.
- Dr. Fiddler: There are those individuals that need to be looked at.
- Dr. Vinson: Since we don't know who the provider is, we should make sure that it's not an attending physician that is overseeing a bunch of residents and all the billing is done under one physician. I would be interested to see that as well.
- Montgomery: That is some of the issues with utilizing claims data and the way that it is billed. It's difficult to discern whether it is an individual physician or a physician group. Internally, we have thought about that and that is where some of the difficulty in showing provider variation, but we take this information and look into that.
- Dr. Kahn: With claims data, you will be able to say whether it is a group or not a group, but you won't be able to say anything about who is billing it within a group.
- Howlett: **If you can get as granular as possible with that, then we can go back and establish a baseline mechanism to go back and look at prior years claims.**
- Dr. Fiddler: With all this information, are we looking at January to determine if these are unnecessary and we need to cut these services out or decide what to do about them?
- Howlett: The ACHI research is done by my request when looking to tighten things up. It's not always fiscal in nature, but also overseeing the benefit design and service orientation that we are providing to our membership and how it is delivered. The goal is to present the information and then go up through the Benefits and to the full Board. I would anticipate, based on the timeline of information, a decision in January if there was anything we wanted to tackle. Is there something specific you might want to look at, that might give us direction?

Dr. Fiddler: I'm never for saving money if it is taking away from the benefit of the patient. But, we are looking at \$7 million in cost and if that could be better spent to help the health of the patient then why would we not make a recommendation to help that.

Howlett: The approach of this plan should be to take all the evidence now, look at it from a futuristic standpoint, and make the best directional decision for the plan.

Dr. Fiddler: After we get through these get healthy pilots, I'd be interested to see that once they start losing weight and getting healthier, if we don't see a change in the age distribution and we won't be having these issues because they are healthier.

Dr. Kahn: I was skeptical that this health waste calculator would specifically denote (example: an obese patient) which patients should be excluded from these results. It's extraordinary how good they were at making sure an obese patient would be allowed to have these tests and not be considered wasteful. When they say wasteful they really are wasteful. I'd be interested to see as part of our wellness program that requires lipid profiles, if those profiles are submitted as separate claims or if they are rolled up in a single fee. If those claims are submitted, there will be 40,000-60,000 more lipid profiles that will most likely be deemed unnecessary.

Howlett: They are rolled into one under one code from Catapult. If they go to their PCP, there might be a little bit of a discrepancy. We request a certain minimum to qualify for that potential discount, but their doctor may run a larger panel than needed.

Motley: I believe it is a one-time lipid panel so it's not an annual thing. Individuals shouldn't have to get one next year.

Dr. Vinson: I'm still curious about the cervical cancer one, just because we implemented a change in the plan. When did that go into effect, operationally? It would be nice to have that information.

Motley: That was the middle of '16 and we have that measure on deck for the December meeting. There is a drop in '16 from '15 and then back up in '17. I would be surprised if it's not related to the new policy which is more in alignment with the preventative task force recommendation.

Howlett: We had quite a bit of pushback on that.

Montgomery: When we initially did some of the research on Pap tests we didn't use this tool at the time, but we will have some 3-year data analyses on this. **We can do some internal scoping to see if some of that might be useful in seeing the impact of the policy change.**

Murtha: Is there a way to tell how many patients that had this image for uncomplicated headache were negative or actually had an issue?

Montgomery: Unfortunately, that is the limits of the claims data. If we had the clinical chart available, we could discern that a little more.

Motley: **That could be something that we could get from national literature and those who have looked into this in different ways.**

Murtha: With all of these providers, can you correlate to see if the highest provider is the highest across multiple fields?

Montgomery: Yes, I believe that is something we could see.

Murtha: It would be beneficial in who needs to be educated.

Montgomery: That is really part of the goal. Knowing the limitations of the claims data but getting see the providers can be beneficial. Provider outreach is one of our potential recommendations and may want to target first.

Howlett: As we go into 2019, when forming a recommendation, from a physician standpoint, how do you get them on board with decisions? Could we also do a cross providing old data with current outcomes? Also, look at data that will show that we can produce two physicians or physician groups that are not in align with their field of study. If we can have tangible evidence for providers to help them see some of the wasteful testing, it will help our recommendation come full circle.

Dr. Vinson: Do we do audits on the medical side?

Howlett: The plan does audits on the medical and pharmacy side relative to the billable claim that has come back to the plan. We also do sample audits. We rely on the carriers, as well, that do their own sampling with their network of providers.

Dr Vinson: That's not on the list, audits of physician records or hospital records as a possible tool to dive deeper into the clinical notes since we are only seeing the claims. Is it an option or not, or something we already do? Could it be something we have in our repertoire?

Howlett: From a provider network and plan perspective, I think we are limited to a certain scope. Instead of creating another path, I would like to identify the "bad actor" and deal with them directly. I also don't think the plan needs to have the additional responsibility.

Dr. Vinson: On the wellness screening, when Jayme Mayo came and presented, she talked about how they revamped the way the questions were asked and even if the person answered the question a certain way then it provided education to what

needed to be addressed. **I would like to get a PDF of the questions asked on the wellness screening.** If there was anything that ties into the low-value services or the Choosing Wisely initiatives, then it might be an opportunity provide some data right then.

Howlett:

This is the first time in plan history to have aggregate data on its population for those that elected to do it. We are going to refined and requested data coming from the PCP's and Catapult. We are taking that data and partnering with our medical management vendor for proactive engagement. We are going to be able to see some tangible data that can be seen for the first time.

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

We have 81% that are complete on the wellness visits. The question was asked how the plan attempts to address the potential impact with wellness and the EEOC. We are status quo with that and will address it at a later time if necessary.

MOTION by Dr. Kahn.

Move to adjourn.

Dr. Vinson seconded. All were in favor.

Meeting adjourned.

November 2018 Quality of Care Committee Presentation

Mike Motley, MPH

Assistant Director of Health Policy, ACHI

Izzy Montgomery, MPA

Policy Analyst, ACHI



ARKANSAS CENTER FOR HEALTH IMPROVEMENT

Objectives for Presentation

- Review the following items:
 - Updated Health Waste Calculator output
 - Follow-up analyses from previous meeting
 - 3 additional low-value services
- Discuss next steps for analyses and recommendations



Choosing Wisely Initiative Background

- Promotes conversations between clinicians and patients by helping patients choose care that is:
 - Supported by evidence
 - Not duplicative of other tests or procedures received
 - Free from harm
 - Truly necessary
- Recommendations developed by specialty societies
- Sparks discussion about need — or lack thereof — for many frequently ordered tests or treatments

Source: Choosing Wisely Initiative Website, <http://www.choosingwisely.org/about-us/>



Assessing Wasteful Services Within EBD

- MedInsight Health Waste Calculator is a tool which identifies low-value services and spending
- ACHI utilized tool to examine 42 common treatments deemed to be low-value or potentially unnecessary
- Two additional states have published reports based on findings from this tool, including Virginia and Washington

Disclaimer: Due to inherent variation in billing and related claims data, the costs included in this presentation should be considered close estimates.



Top 8 Low-Value Services Within EBD (2017)

Low-Value Service	Number of Distinct Members with a Low-Value Service	Number of Low-Value Services	Low-Value Total Dollars
1. Don't obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery — specifically complete blood count, basic or comprehensive metabolic panel, coagulation studies when blood loss (or fluid shifts) is expected to be minimal.	9,118	13,060	\$4,028,766
2. Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.	9,643	10,274	\$1,612,932
3. Don't routinely order imaging tests for patients without symptoms or signs of significant eye disease.	8,187	12,875	\$1,236,098
4. Don't order unnecessary cervical cancer screening (Pap smear and HPV tests) in all women who have had adequate prior screening and are not otherwise at high risk for cervical cancer.	7,676	7,762	\$740,322
5. Don't perform coronary angiography in patients without cardiac symptoms unless high-risk markers are present.	202	205	\$372,219
6. Don't do imaging for uncomplicated headache.	557	584	\$258,925
7. Don't perform population-based screening for 25-OH-Vitamin D deficiency.	2,925	3,050	\$193,703
8. Don't prescribe oral antibiotics for members with upper URI or ear infection (acute sinusitis, URI, viral respiratory illness, or acute otitis externa).	24,853	32,503	\$186,219

Unnecessary Preoperative Baseline Lab Studies



Unnecessary Preoperative Baseline Lab Studies

- Measure based on Choosing Wisely recommendations from 2 physician specialty societies:
 - American Society of Anesthesiologists: *Don't obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery.*
 - American Academy of Ophthalmology: *Don't perform preoperative medical tests for eye surgery unless there are specific medical indications.*

Source: Choosing Wisely, [American Society of Anesthesiologists Recommendation](#) (released October 12, 2013) and Choosing Wisely, [American Academy of Ophthalmology](#) (released February 21, 2013)



Unnecessary Preoperative Baseline Lab Studies

- Rationale for recommendations:
 - For many, preoperative tests are not necessary because some surgeries are short in duration and do not pose serious risks (such as eye surgeries)
 - Tests typically include complete blood panel, basic or comprehensive metabolic panel, urine testing, and/or coagulation studies
 - However, exceptions arise when an individual's medical history or exam indicate need for preoperative testing (e.g., blood glucose test for individuals with diabetes)

