



## AGENDA

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

**January 15, 2019**

**1:00 p.m.**

**EBD Board Room – 501 Building, Suite 500**

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

***Upcoming Meetings***

***February 12, 2019, March 12, 2019, April 9<sup>th</sup>, 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**

### **January 15, 2019**

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*Date / time 1/15/2019 1:00 PM | Meeting called to order by Margo Bushmiaer, Chair*

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#### **Attendance**

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##### **Members Present**

Michelle Murtha - Vice-Chair  
Dr. John Vinson - Proxy - Lauren Jimerson  
Margo Bushmiaer - Chair  
Dr. Arlo Kahn  
Dr. Terry Fiddler  
Melissa Moore - Teleconference  
Cindy Gillespie  
Pam Brown - Proxy - Nikki Wallace  
Zinnia Clanton  
Dr. Namvar Zohoori  
Chris Howlett, EBD Executive Director, Employee Benefits Division

##### **Members Absent**

##### **Others Present:**

Eric Gallo, Rhoda Classen, Shalada Toles, Theresa Huber, EBD; Mike Motley, Elizabeth Montgomery, ACHI; Takisha Sanders, Jessica Akins, HA; Ronda Walthall, ARDOT

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#### **Approval of Minutes by: Margo Bushmiaer, Chair**

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##### **MOTION by Dr. Fiddler**

I motion to approve the December 11, 2018 minutes.

Murtha seconded. All were in favor.

**Minutes Approved.**

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#### **ACHI Updates by: Mike Motley, Elizabeth Montgomery, ACHI**

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Mike Motley and Elizabeth Montgomery presented recommendations for the top 8 low-value services within EBD. The following recommendations were made:

##### General recommendations

1. Continue engagement with third-party administrator regarding changes to coverage policies:

- Review any Blue Cross Blue Shield (BCBS) policy changes in Benefits and Quality of Care Subcommittees to consider for EBD plan adoption.
  - Consider any policy changes in context of applicable Choosing Wisely and/or United States Preventive Service Task Force (USPSTF) recommendations.
2. Perform annual follow-up reports on all low-value services:
- Re-Run Health Waste Calculator output annually.
  - Assess the impacts of policy changes made from the recommendations adopted by the Board annually.
3. For each of the top 8 low-value services, utilize the following framework:
- Provider outreach
    - When applicable, request that third-party administrator notify all providers of policy change.
    - Incorporate *Choosing Wisely* provider education materials when messaging providers about unnecessary/low-value population-based screening.
    - Consider targeted communications to those who are providing the highest volume of low-value services.
  - Patient outreach
    - When applicable, request that third-party administrator notify all beneficiaries of policy change.
    - Utilize *Consumer Reports* handout to include in member messaging efforts, including EBD quarterly newsletter.
    - For all low-value services listed in top 8, include “5 things to ask your doctor” handouts for member education.
  - Evaluation
    - After implementation of policy change, complete annual analyses to assess impact of change.

### Specific Recommendations

1. Adopt Blue Cross Blue Shield (BCBS) coverage policy on population-based screening for Vitamin D deficiency.
  - Benefits design component - Adoption of BCBS coverage policy

2. If not already in place, adopt BCBS coverage policy for anterior segment optical coherence tomography.
  - o Engage appropriate individuals at third party administrator in designing and implementing policy changes for:
    - Posterior optical coherence tomography;
    - Fundus photography;
    - Visual field testing;
    - External eye photography; and
    - Internal eye photography.

### **Discussion:**

- Dr. Fiddler: Is the annual analyses too long to impact change? Do you need to start at maybe 6 months and see where you are on this?
- Howlett: Yes and no. We would want to look to see change from a quarterly perspective, and potentially see that year to year. Six months would be optimal but, typically, it is hard to see change in a quarter with certain things.
- Murtha: Is this test done for people who have been diagnosed with glaucoma, or is it done to see if they have glaucoma? How would we let the members know that this test is not paid for by the plan?
- Motley: It could be either, but it should not be done unless there is a documented observance of that. Secondly, their history should be reflective of their condition with their provider to let them know if it should be covered.
- Murtha: As a patient, if I go to the doctor and they do a whole list of stuff, I need to be aware that I don't need to have this eye test done unless it deemed necessary from other findings. They're not going to know what my insurance specifically covers.
- Dr. Kahn: From a patient perspective, if your eye doctor just starts doing a bunch of tests before examining you, you would hopefully be educated to ask why you need that test.

- Murtha: Even with education being put out there, if the test is done, is it going to reflect back on the provider or is it going to come back on the beneficiaries and I'm going to get a bill more than my copay because they did a test that I didn't need?
- Dr. Zohoori: I would say it would depend on what provider you are going to and what they are willing to do. Some places, they give you a piece of paper (Opt-In sheet) presented as a screening test to fill out that lets you know that this won't be paid for and it will be an out of pocket expense.
- Murtha: I agree with both recommendations, but can BCBS send something out to all providers that take care of the beneficiaries to let them know they are not going to get paid if they do these tests unnecessarily? Or is that already done?
- Motley: When BlueCross sends out their provider newsletter, when there is a coverage change for their fully insured business, they make note of that and have a page dedicated to letting them know of a new policy and the details of that. This is a big enough plan that they could consider putting something in the newsletter stating the policy change.
- Murtha: I just don't want it to fall back on the beneficiaries. If we recommend and approve of these, then I don't want beneficiaries to have to pay because the provider didn't read.
- Howlett: When dealing with a singular issue, we have to be careful, because we could be shifting that burden back to the plan. Which, in turn, can either support it or not. There are many avenues sending out communications. There has to be a certain level of skin in the game to be educated on what will or won't be covered. We can't guarantee nothing won't come back to the consumer. We do follow BlueCross's coverage policies. Sometimes we may find ourselves a little behind, but we have made every effort to communicate with members to keep them educated.
- Clanton: If we approve these recommendations, is there any time lag between when it's approved and when it goes into effect?
- Howlett: Typically, there is. With pharmacy it is 90 days, but we try to do 60-90 days on any plan changes. If you're going to do this effectively, you would have a targeted approach and draft a communication to get it out there. If we did

anything outside of March or April, we would be able to do that and operationalize it.

Dr. Fiddler: Do we not have more than two recommendations on all 8 that we have looked at?

Motley: Measure specific, we haven't made specific ones on any other than these two. From our perspective, we just have these two specific recommendations and the three general recommendations that have some components within them.

Dr. Kahn: I would favor putting forward these recommendations and seeing how well they work out before we make recommendations on the other five. Just a trial balloon, to make sure we know all the things that we haven't thought about that will inevitably come out. If it all goes smoothly, then do a couple more of these services.

Bushmaier: We may make recommendations for the other ones, but we will start with these and the general framework.

**MOTION** by Dr. Khan

I make the motion that we accept these recommendations as presented with the expectation that they not be implemented until adequate time has passed to do good member and provider education notification.

Howlett: With all our coverage policies, I can't tell you right now any that we aren't following with BlueCross, so I am being descriptive in the fact that we are going to be inclusive of all coverage policies and will adopt any that we are not currently following.

Dr. Kahn: Are you saying that without coming before this board again that you would accept all the BlueCross policy coverages even if they were less than what this board is currently covering?

Howlett: Related to the low-value services, yes.

Dr. Fiddler: If we are giving a blanket statement to everything BlueCross, then what's the purpose because we have left six out. Of all 8 talked about, could you give us a recommendation for the other ones?

Motley: The two measure specific ones are the two that we could see a near term policy change that is not in place right now. The other six have either had a change or

there wasn't a clear direction on a near term policy change. For those six, we will continue to review, still do provider messaging, and still do member education without making them your first line targets.

Gillespie: When I read this, I thought we are saying to continue working with TPA regarding changes and review any policy changes TPA makes here in this committee. Not a comparison back to all their policies, but as BlueCross makes changes in the future, here at this sub-committee, we would review those to see if we wanted to make changes in a forward-looking manner.

Dr. Fiddler: If I am looking at low-value and these are the only two recommendations we are taking to the board. What about the other six? Are we just going to vote those in and take all of those as recommendations or are we only going to talk about those two recommendations?

Dr. Kahn: My motion, to be clear, is just the two. If I were a board member, I would not be comfortable to approve anything on a blanket level just because BlueCross covers it, we will.

Gillespie: As I see it, they have made five recommendations: three are to deal with all eight and for six of the eight, we are going to have an effort, over the next year, to see whether showing more information to the providers and showing them how they fit against the criteria.

Montgomery: It is a spectrum of intervention. These two that have specific recommendations, there is a standard that has been in place with the coverage policy change. For the others, when you can start with patient and provider outreach sometimes that can precipitate the sort of change that you want to see.

Dr. Zohoori: Why did you choose these two to bring specific recommendations on right now?

Motley: These two had specific policies with BlueCross that were in alignment with the Choosing Wisely recommendation to some extent. Some of these already have had realignment of the policy, but it is still at the top of the low-value service list.

Dr. Zohoori: I ask because we are asking ACHI to come back with more recommendations for the others but there may not be any specific recommendations for the other six. I don't want to give the impression or ask for something that may not be necessary.

**MOTION** by Dr. Kahn modified:

I move that we consider the recommendations as presented by ACHI including the three general recommendations and the two specific recommendations with the change that where it says annual evaluations it will be ongoing evaluations, at least quarterly.

Dr. Zohoori seconded. All were in favor.

**Motion Approved.**

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

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Howlett provided an update on the AARP EEOC. There has been no change to this and we don't anticipate a decision in the near future.

**MOTION** by Gillespie

Move to adjourn.

Dr. Fiddler seconded. All were in favor.

**Meeting Adjourned.**

# January 2019 Quality of Care Subcommittee Presentation

**Mike Motley, MPH**

Assistant Director of Health Policy, ACHI

**Izzy Montgomery, MPA**

Policy Analyst, ACHI



# Objectives for Presentation

- Review and discuss draft recommendations
- Discuss next steps for EBD Board consideration
- Consider additional items



# Top 8 Low-Value Services Within EBD<sup>3</sup> (2017)

Low-Value Service	Distinct Members with Low-Value Service	Number of Low-Value Services	Low-Value Total Dollars
1. Don't obtain baseline lab 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



# General Recommendations



# General Recommendation 1

- Continue engagement with third-party administrator regarding changes to coverage policies:
  - Review any Blue Cross Blue Shield (BCBS) policy changes in Benefits and Quality of Care Subcommittees to consider for EBD plan adoption
  - Consider any policy changes in context of applicable *Choosing Wisely* and/or United States Preventive Service Task Force (USPSTF) recommendations



# General Recommendation 2

- Perform annual follow-up reports on all low-value services:
  - Re-run Health Waste Calculator output annually
  - Assess the impacts of policy changes made from the recommendations adopted by the Board annually



# General Recommendation 3

- For each of the top 8 low-value services, utilize the following framework:
  - Provider outreach
    - When applicable, request that third-party administrator notify all providers of policy change
    - Incorporate *Choosing Wisely* provider education materials when messaging providers about unnecessary/low-value population-based screening
    - Consider targeted communications to those who are providing the highest volume of low-value services



# General Recommendation 3 (continued)<sup>8</sup>

- For each of the top 8 low-value services, utilize the following framework:
  - Patient outreach
    - When applicable, request that third-party administrator notify all beneficiaries of policy change
    - Utilize *Consumer Reports* handout to include in member messaging efforts, including EBD quarterly newsletter
    - For all low-value services listed in top 8, include “5 things to ask your doctor” handouts for member education



# General Recommendation 3 (continued)<sup>9</sup>

- For each of the top 8 low-value services, utilize the following framework:
  - Evaluation
    - After implementation of policy change, complete annual analyses to assess impact of change



# Specific Recommendations



# Specific Recommendation 1

- Adopt Blue Cross Blue Shield (BCBS) coverage policy on population-based screening for Vitamin D deficiency
  - Benefit design component—Adoption of [BCBS coverage policy](#)



# Specific Recommendation 2

- If not already in place, adopt BCBS coverage policy for anterior segment optical coherence tomography
  - Engage appropriate individuals at third party administrator in designing and implementing policy changes for:
    - posterior optical coherence tomography
    - fundus photography
    - visual field testing
    - external eye photography
    - internal eye photography



