



AGENDA

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

August 13th, 2019

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

- I. Call to Order.....Margo Bushmaier, Chair*
- II. Approval of June Minutes.....Margo Bushmaier, Chair*
- III. Election of Chair/Vice-Chair Chris Howlett, EBD Director*
- IV. Diabetic Population UpdateElizabeth Montgomery & Mike Motley, ACHI*
- V. Director’s Report..... Chris Howlett, EBD Director*
- VI. Adjournment.....Margo Bushmaier, Chair*

Upcoming Meetings

September 10th, 2019, October 15th, 2019, November 12th, 2019

NOTE: All material for this meeting will be available by electronic means only.

Notice: Please silence your cell phones. Keep your personal conversations to a minimum.

State and Public School Life and Health Insurance Board

Quality of Care Sub-Committee Minutes

August 13, 2019

Date | time 08/13/2019 1:00 PM | Meeting called to order by Margo Bushmiaer, Chair

Attendance

Members Present

Dr. Terry Fiddler
Michelle Murtha - Vice-Chair
Zinnia Clanton - Teleconference
Margo Bushmiaer - Chair
Dr. Arlo Kahn
Pam Brown
Dr. John Vinson
Cindy Gillespie - Teleconference
Chris Howlett, Employee Benefits Division (EBD) Director

Members Absent

Others Present:

Rhoda Classen, Shalada Toles, Theresa Huber, Sharon Parker, Laurie Fowler, Renita Garrett, Lanita Wasson, Krista Grafe, EBD; Elizabeth Montgomery, Mike Motley, ACHI; Takisha Sanders, Jessica Akins, HA; Treg Long, ACS; Micah Bard, Oktawia DeYoung, UAMS

Approval of Minutes by: Margo Bushmiaer, Chair

MOTION by Brown

I motion to approve the June 11, 2019 minutes.

Dr. Kahn seconded. All were in favor.

Minutes Approved.

Election of Chair/Vice-Chair by: Margo Bushmiaer, Chair

Bushmiaer asked for nominations for chair and vice-chair.

Dr. Kahn nominated Dr. Vinson as chair.

All were in favor.

He accepted the position as chair.

Dr. Kahn nominated Bushmiaer as vice-chair.

All were in favor.

She accepted the position as vice-chair.

Diabetic Population Update by: Elizabeth Montgomery & Mike Motley, ACHI

Montgomery and Motley provided a review of the initial analyses of EBD members with type 2 diabetes, an overview of healthcare plan quality measurement and quality of care for EBD members with diabetes.

Discussion:

- Dr. Vinson: Help me understand what it means for the cost for EBD for type 2 diabetes with and without complications. Is this the total medical expenditures, or just the ones directly attributed to diabetes?
- Motley: This is their total cost of care, medical and pharmacy.
- Dr. Vinson: So, the most common expense is only \$3,400 a year even in patients with complications? That just seems low to me based on national averages.
- Dr. Kahn: The majority of diabetes with complications won't be on dialysis. Dialysis costs about \$100,000 a year. That alone will tip this whole thing, so the median is \$3,400 but the average would be way higher.
- Motley: We would be glad to provide the range of this.
- Montgomery: We can come back with a more detailed analysis on how we have derived this particular number.
- Dr. Vinson: For context, thinking about making any kind of change or intervention you might do, you would want to know which patients that intervention could apply to and what possible savings could you achieve.
- Howlett: Are we assuming with and without complications is not the same as being compliant or noncompliant, but solely based on the medical experience based on the claims data?
- Montgomery: It's not in regard to compliance, correct.
- Motley: We can come back and show you a cost distribution, the entire curve, if it would help you visualize it better.
- Dr. Kahn: It doesn't take much to have a complication.
- Dr. Fiddler: What was the total claims in 2018?
- Howlett: From a legislative audit standpoint, roughly \$550 million in 2018.
- Dr. Vinson: 20% of all the spend is related to diabetes for the entire plan.
- Howlett: Is there bleed over in the without complications that bleed over into other EBD members, or did you segment that population to be a static group regardless?
- Motley: These are mutually exclusive groups.
- Dr. Kahn: Today you don't have a complication, but next year you do. As time goes on, people with diabetes tend to develop more complications. So, if EBD has a stable population of employees, which I understand we do, then you would expect those who are without complications this year a certain percentage will switch over to the other group next year.
- Dr. Fiddler: With all these new get healthy programs we are starting up, we are talking about those individuals who would go off that, type 2 diabetes, because that is the whole idea of doing these programs is to get off of this list.
- Dr. Kahn: The percent that would actually go from having type 2 diabetes to not having type 2 diabetes is very small. The ones that you really hope to get are the ones who