Source: Choosing Wisely, [American Society of Anesthesiologists Recommendation](#) (released October 12, 2013) & Choosing Wisely, [American Academy of Ophthalmology](#) (released February 21, 2013); Washington Health Alliance, ["First, Do No Harm"](#) (released February 2018)

Unnecessary Preoperative Baseline Lab Studies

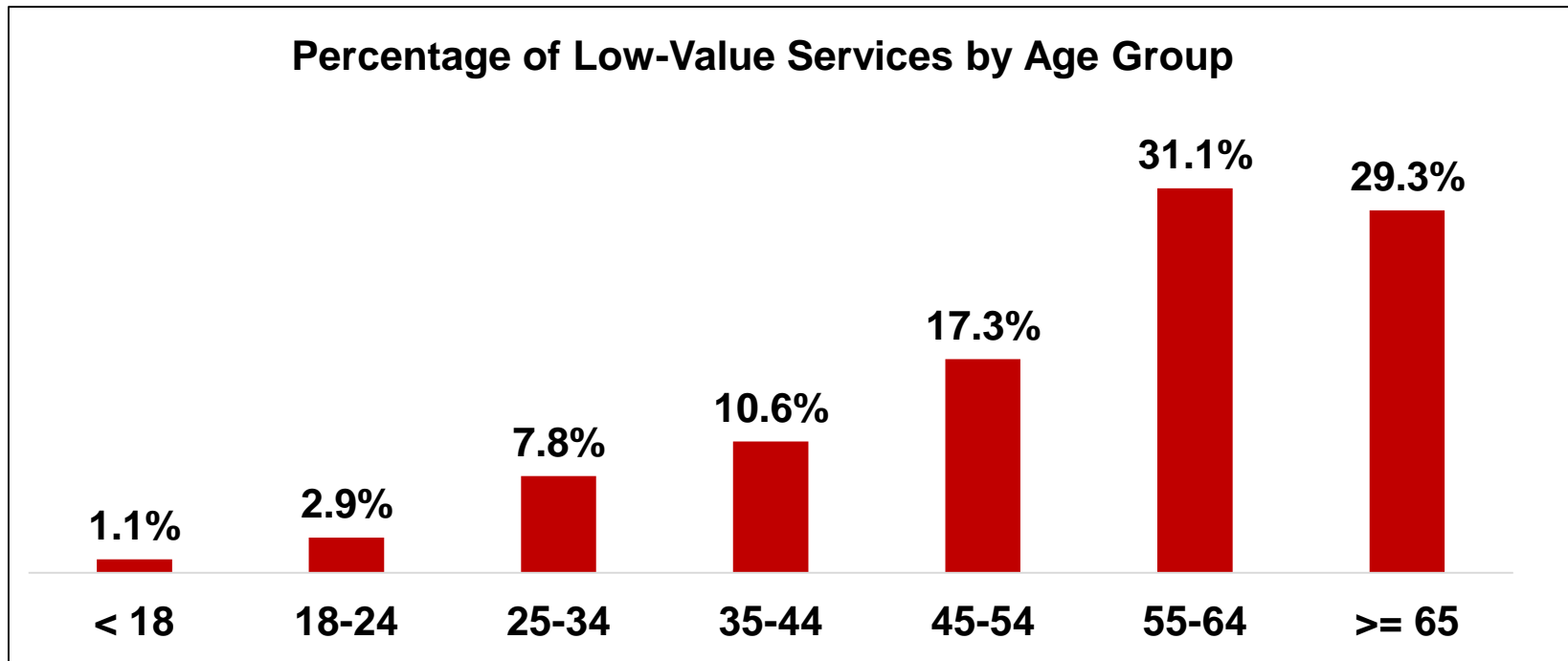
- Some necessary services are excluded from the analysis based on conditions and other criteria, for example:
 - Services where low-risk surgery is on, or one day after, the evaluation visit for emergency care or urgent care visit
 - Diagnosis of endocrine, liver, or renal disorders
 - History of anemia or recent blood loss
 - Diagnosis of coagulation disorders



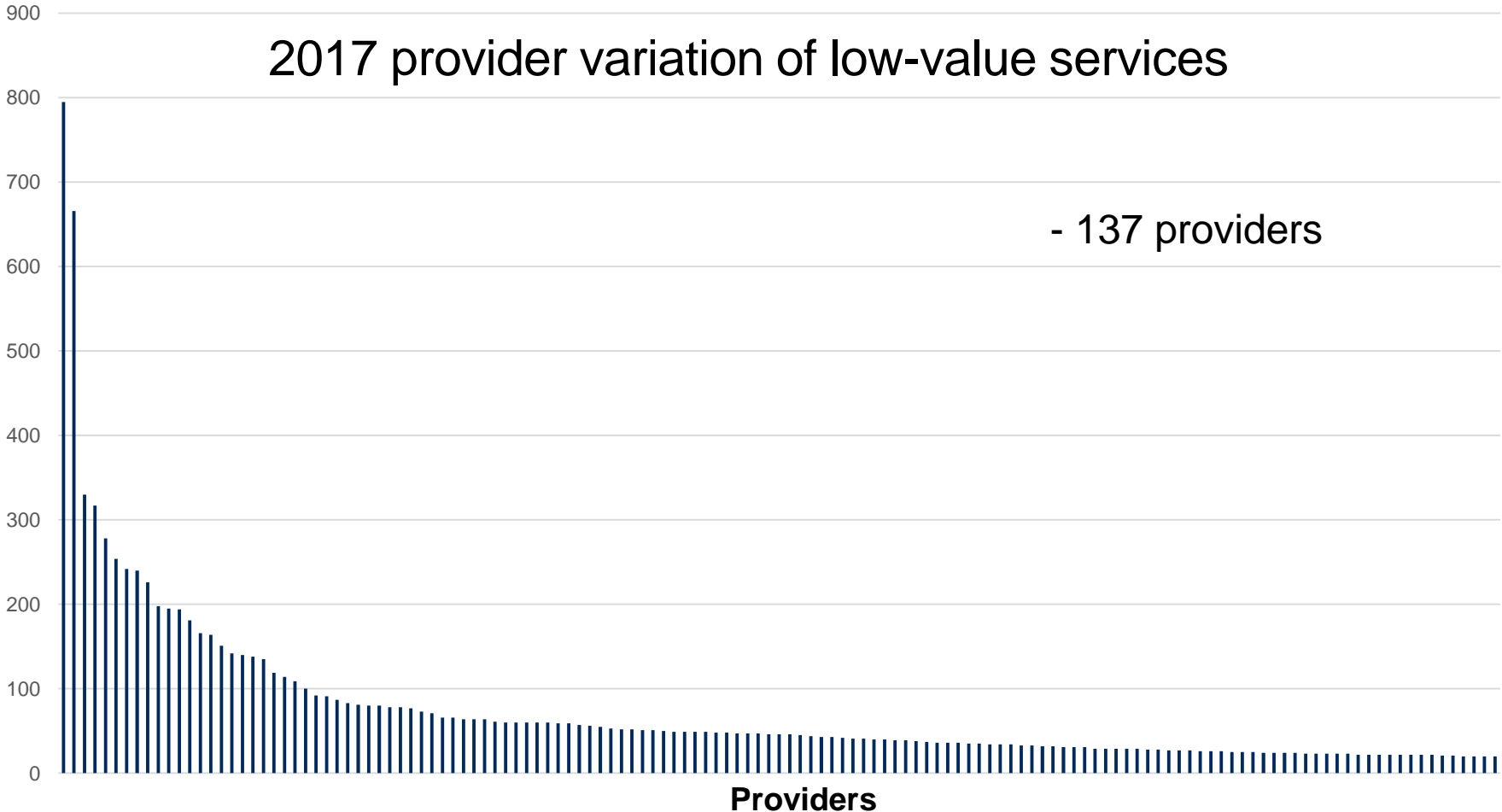
Unnecessary Preoperative Baseline Lab Studies

Year	Total Low-Value Dollars	Number of Low-Value Services	Number of Distinct Members with a Low-Value Services
2017	\$4,937,308	13,060	9,118