# Appendix — Previous Presentations



# November 2018 Quality of Care Committee Presentation

**Mike Motley, MPH**

Assistant Director of Health Policy, ACHI

**Izzy Montgomery, MPA**

Policy Analyst, ACHI



# 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<sup>16</sup>

- 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<sup>17</sup>

- 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
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# Unnecessary Preoperative Baseline Lab Studies



# Unnecessary Preoperative Baseline Lab<sup>20</sup> 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<sup>21</sup> 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<sup>22</sup> Studies

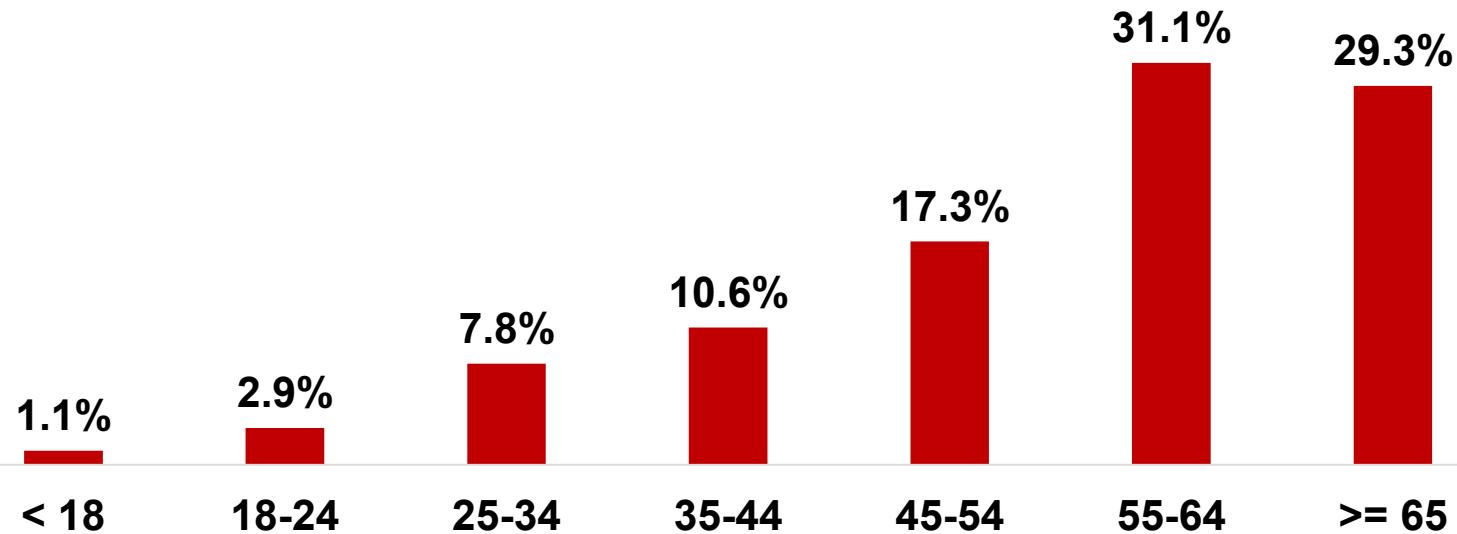
- Some necessary services are excluded from the analysis based on conditions and other criteria, for example:
  - Services where low-risk surgery is on, or one day after, the evaluation visit for emergency care or urgent care visit
  - Diagnosis of endocrine, liver, or renal disorders
  - History of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



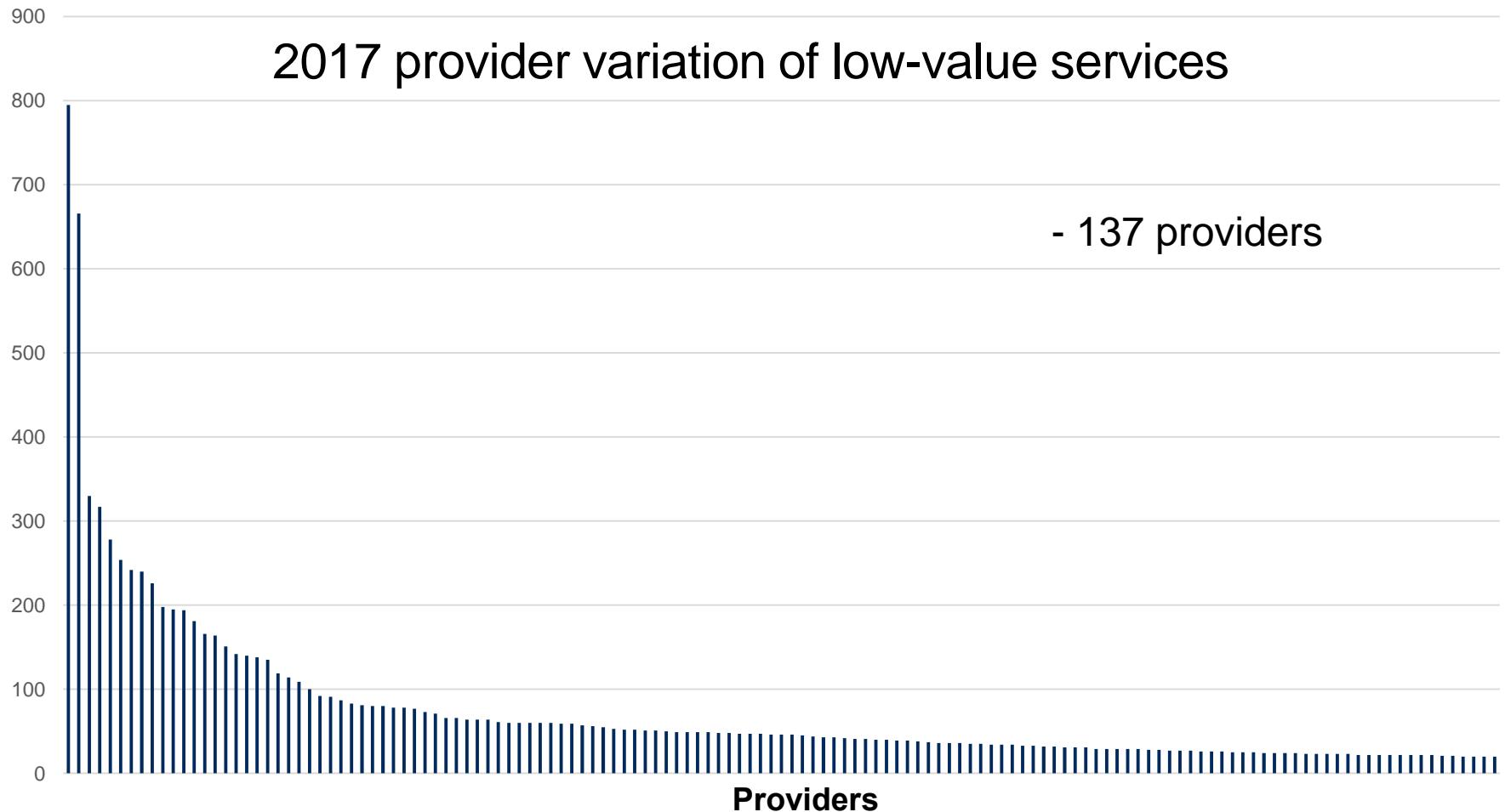
# Unnecessary Preoperative Baseline Lab<sup>23</sup> Studies