have pre-diabetes. By getting them to lose 5%-7% of their excess weight, you can keep them from ever getting type 2 diabetes.

Dr. Vinson: It would be nice to see if that second category (members with type 2 diabetes (with complications)) had two subcategories, most everybody and then complications including dialysis. How many patients is that?

Montgomery: We will take that back and perhaps we can do a rank order by additional complication.

Motley: This does include medical and pharmacy spending, I think with us using the function of the median that makes it seem low. If we come back with the distribution and do the top 5% as a group of those with the highest total spend and look into their use of dialysis and use of procedures.

Dr. Fiddler: With all these new programs we are starting, I'd like to prove or disprove how many of them actually go back. Now long term, 10 years, if I get fat again, I'm more than likely going to go back to being a type 2 diabetic. I am just curious on the worth of these programs. You can't say they are different but statistically different from where they were.

Dr. Kahn: I think we need to see reports from all of our programs to see what kind of results we are getting.

Dr. Vinson: Practically speaking, what's the likelihood that once that code is on their diagnosis list of it being removed and deleted and not in their medical records. From a billing perspective, reality may not match how they are being managed.

Dr. Kahn: I don't think I have ever had a patient with a type 2 diabetic who had that diagnosis taken away.

Howlett: From a plan perspective, Naturally Slim and Catapult have started to integrate their data. I would like to look at the integration across all inputs or all engagement opportunities to see the worth of it all.

Dr. Vinson: Is this HEDIS measurement statewide or regional?

Motley: This is the national measurement.

Montgomery: We can provide the regional comparison.

Brown: We have seen focus with the Department of Health through their statewide chronic illness collaborative on these metrics, we've seen the onslaught of the primary medical home, focus on population health. Arkansas has always been near the bottom of the lists with these metrics. To only see such small improvement in the numbers is a disappointment. I know AFMC has had multiple statewide projects. We know providers are required to report on many of these metrics for their quality payment programs. I just don't know what else to do.

Murtha: Is it possible for us to look at each provider and how many diabetics they have? Did the patients come in for their visit and when they did come for a visit were these things done or is the patient just not coming to the doctor? We can't fix anything until we know where the problem lies. If we don't have the data to pinpoint anything the we're just running in place.

Dr. Vinson: Working in a physician's office for 15 years, even with incentive money, whenever we were getting incentive money, it wasn't disease state focused it was all of their care. For us, in my experience, until we had a population health tool where we could see, not only the individual patients but across our whole practice, and then share that back with the nurses and physicians, we weren't

able to ever really move the needle. Once we had that technology, data, and commitment for our leadership we were able to cross all of the UAMS family medical centers and make tremendous strides.

Dr. Kahn: Primary care doctors have way more expected of them than they can ever do anymore. If you really want to do something about these three measures. The more we can do that doesn't involve asking primary care doctors to do everything the more likely we are to be successful. I believe that if you incentivize the patients, with an incentive that matters, you could get them to insist on getting a statin. You could allow pharmacists to prescribe statins.