Percentage of Low-Value Services by Age Group

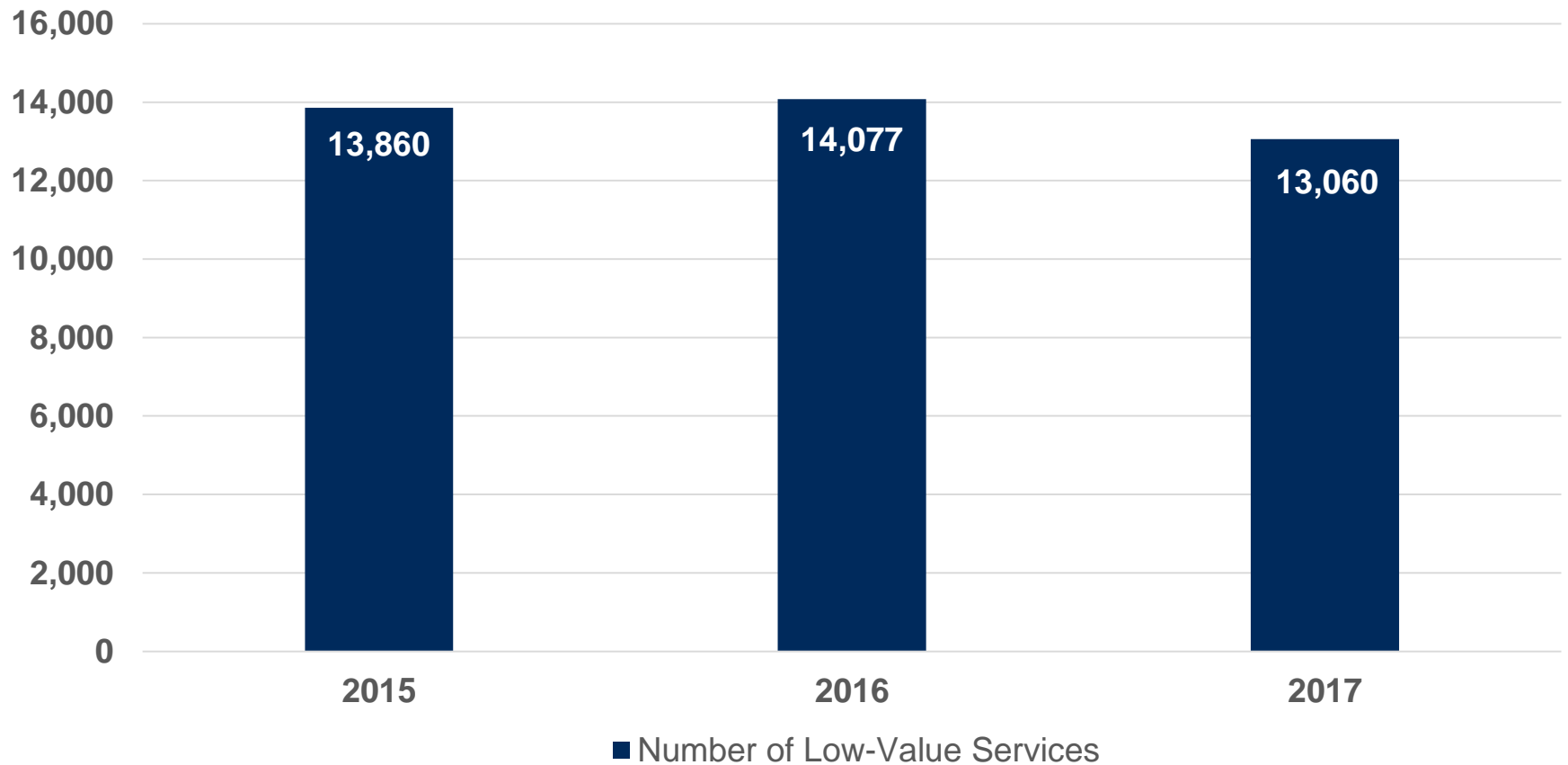


Unnecessary Preoperative Baseline Lab Studies



Unnecessary Preoperative Baseline Lab Studies

2015–2017 low-value service volume trends



Annual EKGs and Other Cardiac Screenings



Annual EKGs & Other Cardiac Screenings

- Measure is based on Choosing Wisely recommendation from 1 physician specialty society:
 - American Academy of Family Physicians: *Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.*
- Other types of cardiac screenings may also include lab tests such as lipid panels, C-reactive protein tests, etc.

Source: Choosing Wisely, [American Academy of Family Physicians](#) (released on April 4, 2012)



Annual EKGs & Other Cardiac Screenings

- Rationale for recommendation:
 - Little evidence that detection of coronary artery stenosis (blocking or narrowing of the arteries) in low-risk patients improves health outcomes
 - False positive tests are likely to lead to unnecessary invasive procedures, overtreatment, and misdiagnosis
 - Potential harms of routine annual screenings exceed potential benefits

Source: *Choosing Wisely*, [American Academy of Family Physicians](#) (released on April 4, 2012)



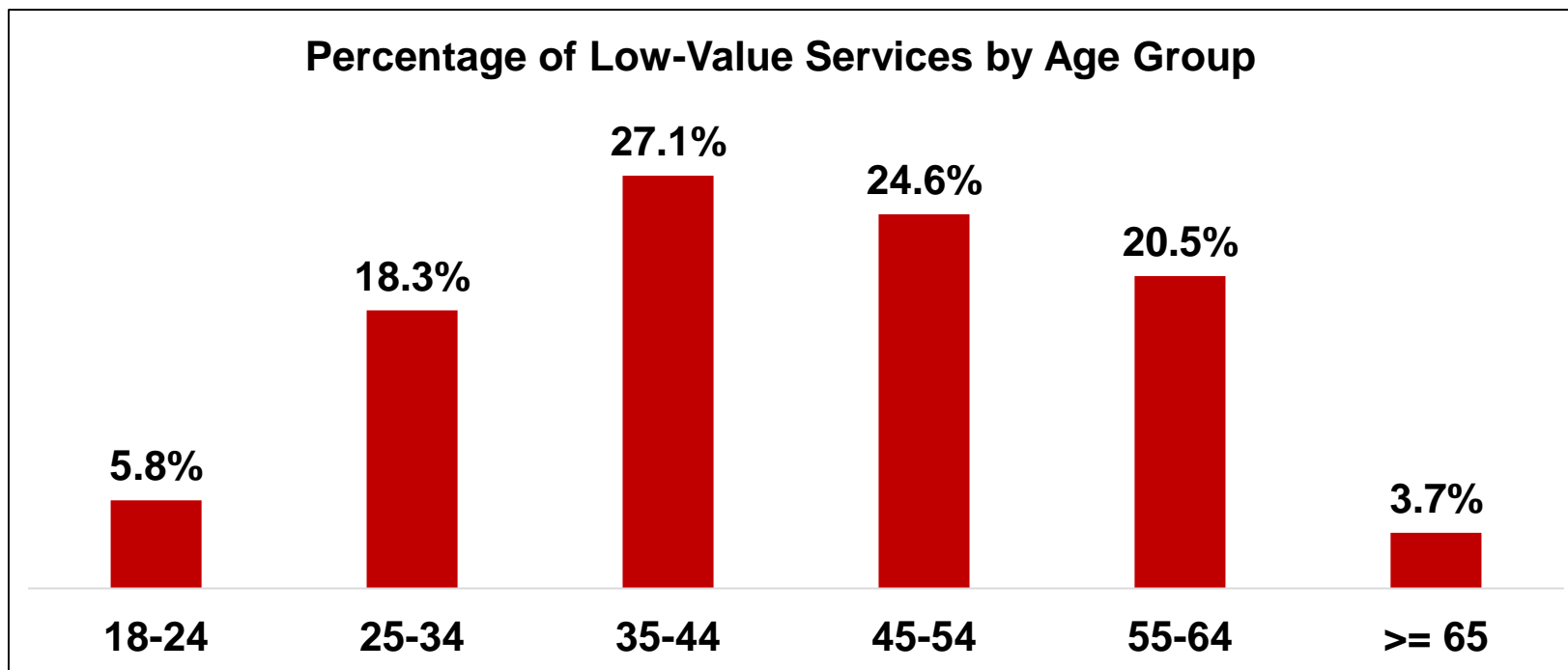
Annual EKGs & Other Cardiac Screenings

- For this measure, cardiac screening tests were deemed appropriate (and excluded from analysis) for a number of clinical circumstances, for example:
 - History of coronary heart disease (CHD)
 - Presence of risk factors suggestive of intermediate CHD risk
 - Inflammatory conditions such as arthritis, joint pain, or muscle inflammation