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

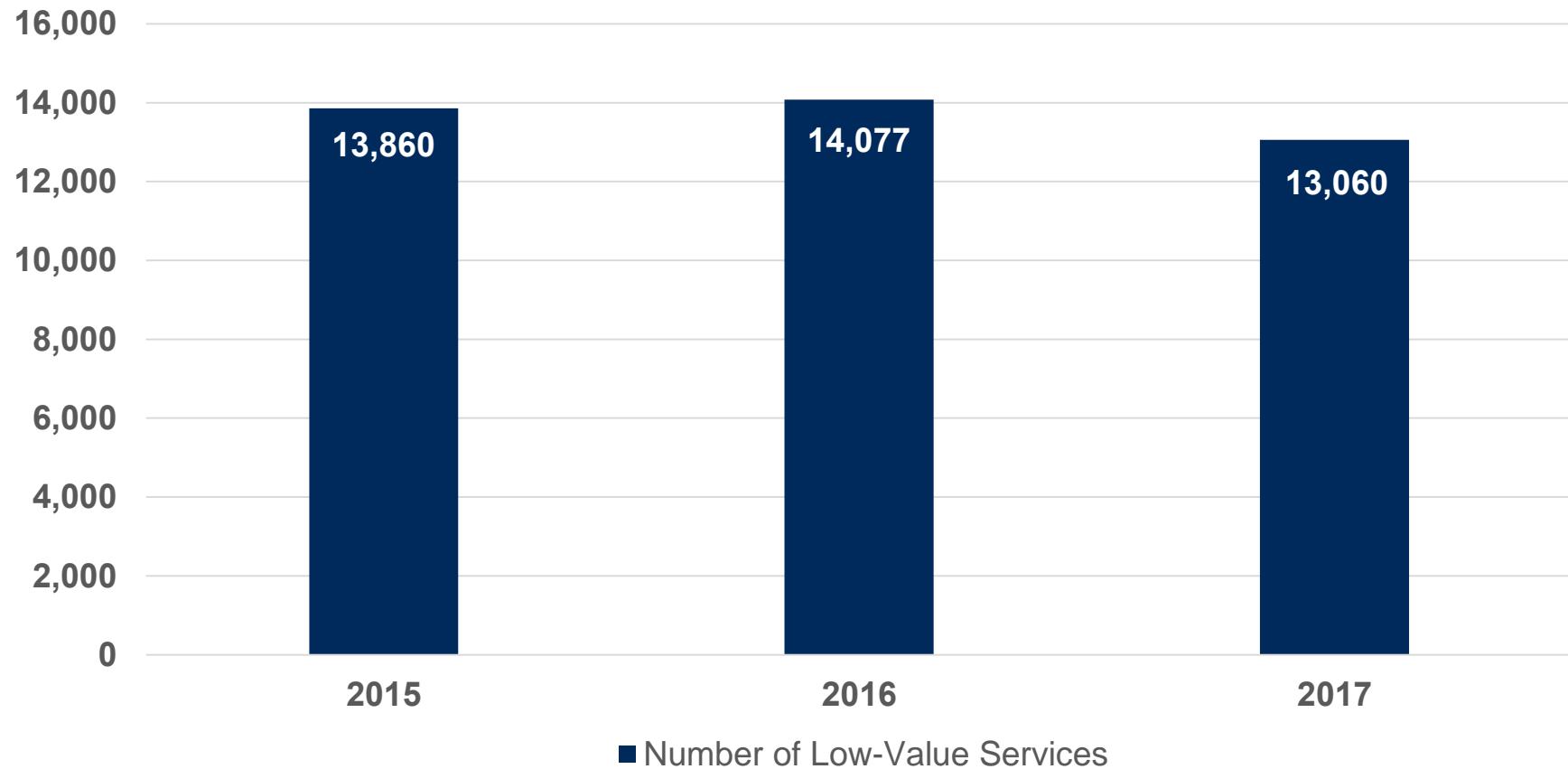


# Unnecessary Preoperative Baseline Lab<sup>24</sup> Studies



# Unnecessary Preoperative Baseline Lab<sup>25</sup> Studies

2015–2017 low-value service volume trends



# Annual EKGs and Other Cardiac Screenings



# Annual EKGs & Other Cardiac Screenings<sup>27</sup>

- 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<sup>28</sup>

- 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<sup>29</sup>

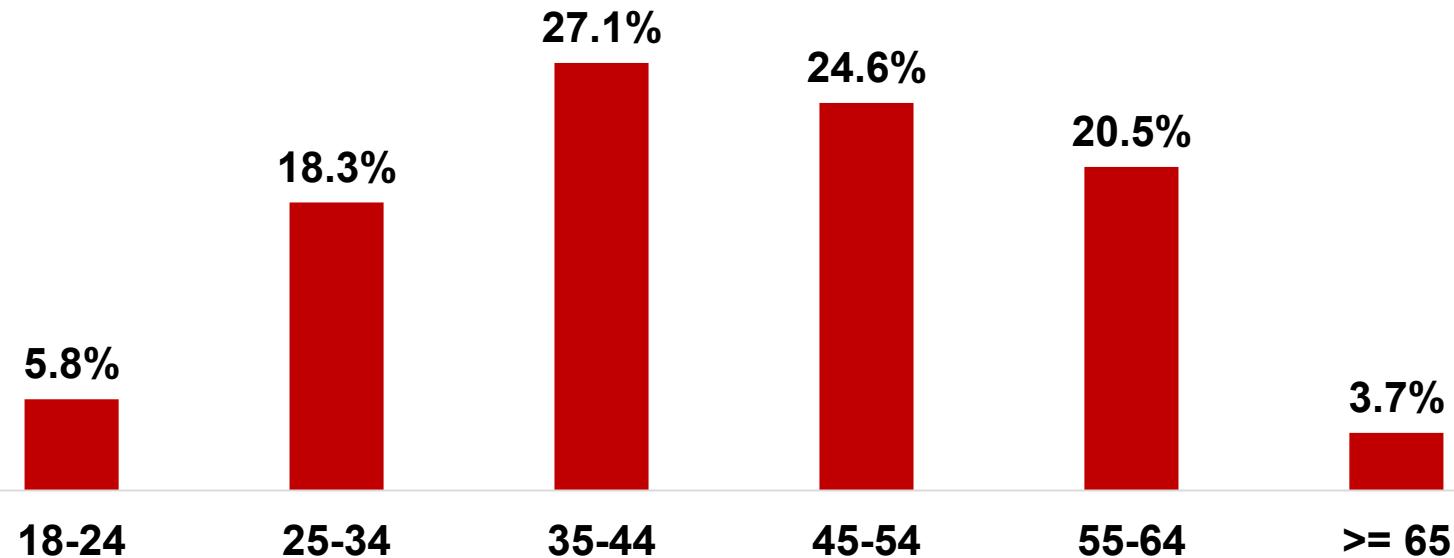
- For this measure, cardiac screening tests were deemed appropriate (and excluded from analysis) for a number of clinical circumstances, for example:
  - History of coronary heart disease (CHD)
  - Presence of risk factors suggestive of intermediate CHD risk
  - Inflammatory conditions such as arthritis,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



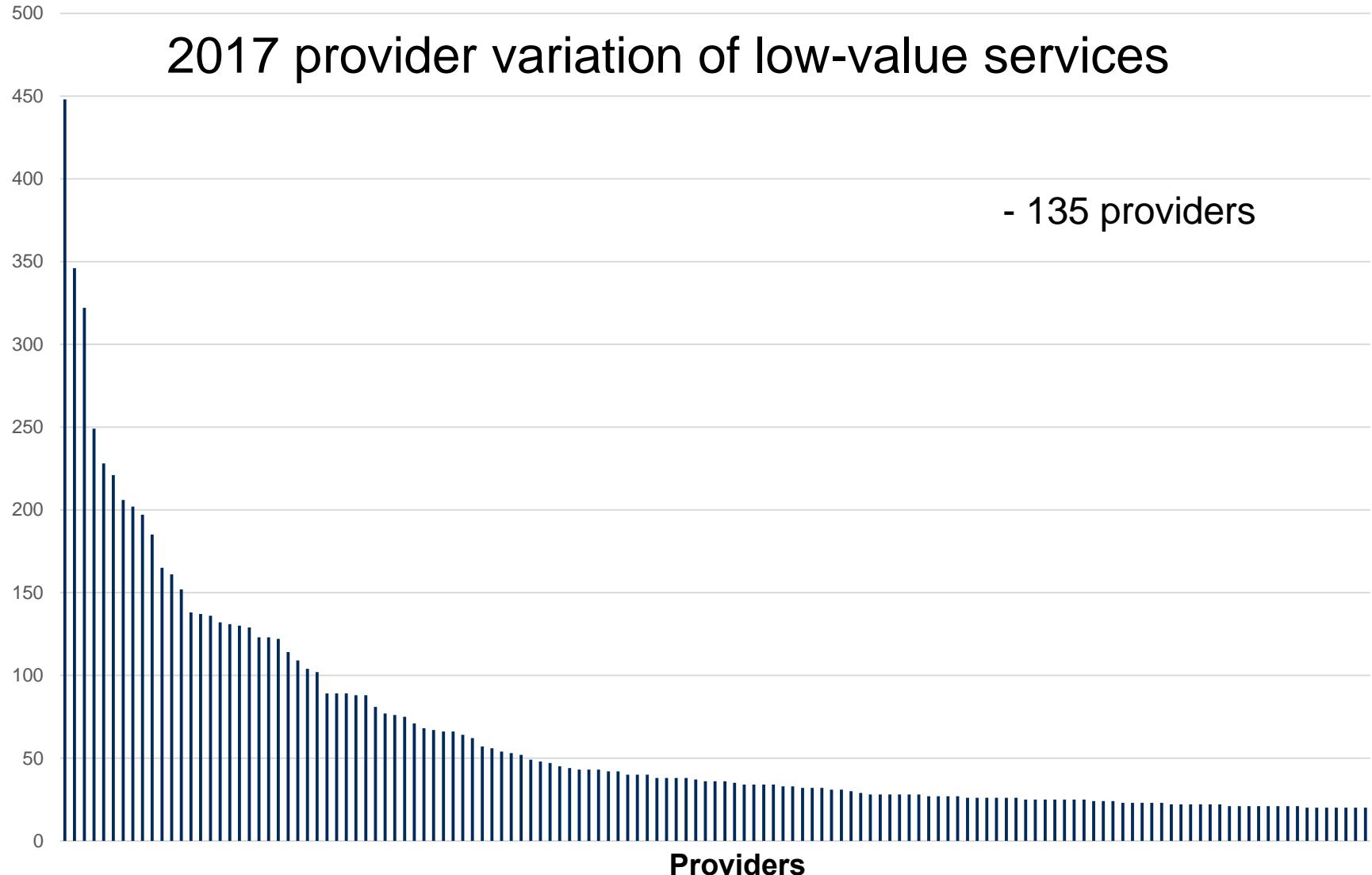
# Annual EKGs & Other Cardiac Screenings<sup>30</sup>

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

Percentage of Low-Value Services by Age Group

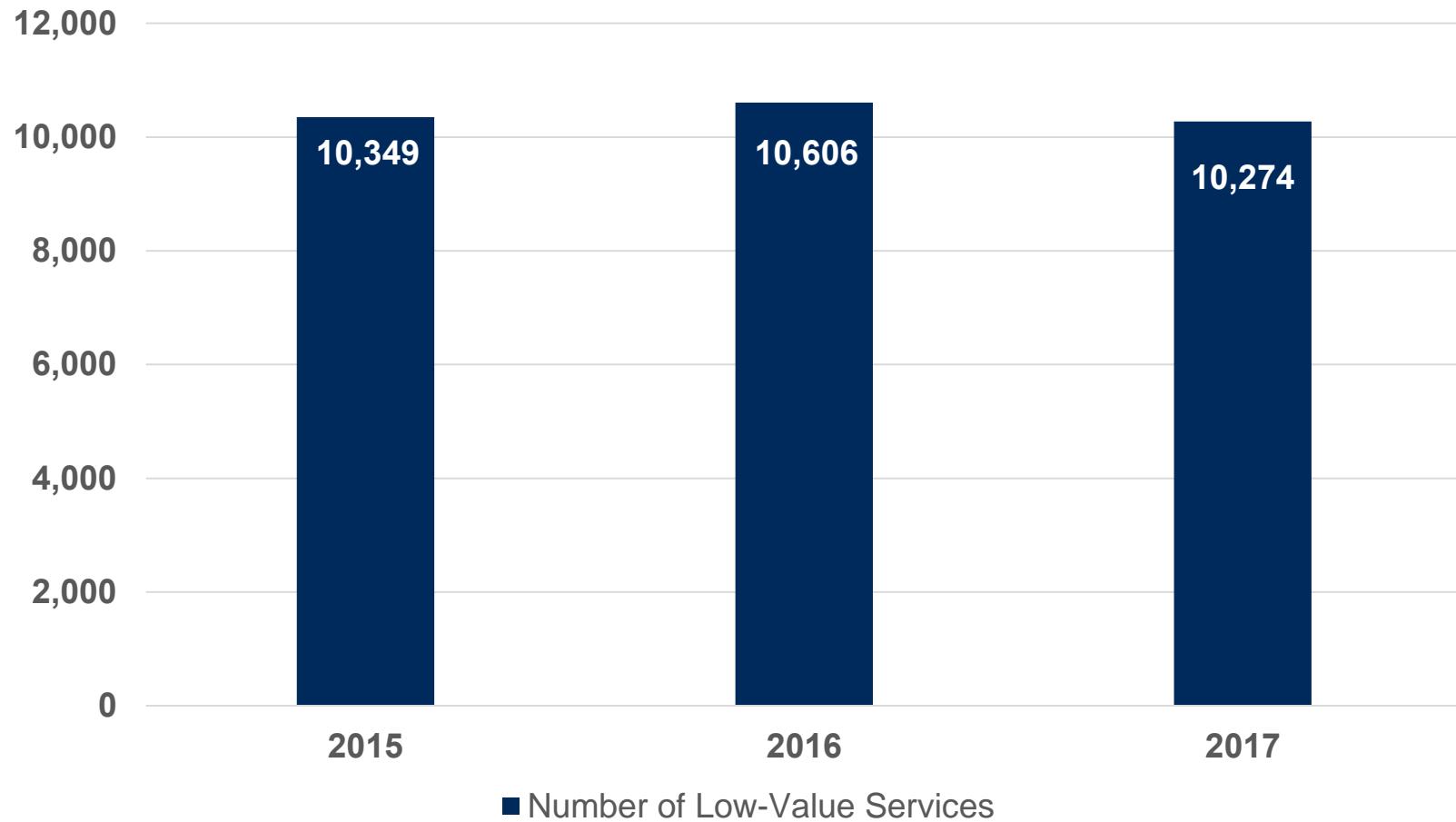


# Annual EKGs & Other Cardiac Screenings<sup>31</sup>



# Annual EKGs & Other Cardiac Screenings<sup>32</sup>

2015–2017 low-value service volume trends



# Imaging for Uncomplicated Headache



# Imaging for Uncomplicated Headache<sup>34</sup>

- 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 <sup>35</sup>

- 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.

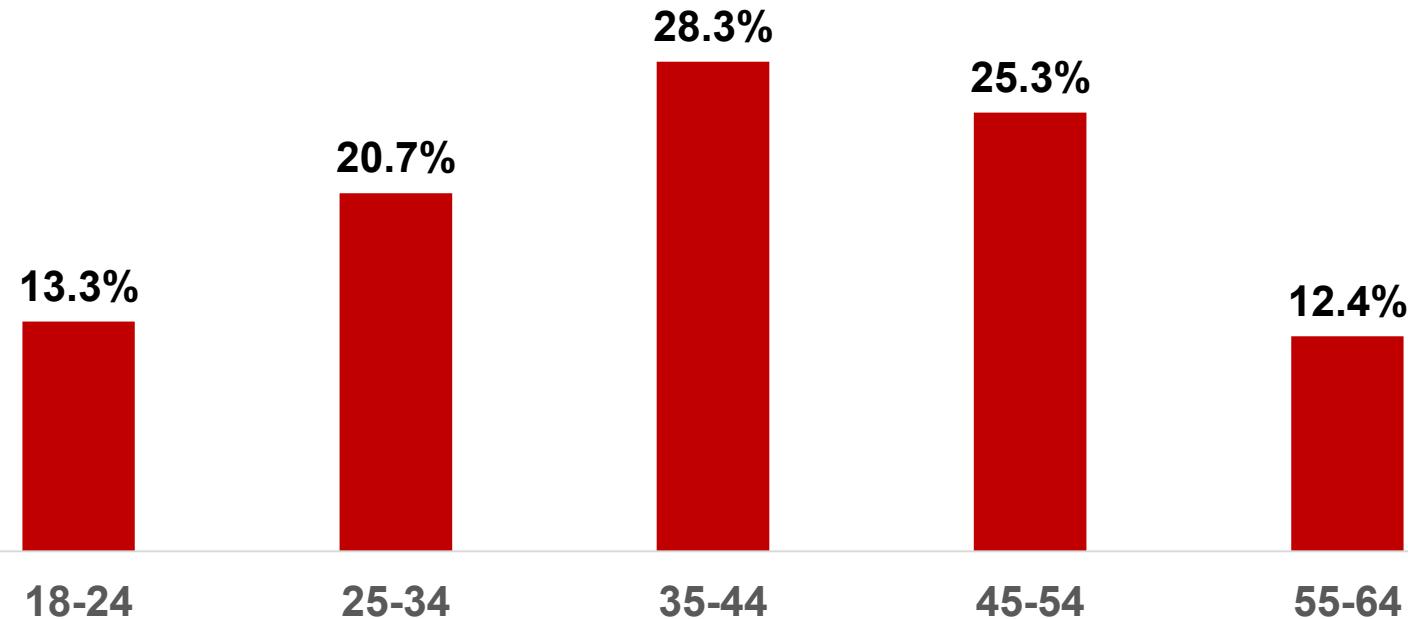
Source: Choosing Wisely, [American College of Radiology](#) (released April 4, 2012)