Howlett: I agree there are education limits and gaps from where our population currently is and where we want to be. I would contend that our issue is a cultural and societal component more than anything. The plan's role is to be able to afford the best opportunities from a fiscal standpoint and overall standpoint that would meet the population where they are and help them achieve the best possible health outcome.

Dr. Fiddler: We have all the programs we need right now. I am interested in the statistics. I want to make sure that something works before we add something else.

Brown: Is it possible to know how many encounters there were that did not receive the A1c?

Motley: Yeah, I think we can look at things at a provider level in a couple different ways. Let us do a couple of proposed measures and consult with director Howlett and come up with the best way to do that.

Howlett: How do you want to define that more? Encounters that were not respective to A1c?

Brown: I would say those that didn't go see a PCP at all during the year or those that did go twice and still didn't have an A1c. The mindset should be that if I go to the doctor for anything and I am a diabetic, I should get my hemoglobin A1c if it's due.

Murtha: I think we also need to look at the ones who go in and get all three of those measures, because those are best practices. We want to know how good they are doing and what is being done to make it happen.

Director's Report by: Chris Howlett, EBD Director

Howlett stated this has touched on what we were wanting to do, from a plan perspective, with the integration of the data and be able to present that back. He has several takeaways and will get back to you on that as well.

MOTION by Brown

Move to adjourn.

Murtha seconded. All were in favor.

Meeting adjourned.

AUGUST 2019

QUALITY OF CARE PRESENTATION

Mike Motley, MPH
Director, Analytics

Izzy Montgomery, MPA
Policy Analyst

08.13.2019



AGENDA

- Review initial analyses of EBD members with type 2 diabetes
- Provide overview of healthcare plan quality measurement
- Review quality of care for EBD members with diabetes



COST OF DIABETES

- More than 30 million Americans have diabetes
- Healthcare costs for Americans with diabetes are 2.3 times greater than those without diabetes
- Diagnosed diabetes costs \$327 billion per year (as of 2017)
- 1 in 7 healthcare dollars is spent treating diabetes and its complications

Source: American Diabetes Association (ADA), "The Staggering Costs of Diabetes." Retrieved from <http://www.diabetes.org/assets/img/advocacy/2018-cost-of-diabetes.jpg>



DIABETES PREVALENCE (NATIONALLY)

- 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

- Arkansas (overall) in 2019 = 13%
 - Highest rate = 18% in Jefferson and St. Francis counties
 - Lowest rate = 10% in Benton County
- EBD members with type 2 diabetes (2018):
 - 11.1%

Source: County Health Rankings & Roadmaps, "Arkansas 2019 — Additional Measures: Diabetes Prevalence." Retrieved from <http://www.countyhealthrankings.org/app/arkansas/2018/measure/outcomes/60/data?sort=sc-2>



TYPE 2 DIABETES: EBD POPULATION PROFILE (2017)

Category	Number of Members	Median Cost	Total Claims Cost for Group
Members with type 2 diabetes (without complications)	8,232	\$1,425	\$40,727,557
Members with type 2 diabetes (with complications)	6,889	\$3,433	\$69,662,730
Other EBD members	135,103	\$517	\$403,150,027



TYPE 2 DIABETES: EBD POPULATION PROFILE (2018)

Category	Number of Members	Median Cost	Total Claims Cost for Group
Members with type 2 diabetes (without complications)	7,184	\$1,402	\$38,853,910
Members with type 2 diabetes (with complications)	8,604	\$3,400	\$83,204,558
Other EBD members	139,256	\$585	\$436,438,756



DEFINING AND MEASURING QUALITY OF CARE

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



DEFINING AND MEASURING QUALITY OF CARE

- Denominator = evidence-based need for procedure/treatment
- Numerator = procedure/treatment of interest & documentation of procedure/treatment
- Example: Screening for Colorectal Cancer
 - Numerator = adults screened for colorectal cancer
 - Denominator = adults 50–75