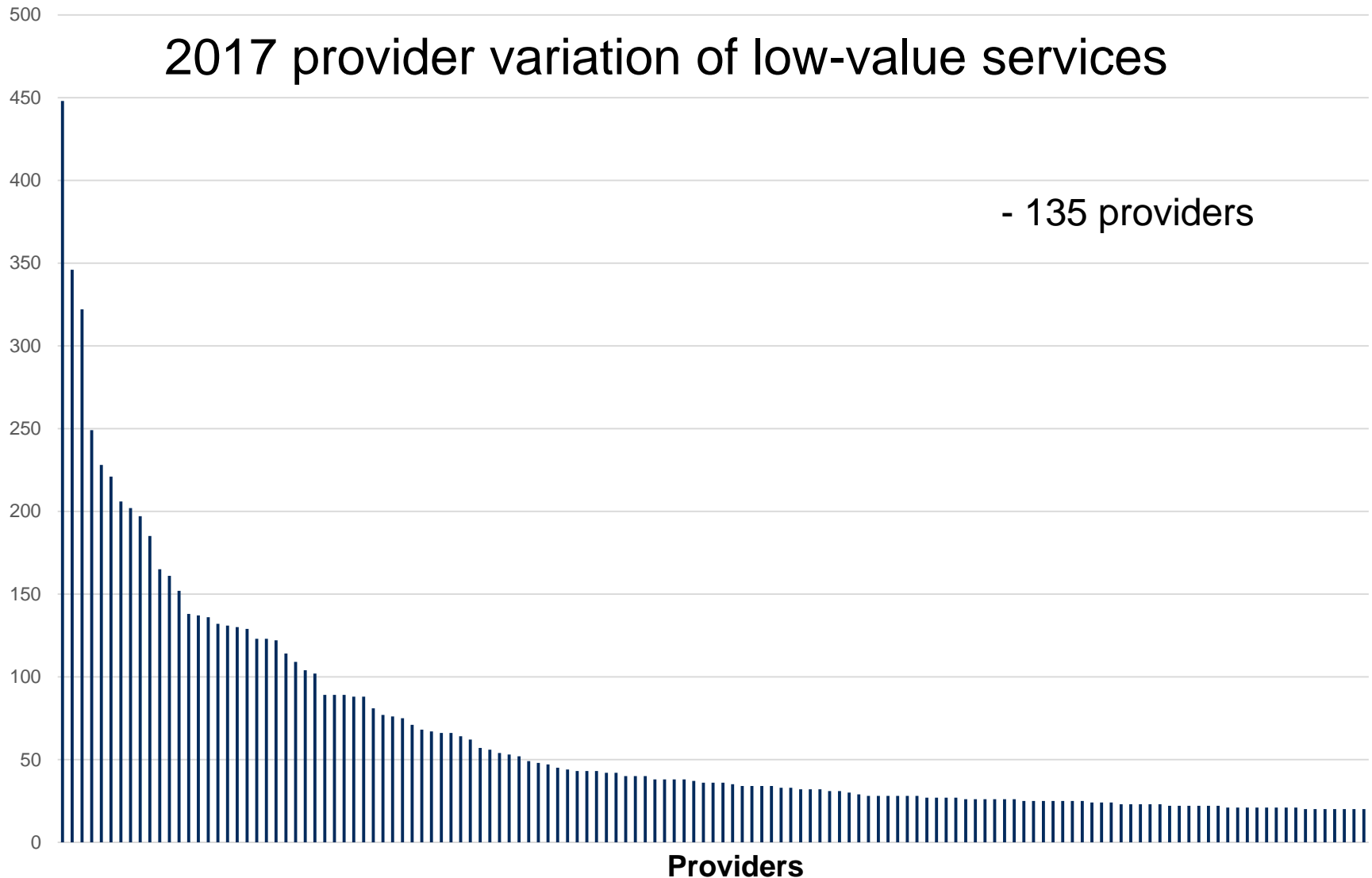


Annual EKGs & Other Cardiac Screenings

Year	Total Low-Value Dollars	Number of Low-Value Services	Number of Distinct Members with a Low-Value Service
2017	\$1,612,932	10,274	9,643

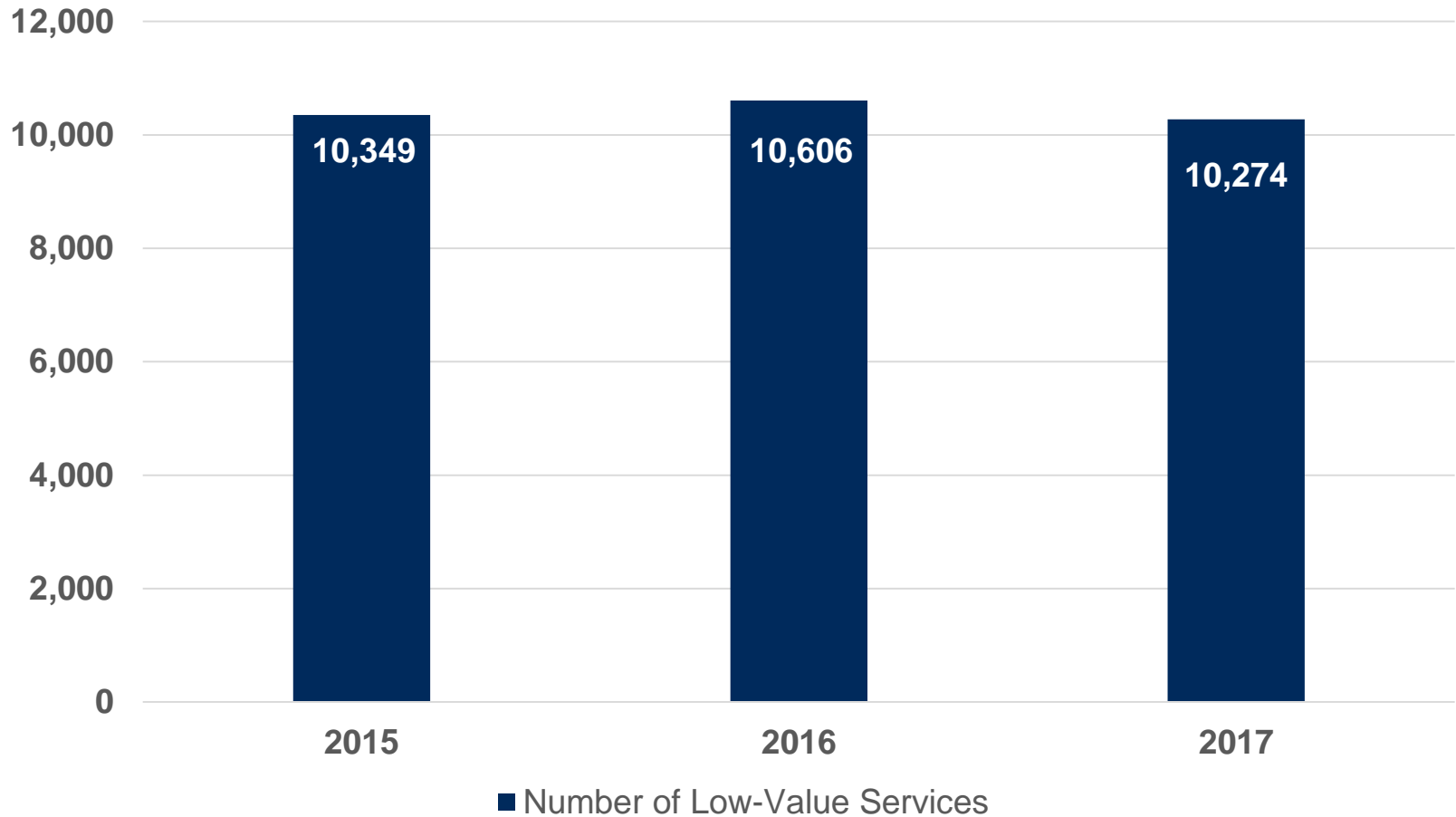


Annual EKGs & Other Cardiac Screenings



Annual EKGs & Other Cardiac Screenings

2015–2017 low-value service volume trends



Imaging for Uncomplicated Headache



Imaging for Uncomplicated Headache

- Measure based on Choosing Wisely recommendations from 1 physician specialty society:
 - American College of Radiology: *Don't do imaging for uncomplicated headache.*

Source: Choosing Wisely, [American College of Radiology](#) (released April 4, 2012)



Imaging for Uncomplicated Headache

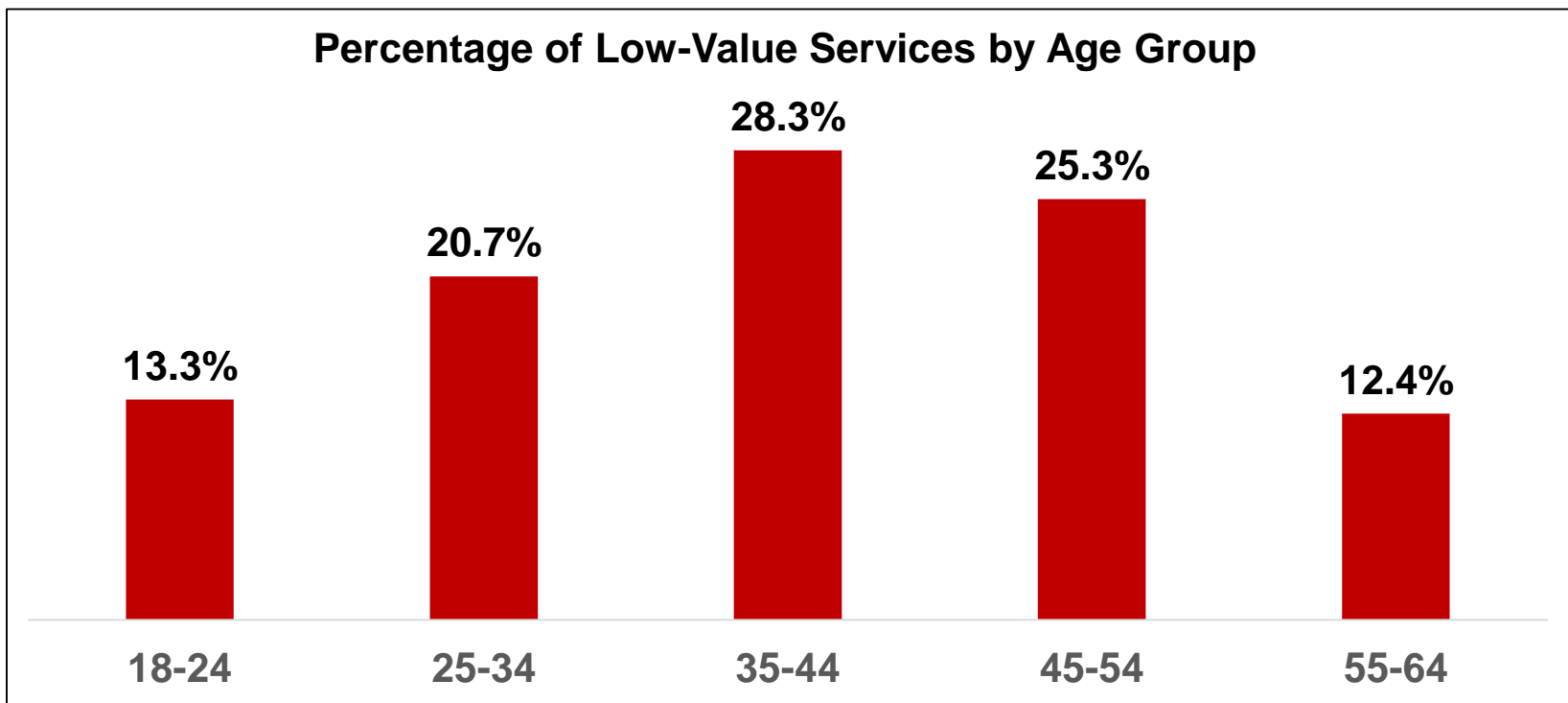
- Rationale for recommendation:
 - Imaging patients, absent risk factors for structural disease, is not likely to change management or improve outcome
 - Incidental findings lead to additional medical procedures and expense that do not improve patient well-being
 - Imaging is recommended under certain circumstances, such as sudden onset of severe headache, suspected carotid or vertebral dissection, etc.