# Imaging for Uncomplicated Headache<sup>36</sup>

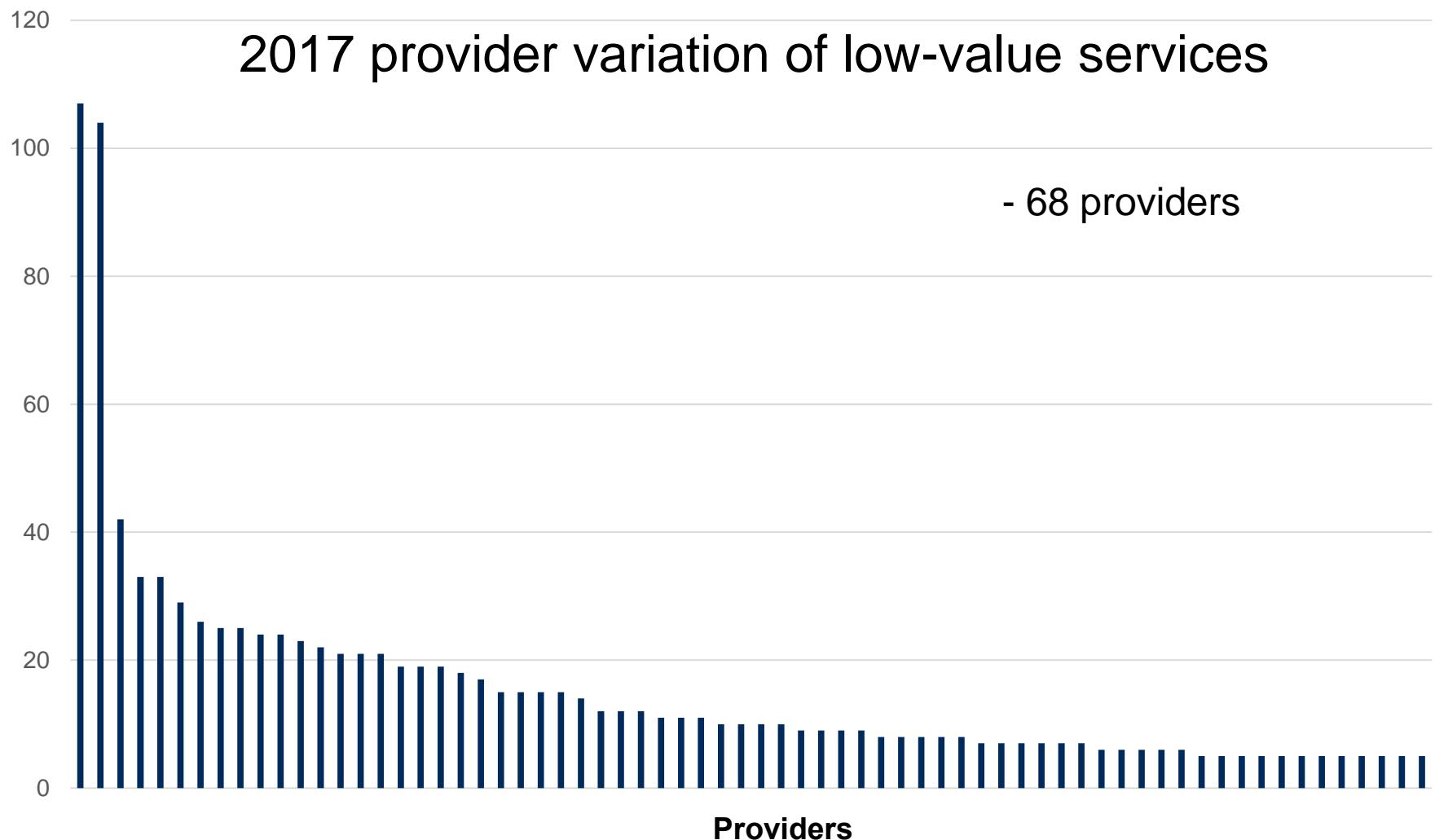
Year	Total Low-Value Dollars	Number of Low-Value Services	Number of Distinct Members with a Low-Value Services
2017	\$258,925	584	557

Percentage of Low-Value Services by Age Group



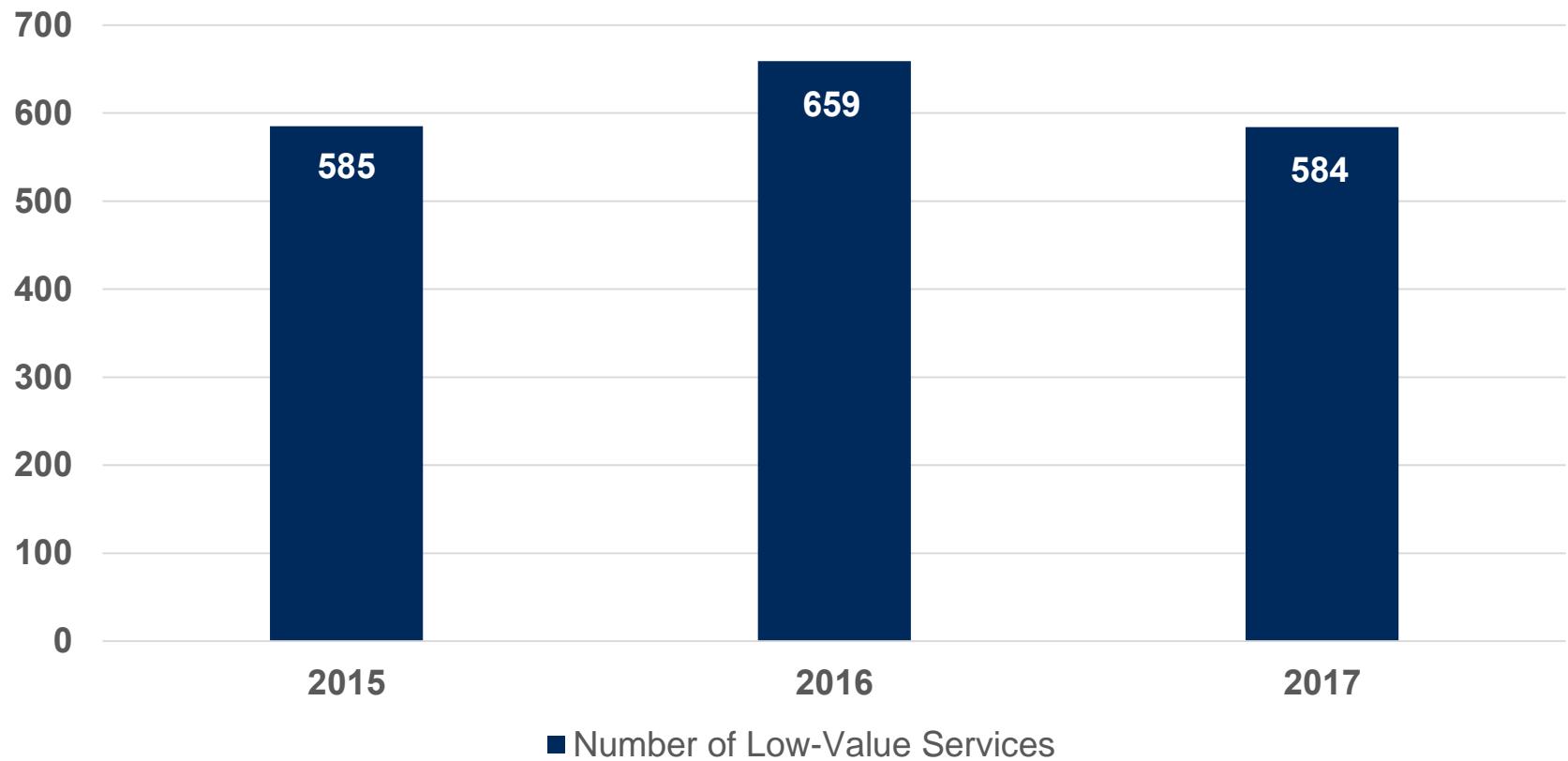
# Imaging for Uncomplicated Headache

37



# Imaging for Uncomplicated Headache<sup>38</sup>

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

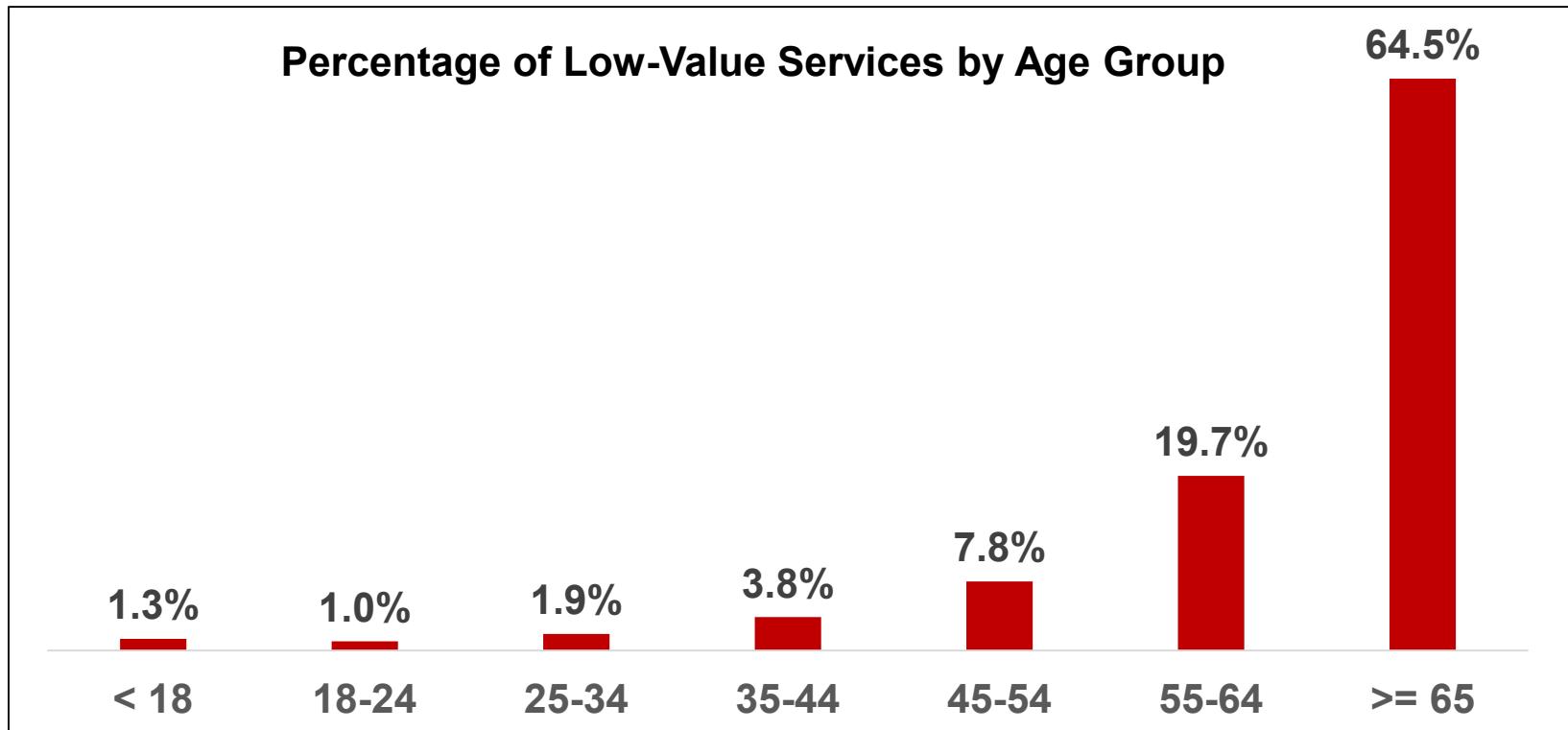
- Rationale for recommendation:
  - In patients without symptoms or signs of significant disease, clinical imaging tests are not needed
  - Comprehensive history and physical examination will usually reveal if eye disease is present or getting worse
- Examples of routine imaging:
  - Visual-field testing
  - 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)