EBD DIABETES MANAGEMENT QUALITY MEASURES

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



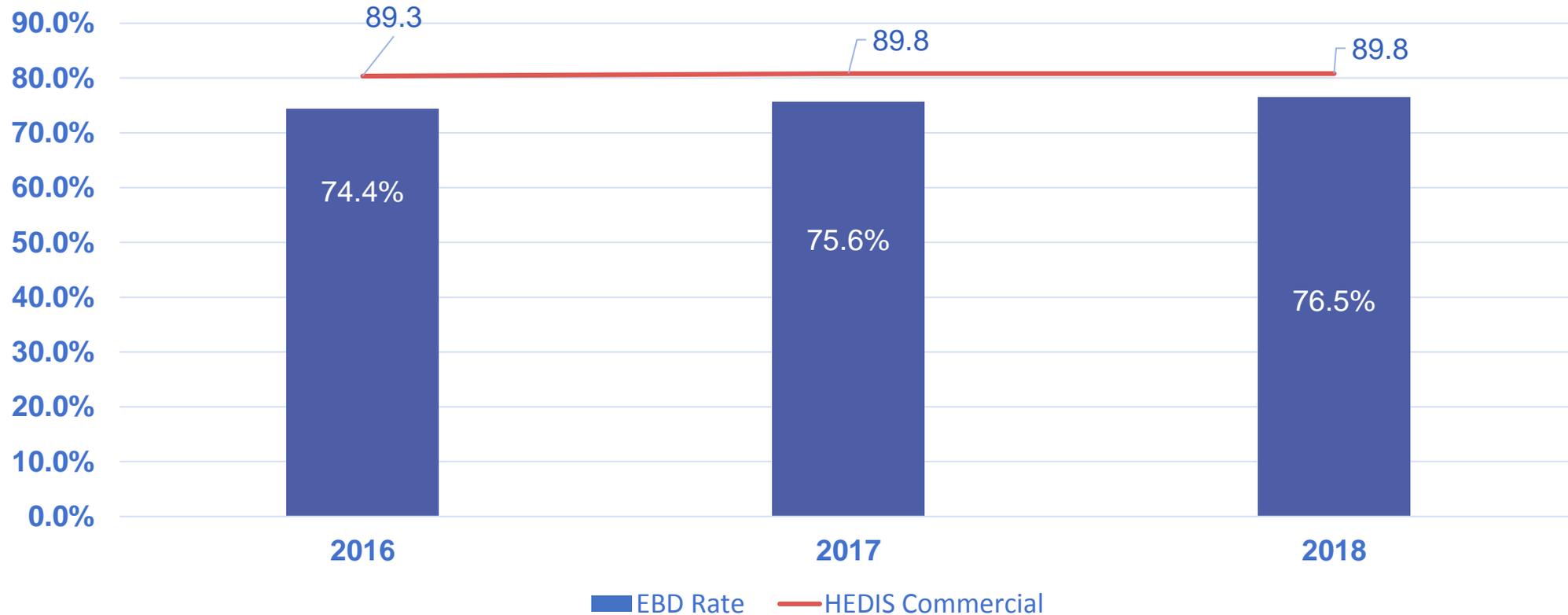
EBD DIABETES MANAGEMENT QUALITY MEASURES

- HbA1c testing — Tests provide information about average levels of blood glucose over the past 3 months and is the primary test used for diabetes management
- Eye exam — People with diabetes should get a comprehensive eye exam at least once a year to monitor risk of diabetic retinopathy
- Statin therapy — American Diabetes Association guidelines recommend statins for primary prevention of cardiovascular disease in patients with diabetes (based on age and other risk factors)