Source: Choosing Wisely, [American College of Radiology](#) (released April 4, 2012)

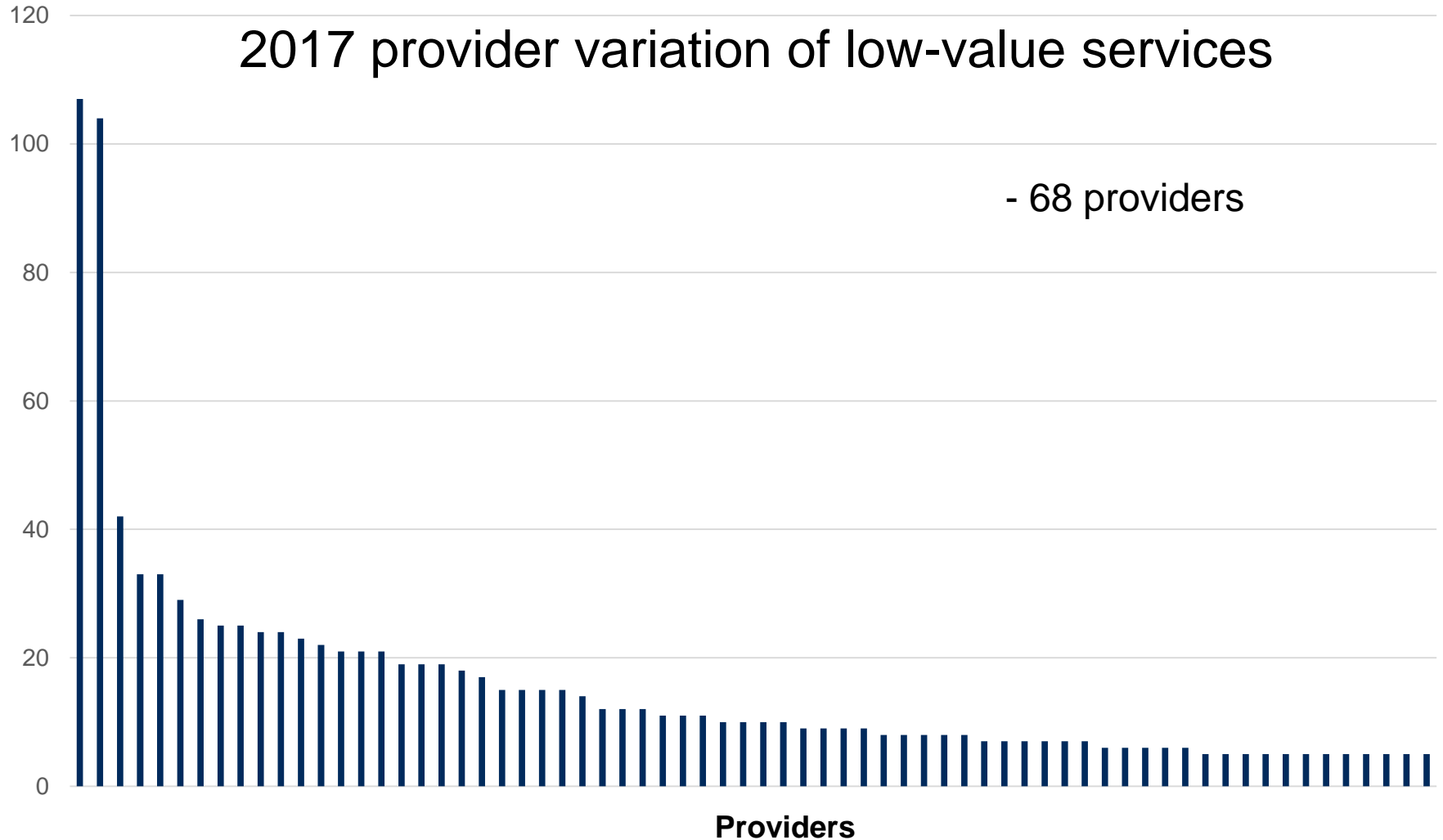


Imaging for Uncomplicated Headache

Year	Total Low-Value Dollars	Number of Low-Value Services	Number of Distinct Members with a Low-Value Services
2017	\$258,925	584	557