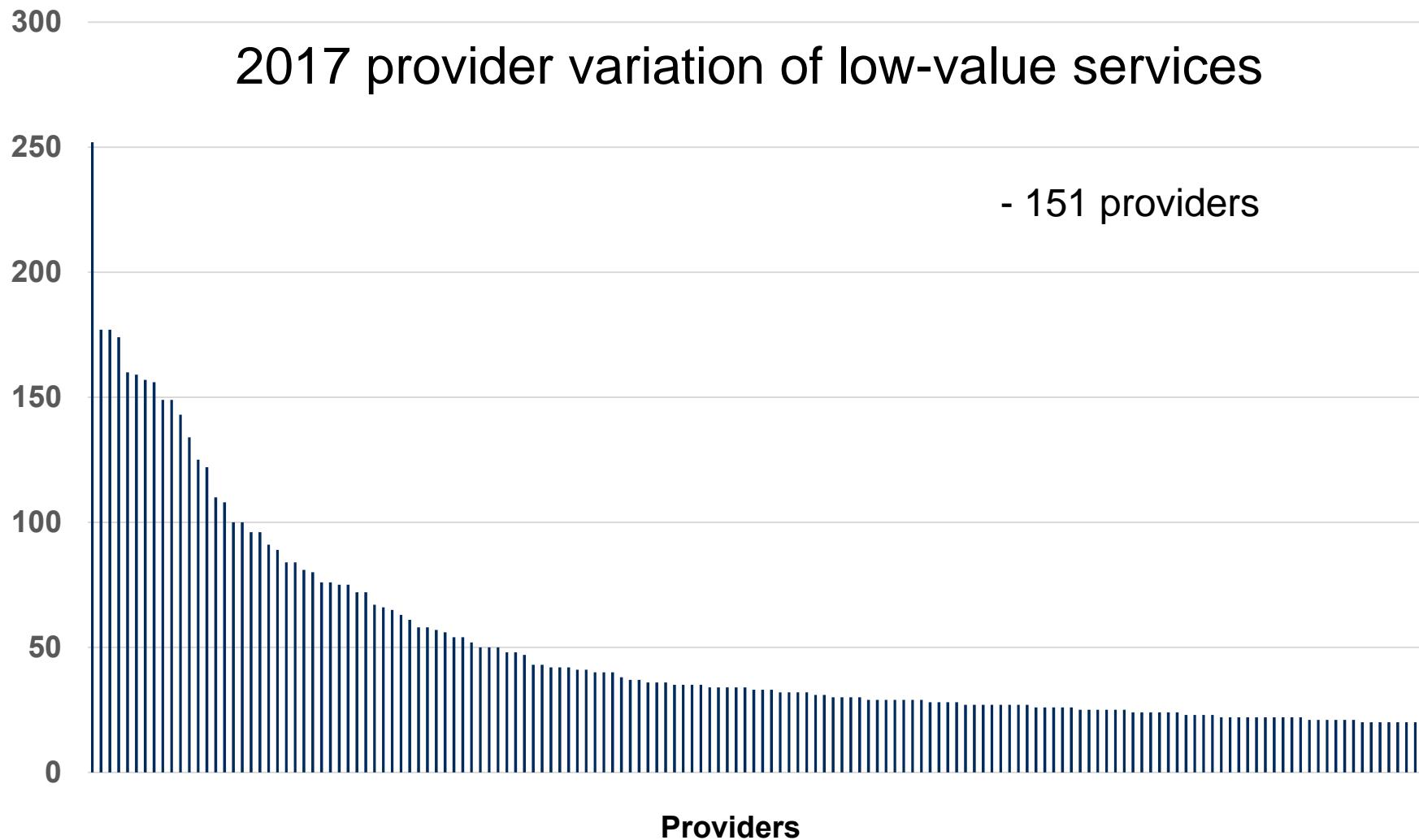


# Imaging for Eye Disease

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

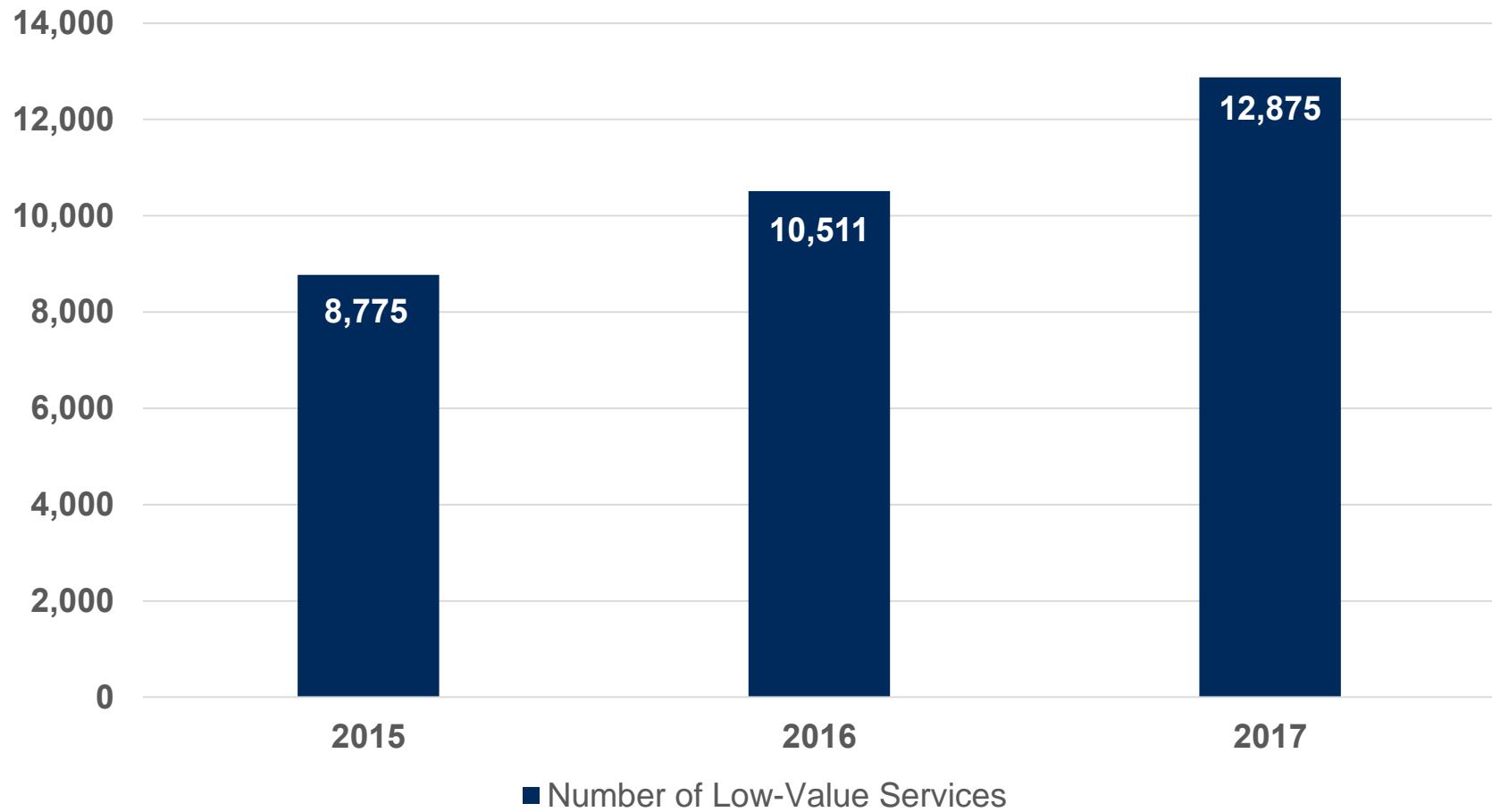


# Imaging for Eye Disease



# 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

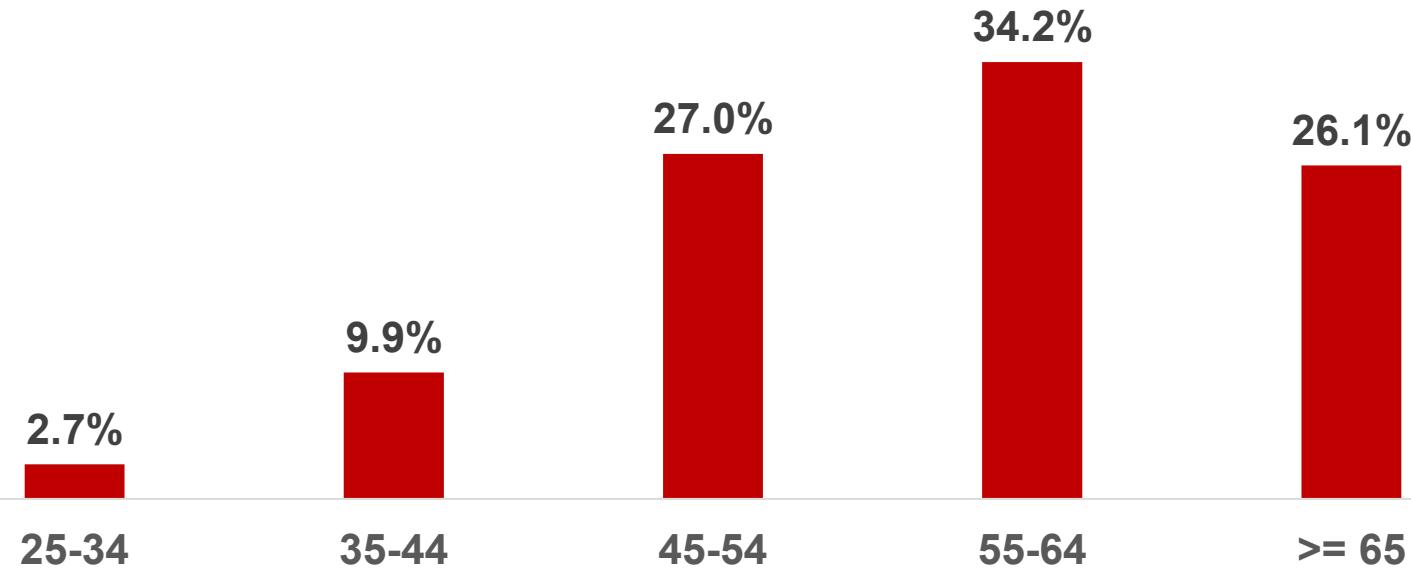
Source: Choosing Wisely, [American Society of Nuclear Cardiology](#) (released April 4, 2012) & [Society for Cardiovascular Angiography and Interventions](#) (released March 31, 2014).