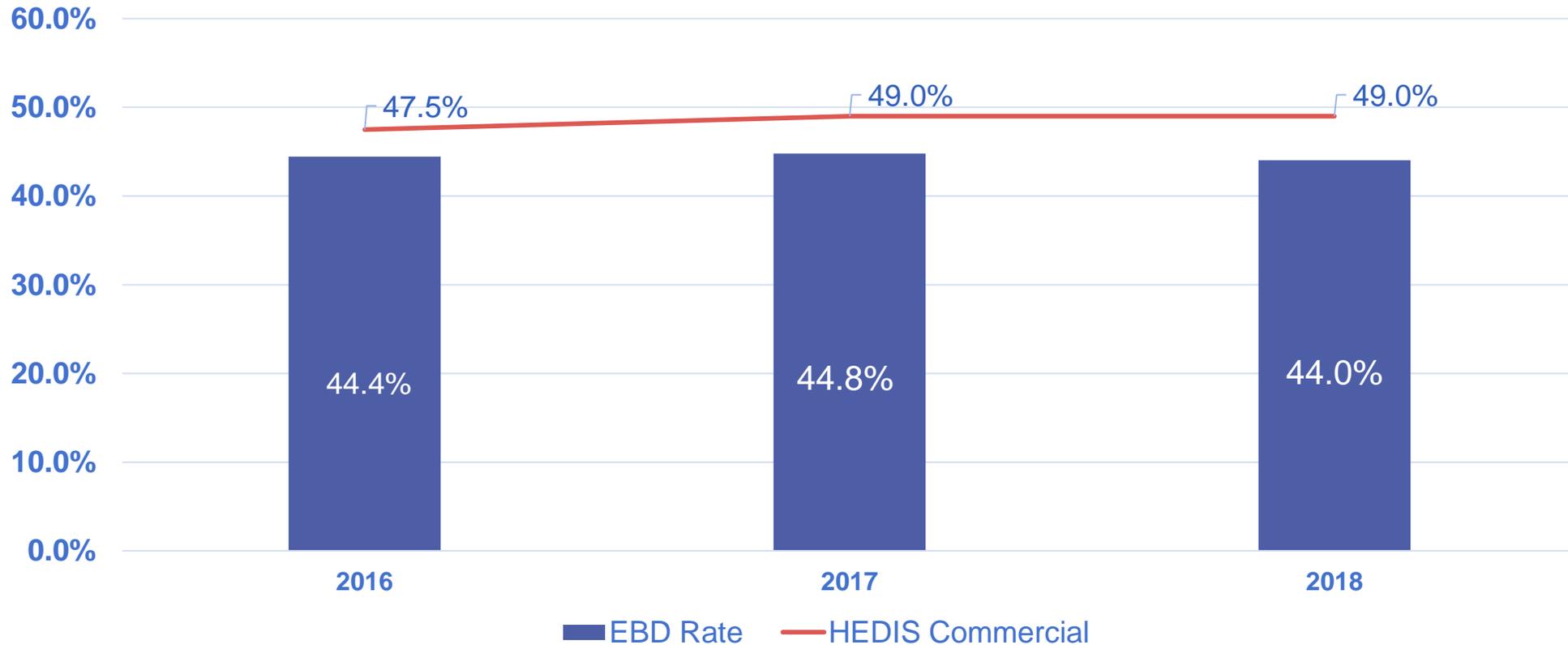
Sources: National Eye Institute, “Facts About Diabetic Eye Disease.” Retrieved from <https://nei.nih.gov/health/diabetic/retinopathy>; National Institute of Diabetes and Digestive and Kidney Disease, “The A1C Test and Diabetes.” Retrieved from <https://www.niddk.nih.gov/health-information/diabetes/overview/tests-diagnosis/a1c-test#changes>; NCQA, “Statin Therapy for Patients with Cardiovascular Disease and Diabetes.” Retrieved from <https://www.ncqa.org/hedis/measures/statin-therapy-for-patients-with-cardiovascular-disease-and-diabetes/>