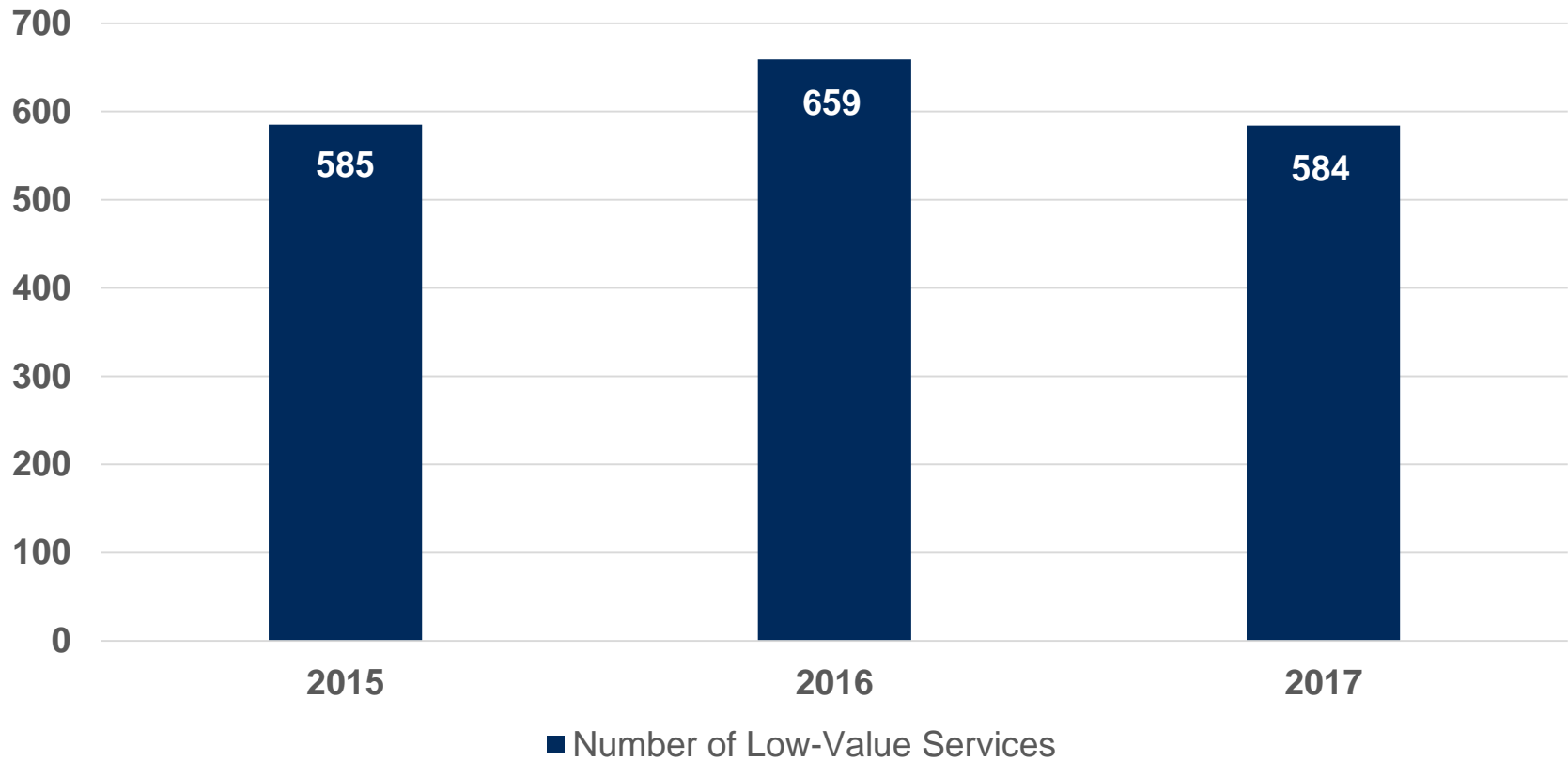


Imaging for Uncomplicated Headache



Imaging for Uncomplicated Headache

2015–2017 low-value service volume trends



Imaging for Eye Disease



Imaging for Eye Disease

- Measure based on Choosing Wisely recommendations from 2 physician specialty societies:
 - American Academy of Ophthalmology: *Don't Routinely order imaging tests for patients without symptoms or signs of significant eye disease.*
 - American Association for Pediatric Ophthalmology and Strabismus: *Don't order retinal imaging tests for children without symptoms or signs of eye disease.*

Source: Choosing Wisely, [American Academy of Ophthalmology](#) (released February 21, 2013) & [American Association for Pediatric Ophthalmology and Strabismus](#) (released October 3, 2013).



Imaging for Eye Disease

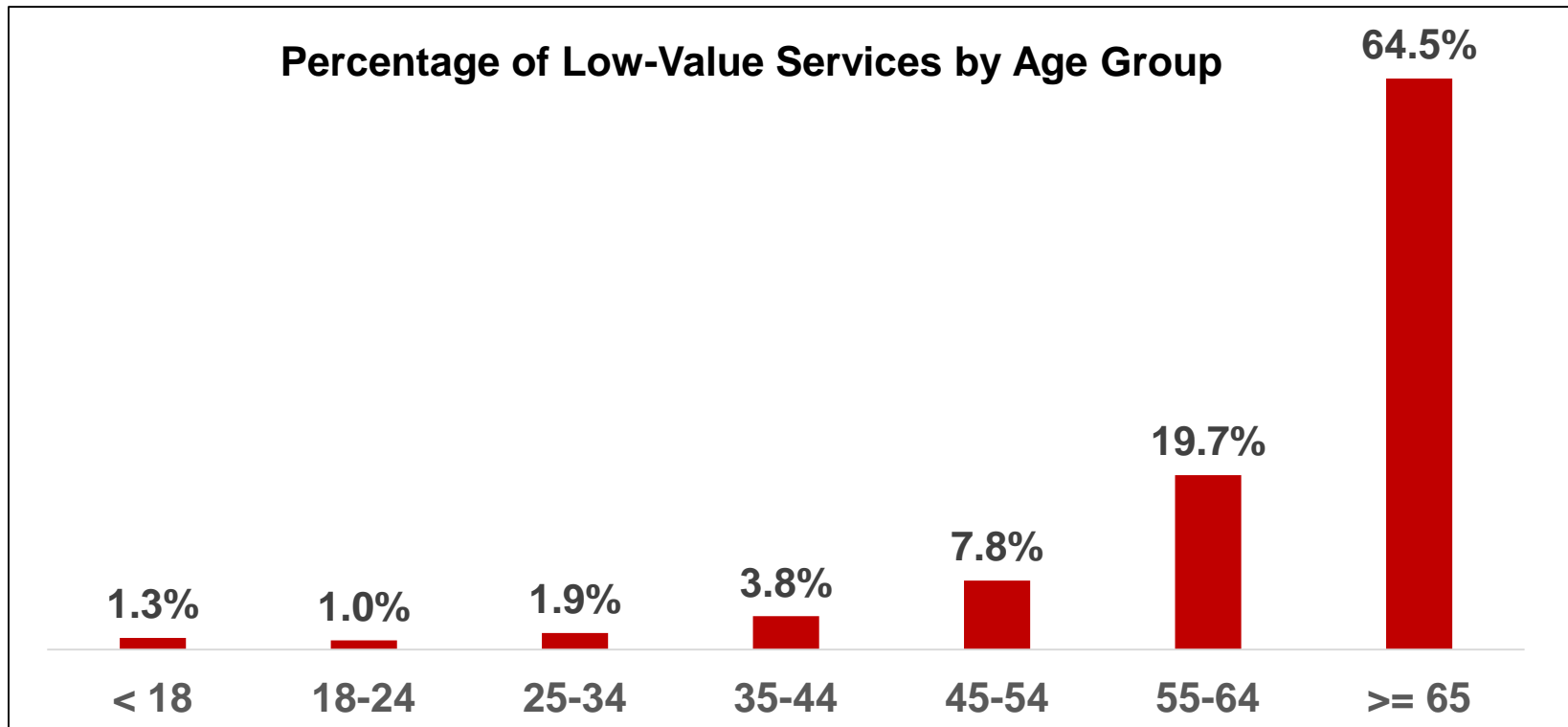
- Rationale for recommendation:
 - In patients without symptoms or signs of significant disease, clinical imaging tests are not needed
 - Comprehensive history and physical examination will usually reveal if eye disease is present or getting worse
- Examples of routine imaging:
 - Visual-field testing
 - Optical coherence tomography (OCT)
 - Retinal imaging of patients with diabetes
 - Neuroimaging or fundus photography

Source: Choosing Wisely, [American Academy of Family Physicians](#) (released on April 4, 2012)

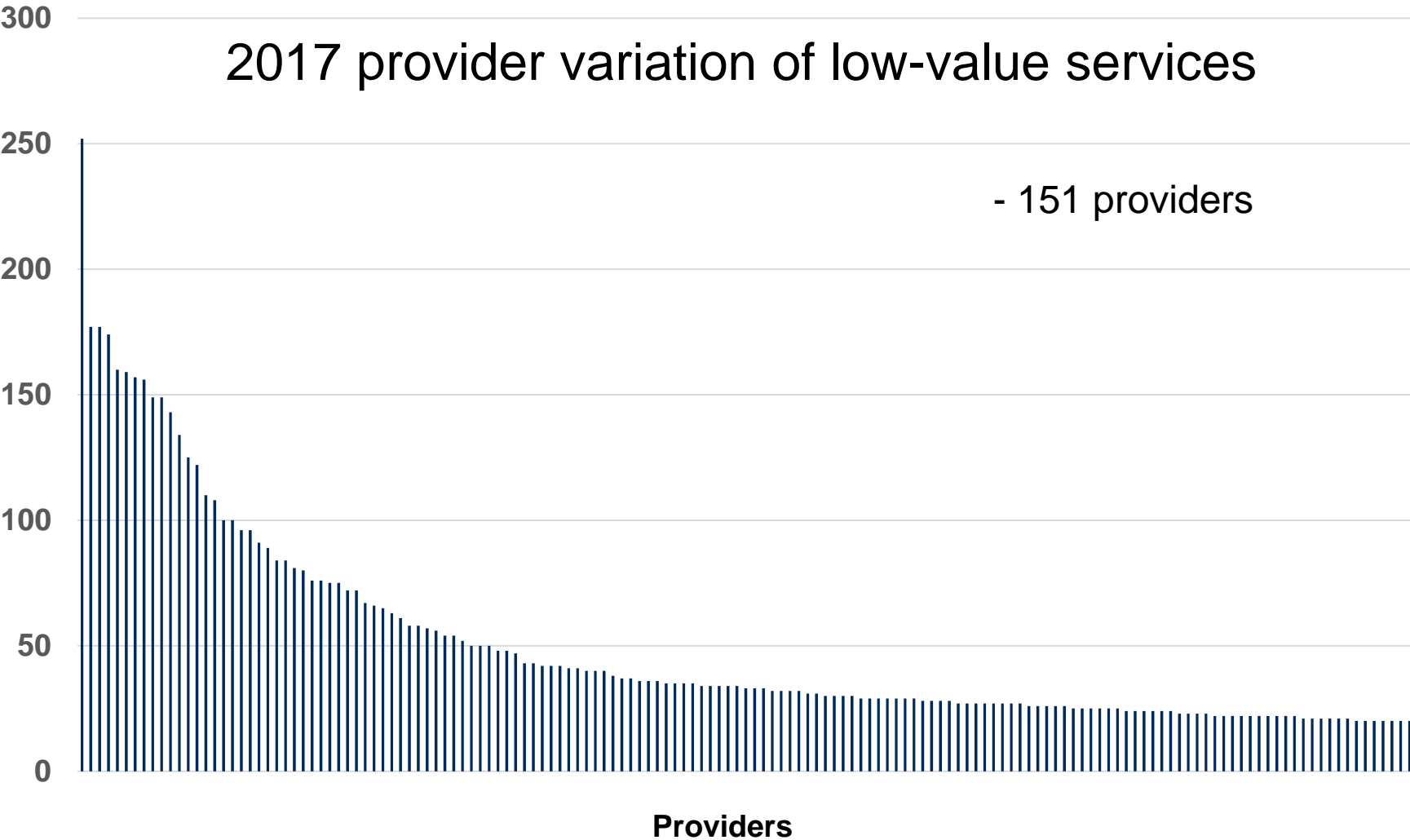


Imaging for Eye Disease

Year	Total Low-Value Dollars	Number of Low-Value Services	Number of Distinct Members with a Low-Value Service
2017	\$1,236,098	12,875	8,187