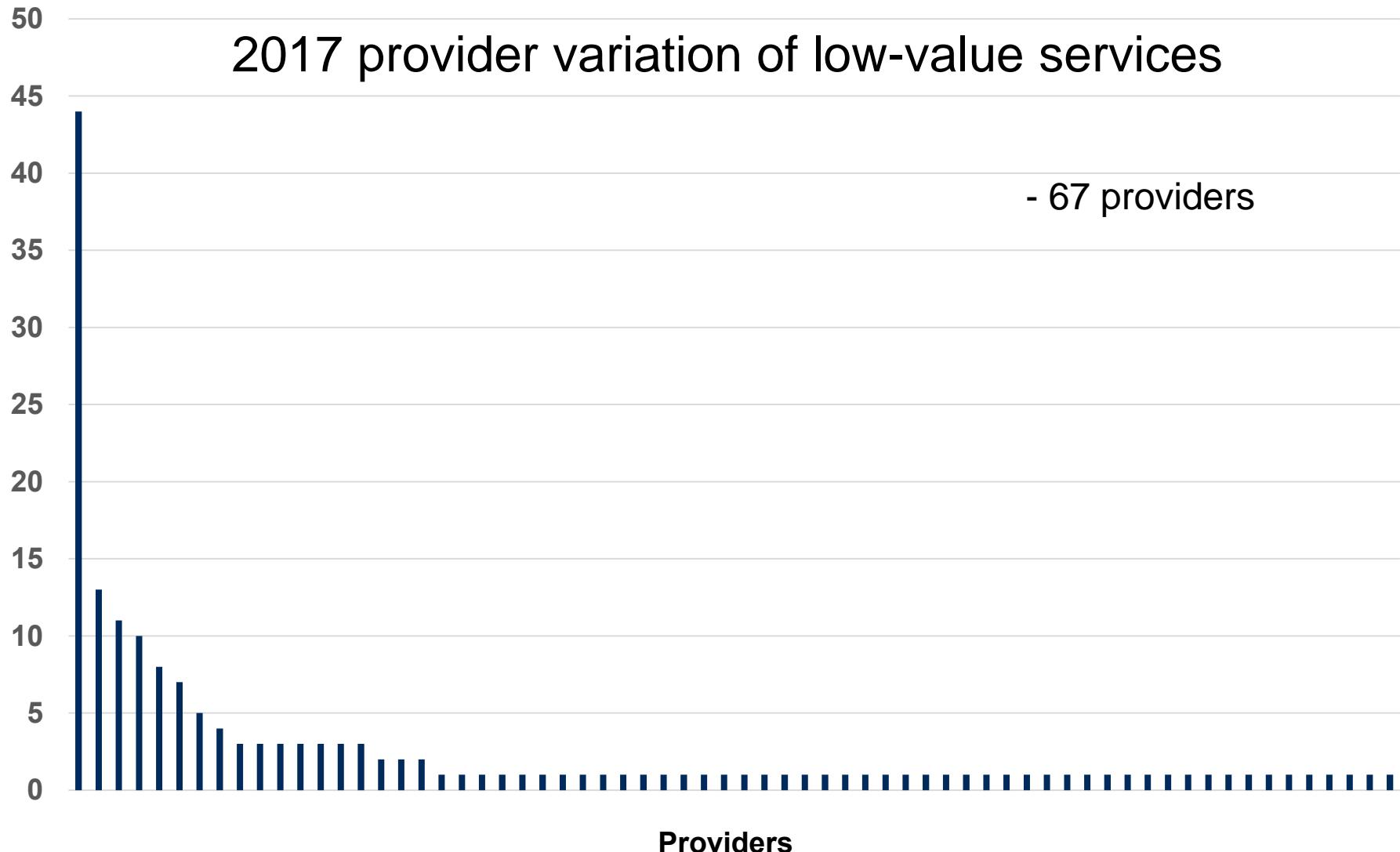
# Coronary Angiography

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

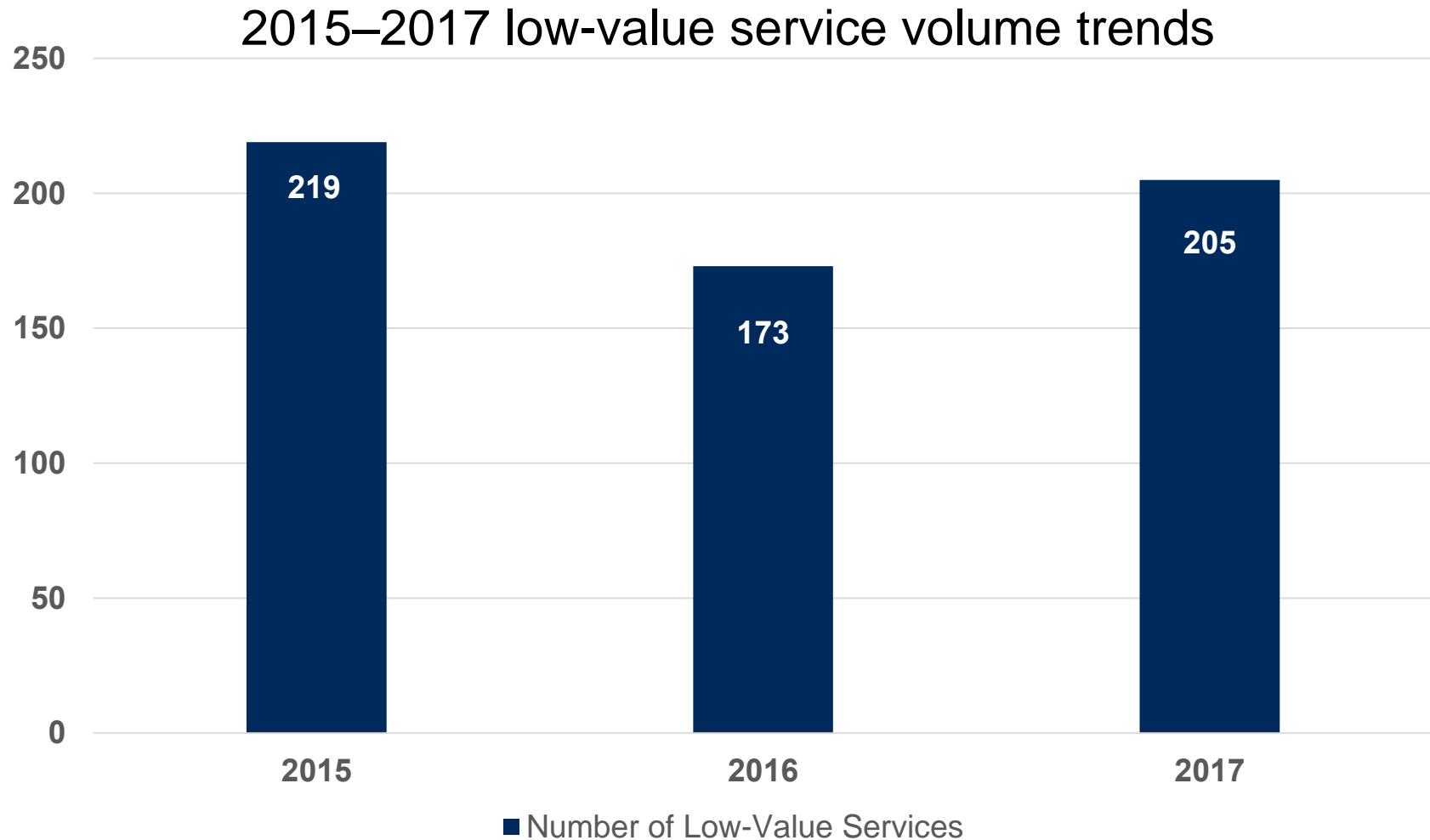
Percentage of Low-Value Services by Age Group



# Coronary Angiography



# Coronary Angiography



# 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



# 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)



# December 2018 Quality of Care Subcommittee Presentation

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Policy Analyst, ACHI



# Objectives for Presentation

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



# Follow up Question: Provider Variation<sup>55</sup> Trends

- Providers in Top 10 of low-value services (comparing 2017 to 2016):
  - Annual EKG: 9 of the same providers in 2016
  - Coronary Angiography: 3 of the same providers in 2016
  - Eye Imaging: 9 of the same providers in 2016
  - Antibiotics: 6 of the same providers in 2016



# Top 8 Low-Value Services Within EBD (2017)<sup>66</sup>

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



# Too Frequent Cervical Cancer Screening



# Too Frequent Cervical Cancer Screening<sup>58</sup>

- Measure based on Choosing Wisely recommendations from 4 physician specialty societies:
  - American College of Obstetricians and Gynecologists: *Don't perform routine annual cervical cytology screening (Pap tests) in women 30–65 years of age*
  - American Academy of Family Physicians: *Don't screen women older than 65 years of age for cervical cancer who have had adequate prior screening and are not otherwise at high risk for cervical cancer*

Source: Choosing Wisely, [American College of Obstetricians and Gynecologists](#) (released February 2013) and Choosing Wisely, [American Academy of Family Physicians](#) (released February 2013)



# Too Frequent Cervical Cancer Screening<sup>59</sup>

- American Academy of Family Physicians: *Don't perform Pap smears on women younger than 21 who have had a hysterectomy for non-cancer disease*
- American Academy of Family Physicians: *Don't screen women younger than 30 years of age for cervical cancer with HPV testing, alone or in combination with cytology*
- American Society for Clinical Pathology: *Don't perform low-risk HPV testing*

Source: Choosing Wisely, [American Academy of Family Physicians](#) (released April 2012), [American Academy of Family Physicians](#) (released February 2013), and [American Society for Clinical Pathology](#) (released February 2013).



# Too Frequent Cervical Cancer Screening<sup>60</sup>

- Rationale for recommendations:
  - Pre-cancerous changes of the cervix lead to cervical cancer, but progression of these changes to invasive cancer is slow
  - Sufficient evidence to suggest that too frequent testing does not add clinical value and is considered wasteful
  - Observed but benign abnormalities can lead to unnecessary anxiety, additional testing, excessive cost

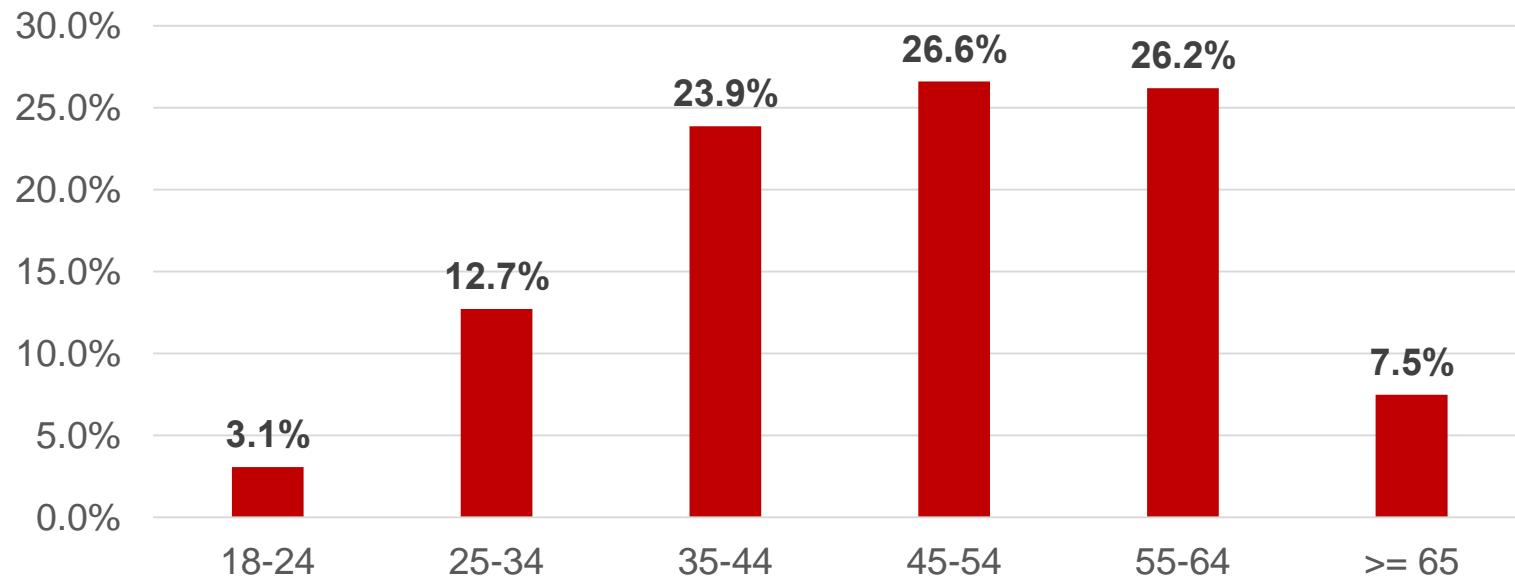
Source: Washington Health Alliance, [“First, Do No Harm”](#) (released February 2018)