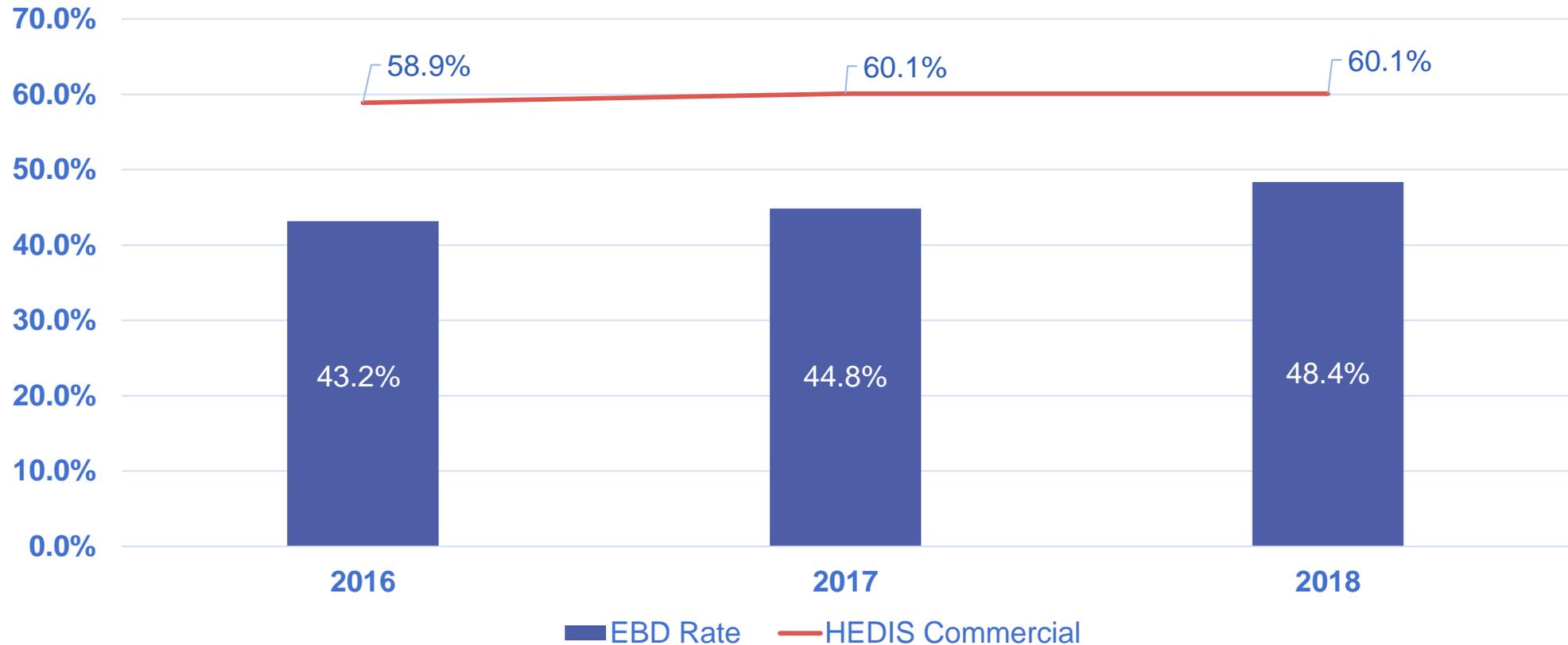
HBA1C SCREENING: EBD RATES AND HEDIS BENCHMARKS (2016-18)



EYE EXAM: EBD RATES AND HEDIS BENCHMARKS (2016-18)



STATIN THERAPY: EBD RATES AND HEDIS BENCHMARKS (2016-18)



RECOMMENDATIONS

- Consider opportunities to further leverage diabetes management program to improve rates
- Develop patient outreach efforts to encourage patients with diabetes to keep appointments and receive routine, comprehensive diabetes care
- Utilize provider outreach efforts to ensure patients with diabetes are screened appropriately
- Reassess these measures in 2019