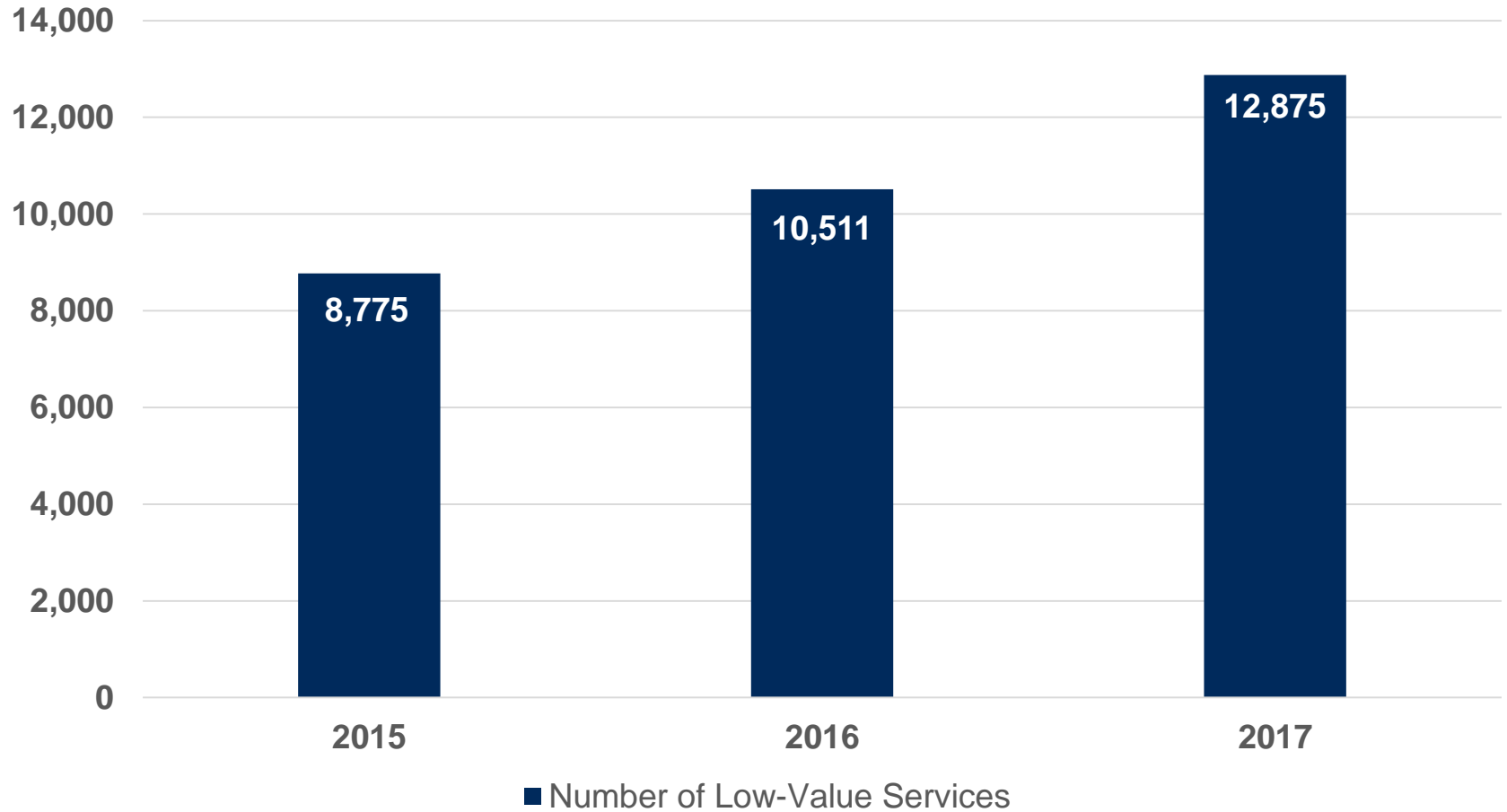


Imaging for Eye Disease



Imaging for Eye Disease

2015–2017 low-value service volume trends



Coronary Angiography



Coronary Angiography

- Measure based on Choosing Wisely recommendations from 2 physician specialty societies:
 - American Society of Nuclear Cardiology: *Don't perform stress cardiac imaging or coronary angiography in patients without cardiac symptoms unless high-risk markers are present.*
 - Society for Cardiovascular Angiography and Interventions: *Avoid coronary angiography to assess risk in asymptomatic patients with no evidence of ischemia or other abnormalities on adequate non-invasive testing.*

Source: Choosing Wisely, [American Society of Nuclear Cardiology](#) (released April 4, 2012) & [Society for Cardiovascular Angiography and Interventions](#) (released March 31, 2014).

Coronary Angiography

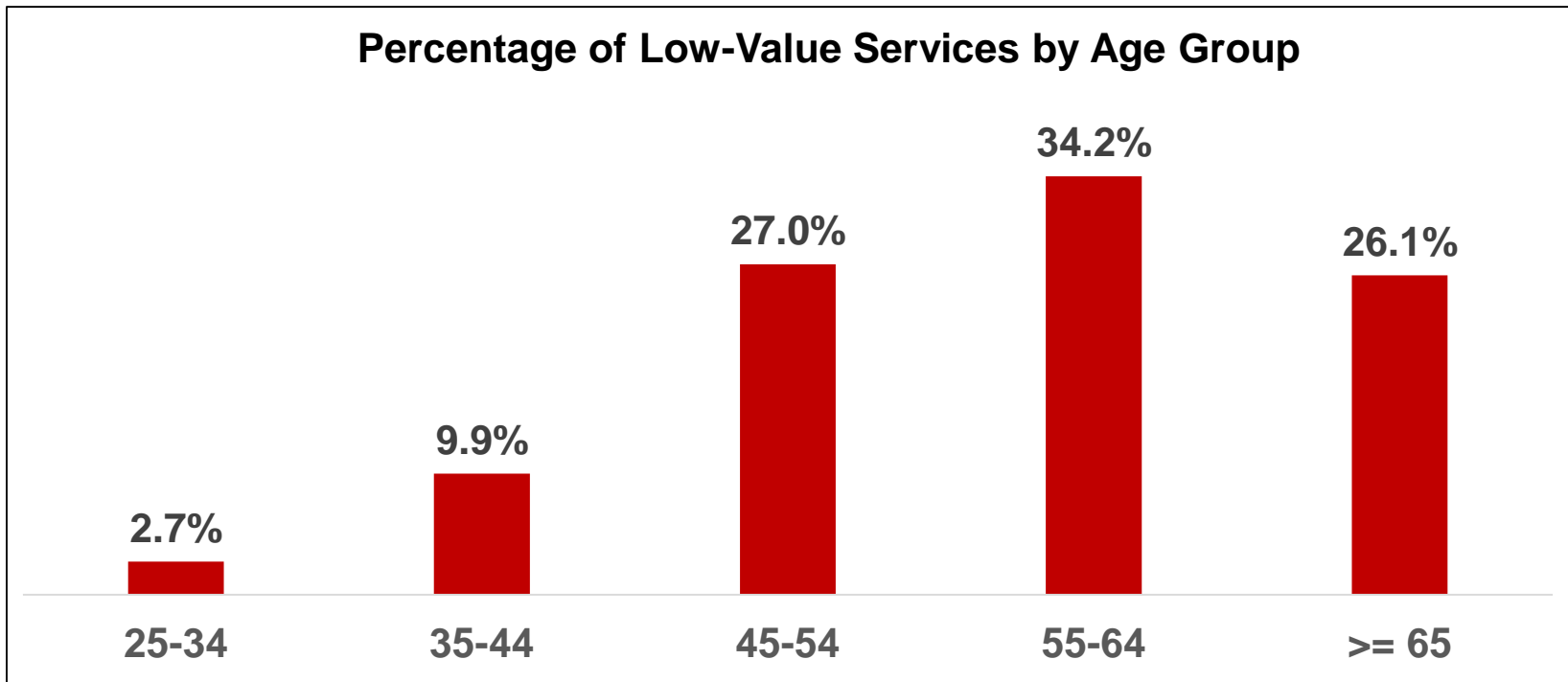
- Rationale for recommendation:
 - Asymptomatic patients who have no evidence of ischemia or other abnormalities on adequate non-invasive testing are at very low risk for cardiac events
 - Physicians should discuss goal of angiography with patients before it is performed, including possible role of revascularization with bypass surgery or coronary intervention
- Perform tests in asymptomatic patients only when the following are present:
 - Diabetes in patients older than 40
 - Peripheral arterial disease
 - Greater than 2% yearly coronary heart disease event rate

Source: Choosing Wisely, [American Society of Nuclear Cardiology](#) (released April 4, 2012) & [Society for Cardiovascular Angiography and Interventions](#) (released March 31, 2014).