# Too Frequent Cervical Cancer Screening<sup>61</sup>

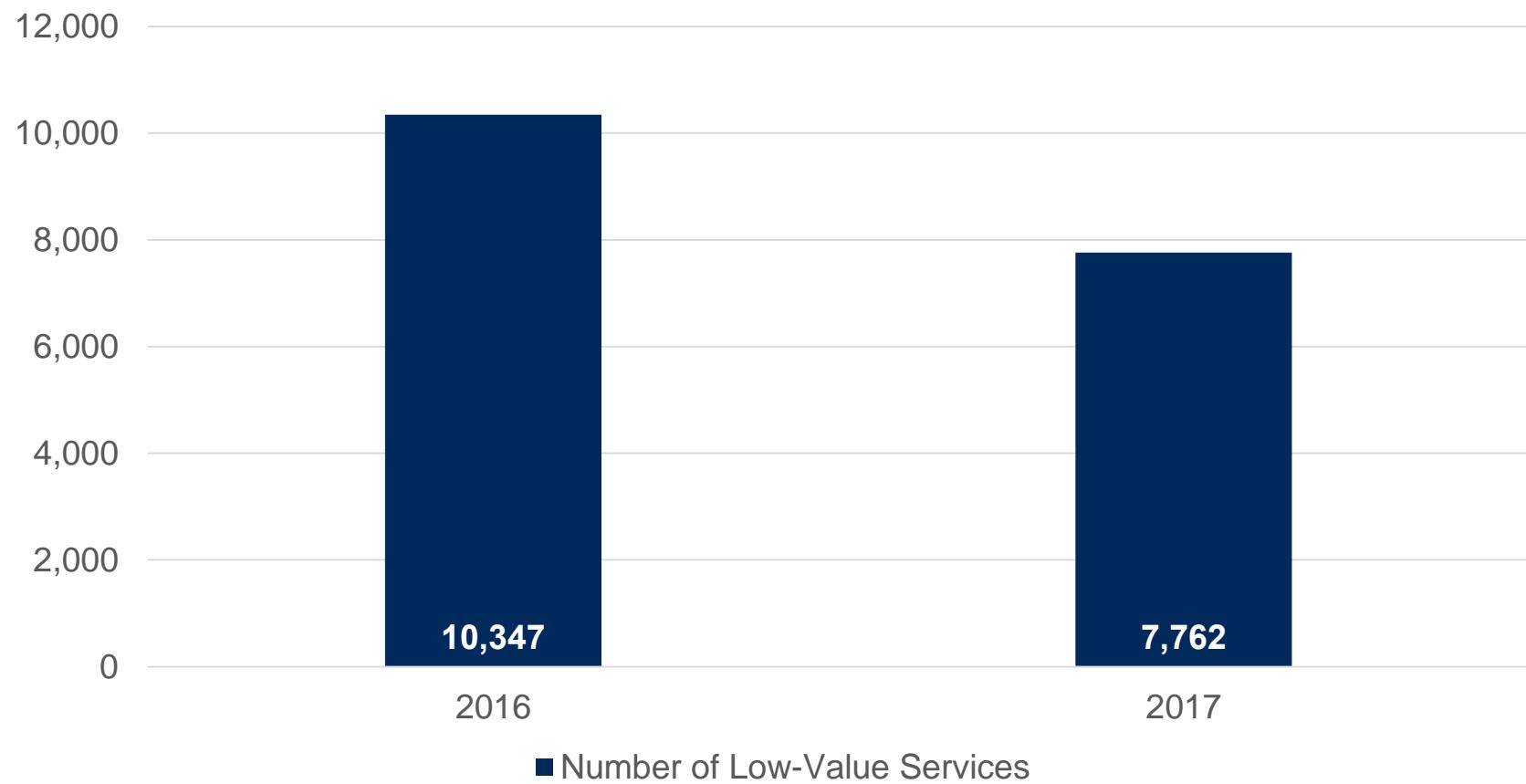
Year	Number of Low-Value Services	Number of Distinct Members with a Low-Value Service
2017	7,762	7,676

**Percentage of Low-Value Services by Age Group**



# Too Frequent Cervical Cancer Screening<sup>62</sup>

2016 and 2017 Low-Value Service Volume Trend



# Population-Based Screening for Vitamin D Deficiency



# Population-Based Screening for Vitamin<sup>64</sup> D Deficiency

- Measure is based on Choosing Wisely recommendation from American Society of Clinical Pathology:
  - *Don't perform population based screening for Vitamin D deficiency*

Source: Choosing Wisely, [American Society for Clinical Pathology](#) (released on February 2013)



# Population-Based Screening for Vitamin<sup>65</sup> D Deficiency

- Rationale for recommendation:
  - Inadequate evidence that screening improves outcomes, except in high-risk patients
  - Examples of high-risk patients include individuals with bone disease, kidney disease, liver failure, obesity, history of falls, or use of certain medications

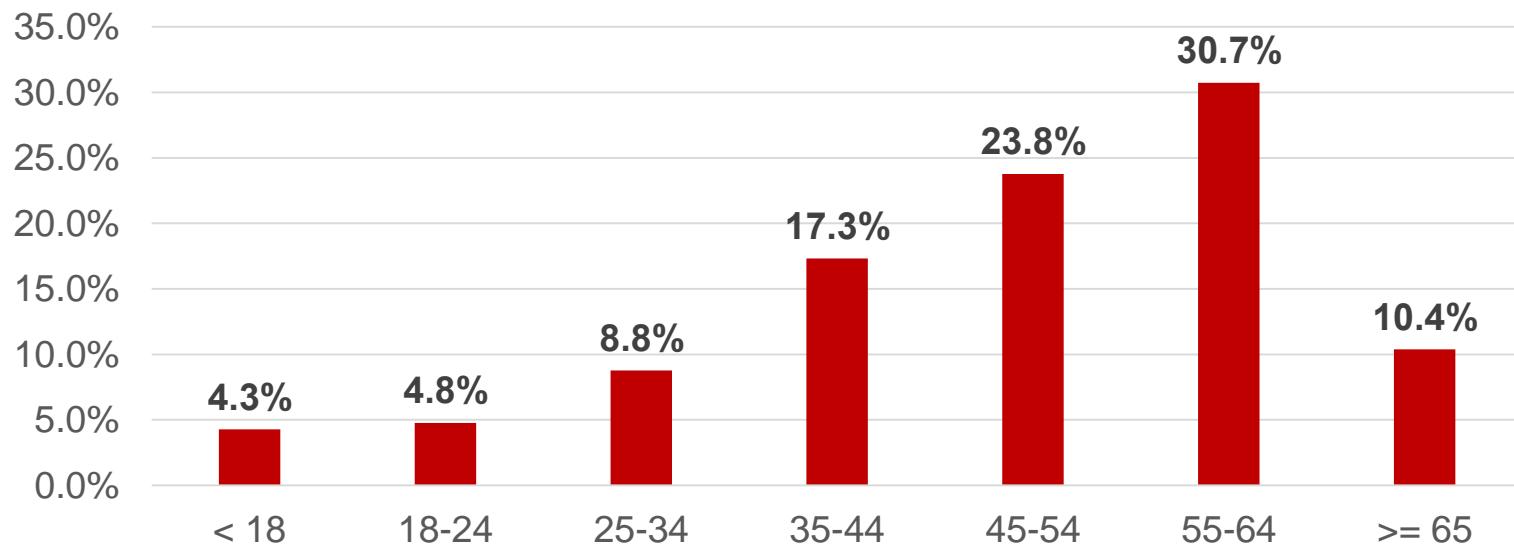
Source: Choosing Wisely, [American Society for Clinical Pathology](#) (released on February 2013)



# Population-Based Screening for Vitamin<sup>66</sup> D Deficiency

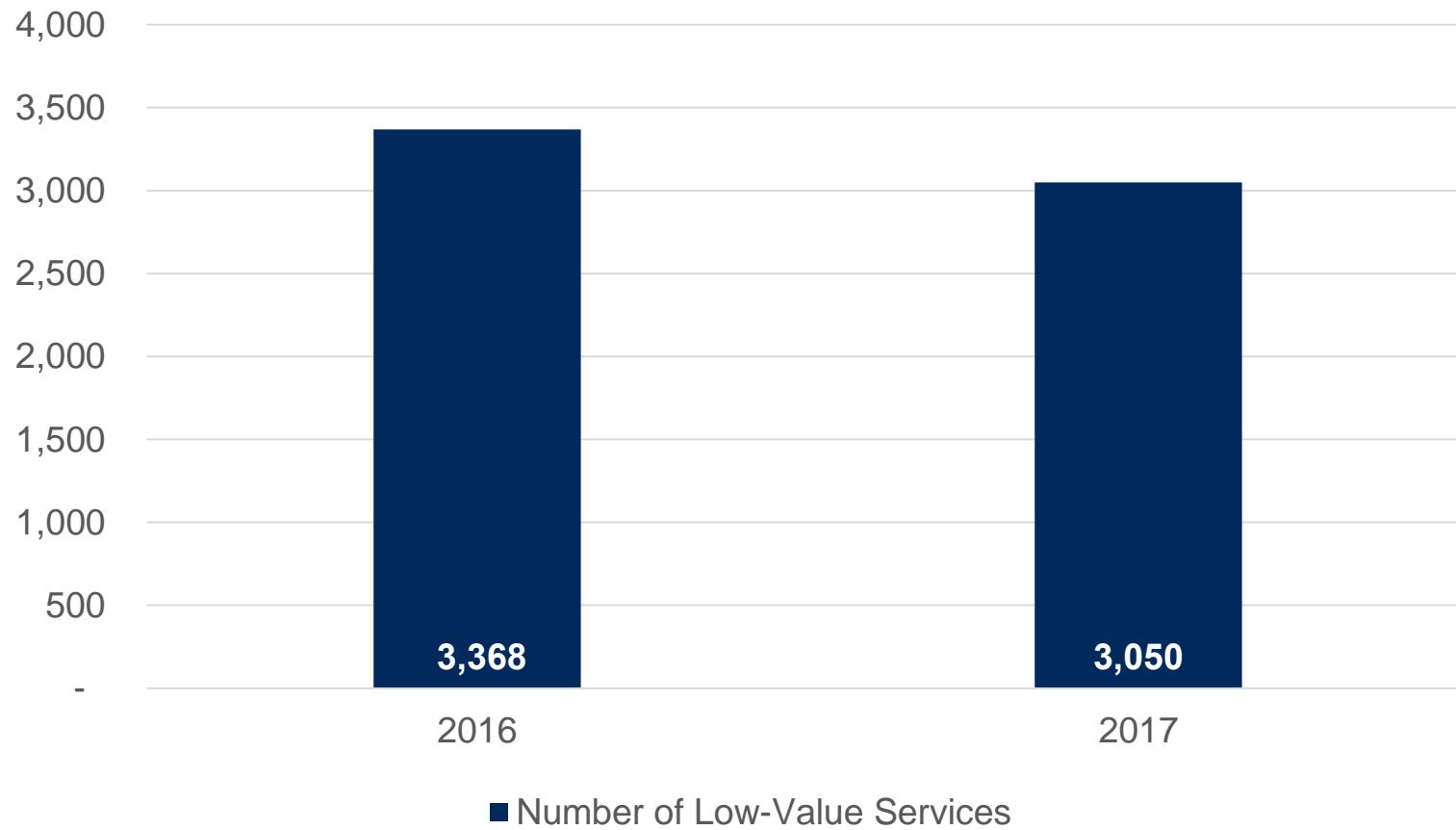
Year	Number of Low-Value Services	Number of Distinct Members with a Low-Value Service
2017	3,050	2,925

**Percentage of Low-Value Services by Age Group**



# Population-Based Screening for Vitamin D Deficiency<sup>67</sup>

**2016 and 2017 Low-Value Service Volume Trend**



# Antibiotics for Acute Upper Respiratory and Ear Infections



# Antibiotics for Acute Upper Respiratory<sup>69</sup> and Ear Infections

- Measure based on Choosing Wisely recommendations from 6 physician specialty societies:
  - American Academy of Pediatrics: *Antibiotics should not be used for apparent viral respiratory illnesses (sinusitis, pharyngitis, bronchitis)*
  - Infectious Disease Society of America: *Avoid prescribing antibiotics for upper respiratory infections*
  - American Academy of Allergy, Asthma & Immunology: *Don't order sinus CT or indiscriminately prescribe antibiotics for uncomplicated acute rhinosinusitis*

Source: Choosing Wisely, [American Academy of Pediatrics](#) (released February 2013; updated July 2016 and June 2018), [Infectious Disease Society of America](#) (released February 2015), [American Academy of Allergy, Asthma & Immunology](#) (released April 2012).