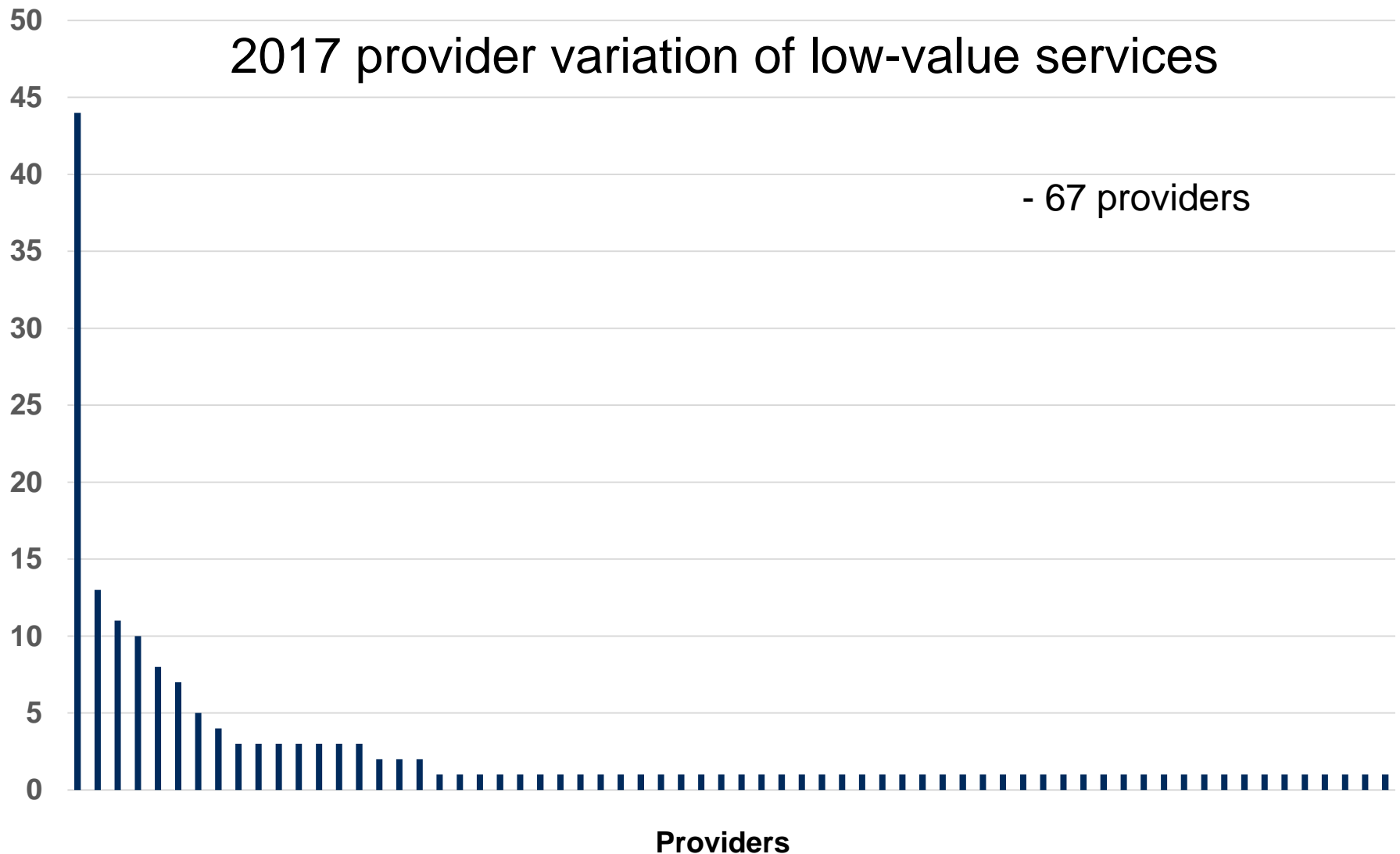


Coronary Angiography

Year	Total Low-Value Dollars	Number of Low-Value Services	Number of Distinct Members with a Low-Value Service
2017	\$372,219	205	202

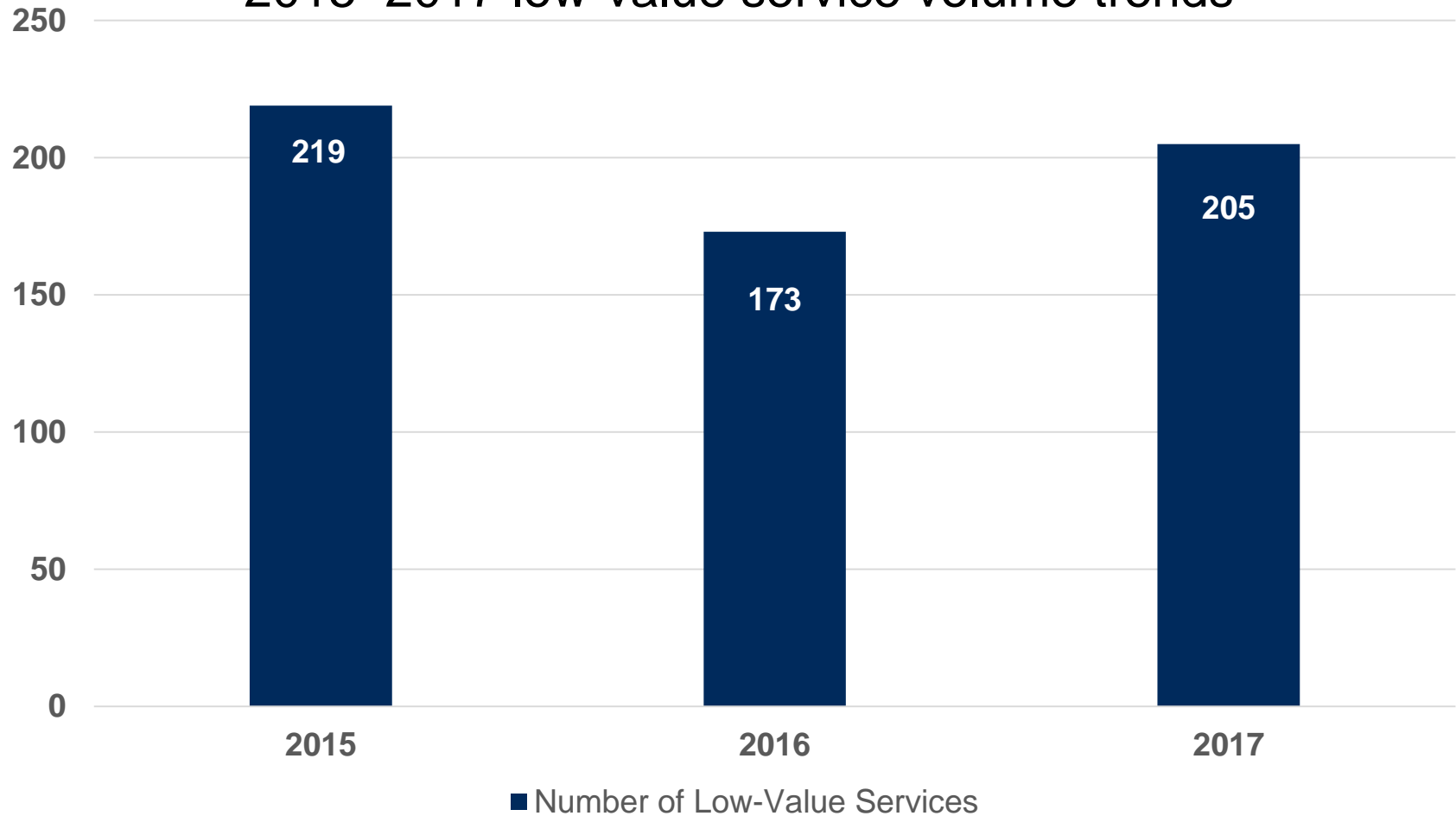


Coronary Angiography



Coronary Angiography

2015–2017 low-value service volume trends



Potential Considerations to Address Overuse

- Tailored member education
- Provider education
- Review of prior authorization criteria or medical management utilization management practices
- Provider-level assessment of variation
- Review of value-based payment models



Appendix

Coronary Angiography

- Society for Cardiovascular Angiography and Interventions: *Avoid coronary angiography risk assessment in patients with stable ischemic heart disease (SIHD) who are unwilling to undergo revascularization or who are not candidates for revascularization based on comorbidities or individual preferences.*
- Society for Cardiovascular Angiography and Interventions: *Avoid coronary angiography in post-coronary artery bypass graft (CABG) and post-PCI patients who are asymptomatic, or who have normal or mildly abnormal stress tests and stable symptoms not limiting quality of life.*

Source: Choosing Wisely, [Society for Cardiovascular Angiography and Interventions](#) (released March 31, 2014) & [Society for Cardiovascular Angiography and Interventions](#) (released March 31, 2014, updated July 19, 2018)