# Antibiotics for Acute Upper Respiratory<sup>70</sup> and Ear Infections

- American Academy of Family Physicians: *Don't routinely prescribe antibiotics for acute mild-to-moderate sinusitis unless symptoms last for seven or more days, or symptoms worsen after initial clinical improvement*
- American College of Emergency Physicians: *Avoid prescribing antibiotics in the emergency department for uncomplicated sinusitis*
- American Academy of Otolaryngology: *Don't prescribe oral antibiotics for uncomplicated acute external otitis*

Source: Choosing Wisely, [American Academy of Family Physicians](#) (released April 2012; updated July 2018), [American College of Emergency Physicians](#) (released October 2014), and [American Academy of Otolaryngology](#) (released February 2013).



# Antibiotics for Acute Upper Respiratory<sup>71</sup> and Ear Infections

- Rationale for recommendation:
  - Most acute upper respiratory infections (URIs) are viral and the use of antibiotic treatment is ineffective, inappropriate and potentially harmful
  - Misusing antibiotics in viral infections may lead to increased costs, antimicrobial resistance, adverse effects

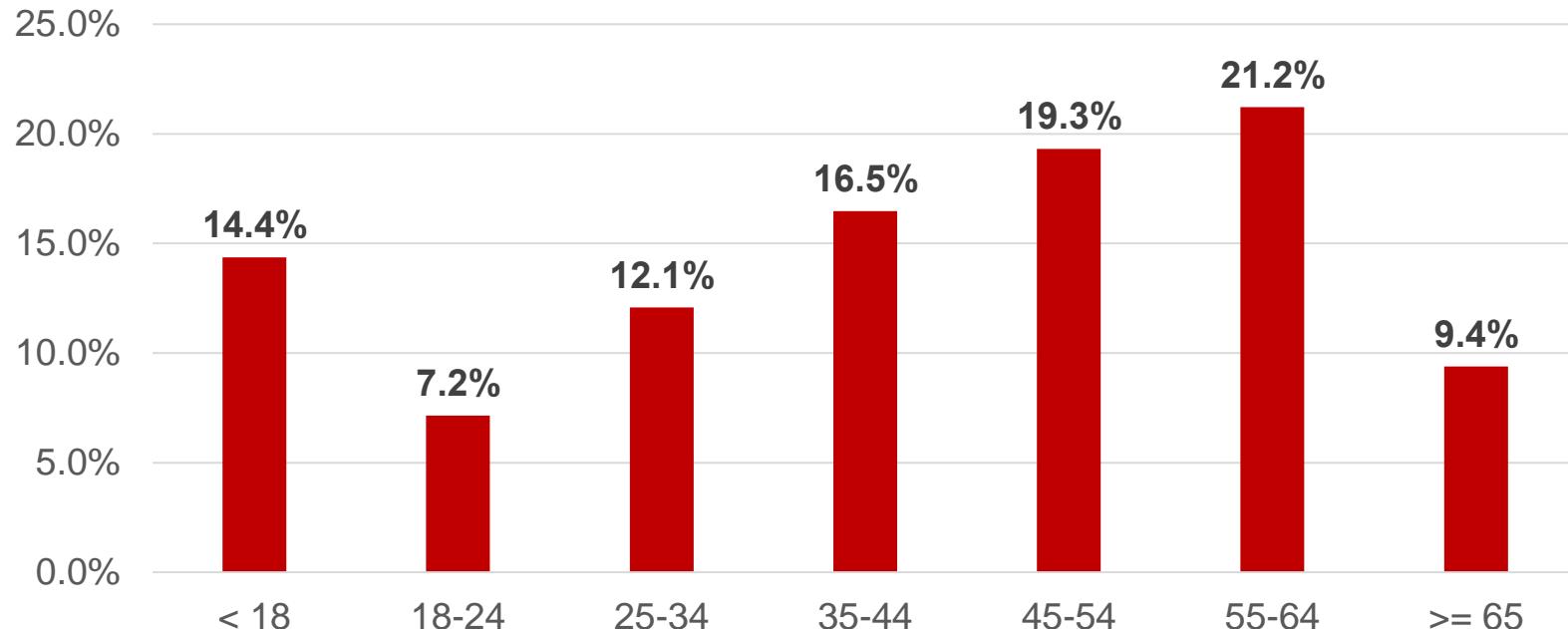
Source: Choosing Wisely, [Infectious Disease Society of America](#) (released February 2015).



# Antibiotics for Acute Upper Respiratory<sup>72</sup> and Ear Infections

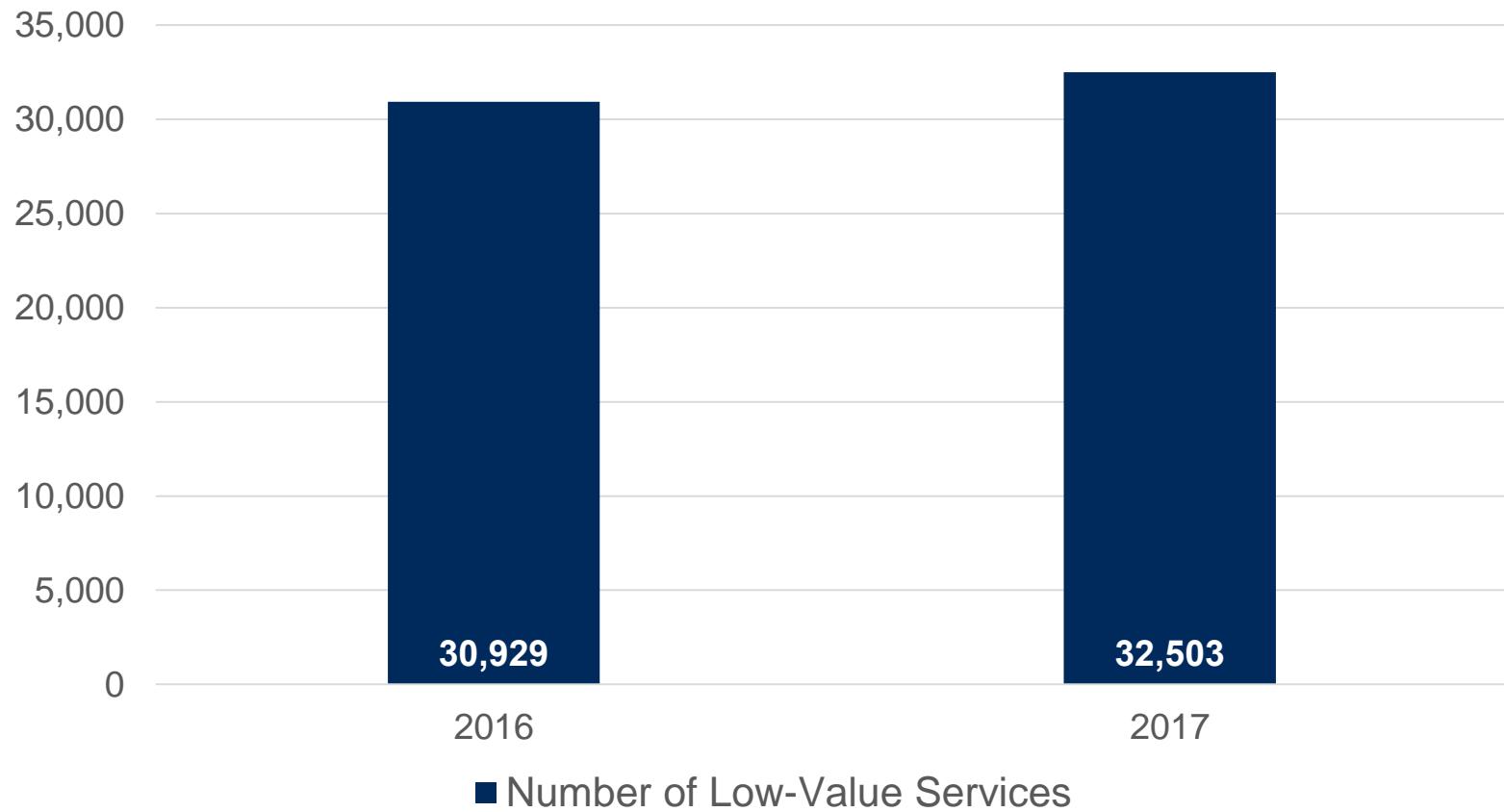
Year	Number of Low-Value Services	Number of Distinct Members with a Low-Value Service
2017	32,503	24,853

Percentage of Low-Value Services by Age Group



# Antibiotics for Acute Upper Respiratory<sup>73</sup> and Ear Infections

**2016 and 2017 Low-Value Service Volume Trend**



# Antibiotics for Acute Upper Respiratory<sup>74</sup> and Ear Infections

300

2017 provider variation of low-value services

250

- 113 providers

200

150

100

50

0

Providers



# Potential Considerations to Address Overuse

- Member and patient engagement strategies:
  - Disseminate information to members about the risks and potential harms of receiving low-value services
  - Engagement can be done through existing EBD communication channels (member newsletters, targeted or general direct mail, etc.)

Source: Institute for Clinical and Economic Review, [Choosing Wisely Recommendation Analysis: Prioritizing Opportunities for Reducing Inappropriate Care: Preoperative Stress Testing](#), [Choosing Wisely Recommendation Analysis: Prioritizing Opportunities for Reducing Inappropriate Care: Annual Pap Testing](#), [Choosing Wisely Recommendation Analysis: Prioritizing Opportunities for Reducing Inappropriate Care: Imaging for Uncomplicated Headache](#).



# Choosing Wisely Patient Education

## Vitamin D tests

**When you need them—and when you don't**

Many people don't have enough vitamin D in their bodies. Low vitamin D increases the risk of broken bones. It may also contribute to other health problems. That's why doctors often order a blood test to measure vitamin D.

But many people do not need the test. Here's why:

**A test usually does not improve treatment.**

Many people have low levels of vitamin D, but few have seriously low levels. Most of us don't need a vitamin D test. We just need to make simple changes to get enough vitamin D. We need to get a little more sun and follow the other advice on the next page.



Source: Choosing Wisely, [Vitamin D Tests: When you need them—and when you don't](#) & Excellus Vitamin D Handout.



# Potential Considerations to Address Overuse

- Benefit design strategies:
  - Identify any existing coverage policies which may be out of line with recommendations and modify accordingly
  - Incentivize members to use online decision-making tools when considering the appropriateness of certain health services
  - Work with third-party administrator on value-based payment design

Source: Institute for Clinical and Economic Review, [Choosing Wisely Recommendation Analysis: Prioritizing Opportunities for Reducing Inappropriate Care: Preoperative Stress Testing](#), [Choosing Wisely Recommendation Analysis: Prioritizing Opportunities for Reducing Inappropriate Care: Annual Pap Testing](#), [Choosing Wisely Recommendation Analysis: Prioritizing Opportunities for Reducing Inappropriate Care: Imaging for Uncomplicated Headache](#).



# Potential Considerations to Address Overuse

- Provider engagement strategies:
  - Reminders for clinicians and their staff on the risks and potential harms of low-value services
  - Collaborate with local chapters of physician specialty societies on a broader education effort around Choosing Wisely
  - Provide patient education materials to physicians
  - Provide information to clinicians on how often they screen relative to their peers

Source: Institute for Clinical and Economic Review, [Choosing Wisely Recommendation Analysis: Prioritizing Opportunities for Reducing Inappropriate Care: Preoperative Stress Testing](#), [Choosing Wisely Recommendation Analysis: Prioritizing Opportunities for Reducing Inappropriate Care: Annual Pap Testing](#), [Choosing Wisely Recommendation Analysis: Prioritizing Opportunities for Reducing Inappropriate Care: Imaging for Uncomplicated Headache](#).



# Addressing Unnecessary Antibiotic Use:<sup>79</sup> Medicaid Episode of Care Example

- Arkansas Medicaid launched a URI episode of care payment model in 2012
- Quality measures include rate of antibiotics filled
- About 600 providers receive quarterly reports detailing their performance compared to peers
- From 2012–2015, prescribing rate decreased from 45% to 32% — a reduction of 28%

