



## **AGENDA**

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

**September 11, 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***

***October 9, 2018, November 13, 2018, December 11, 2018***

***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

### September 11, 2018

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*Date | time 9/11/2018 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  
Cindy Gillespie - Proxy - Jimmy Fields  
Margo Bushmiaer - Chair  
Dr. Arlo Kahn  
Dr. Terry Fiddler  
Dr. Namvar Zohoori  
Zinnia Clanton  
Melissa Moore - Teleconference  
Dr. John Vinson  
Chris Howlett, EBD Executive Director, Employee Benefits Division

##### Members Absent

Frazier Edwards  
Pam Brown

##### Others Present:

Eric Gallo, Rhoda Classen, Jamie Levinsky, Allie Barker, Terri Freeman, EBD; Mike Motley, Elizabeth Montgomery, ACHI; Sandra Wilson, AHM; Jessica Akins, Takisha Sanders, HA; Kristi Jackson, ComPsych; Wayne Whitley, ARDOT; Marc Watts, ASEA,

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

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##### MOTION by Dr. Fiddler

I motion to approve the August 14, 2018 minutes.

Dr. Kahn 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 updates using the Health Waste Calculator output using 2017 EBD data, reviewed top two low-value services based on cost, unnecessary Preoperative Baseline Lab Studies and annual Electrocardiogram (EKG) and other Cardiac Screenings, and they discussed next steps for analyses and recommendation.

Discussion:

- Dr. Fiddler On the first one with the baseline, what is the age demographic? Is it someone from mid-thirties to retirement age or is it across the board? Usually younger folks don't have a physical, or these tests.
- Montgomery We did not do any age restrictions, and these are all members of the EBD population. This is something we can look into and break down.
- Dr. Fiddler **Unless someone has a comorbidity problem, someone in their thirties does not have an EKG done. Is there some way of looking at that?**
- Montgomery Yes, we can do that, but we do not have it today.
- Motley We could do a decade of life breakdown.
- Dr. Fiddler Some people feel their salary is not that great, but they go get every test that is possible even if not needed. They feel it is a value of their job. I am just curious where that starts.
- Dr. Zohoori Does this mean that there were 1,227 patients who had a coronary angiography without any systems, and how would these have been done and paid for without any cardiac symptoms?
- Dr. Kahn There are people doing them. Your question is why would someone do a cardiac angiogram without any symptoms, but the answer is it happened and was paid for.
- Howlett Dealing with about 6,000 distinct members and the number of services, and if 1/3 of that is EKG related, could we also deduce that one person could have had one or more events?
- Montgomery That is a reasonable assumption. We would like to do some more analyses and see what is driving the volume based EKG.
- Dr. Fiddler What is the standard on review of prior authorization criteria? On new Medicaid and Medicare criteria, the prior authorization has increased immensely, and it has turned a lot of practitioners off from certain practices. If I go to my physician, and he wants to have this done, what if there was a tighter stigma or greater PA on more programs? Would it decrease the number of people using the services, and decrease the number of people taking part in those services?
- Dr. Kahn I would say anytime you inject a prior authorization requirement, you will lower the number of services. This is not a first resort because it is not appreciated by people spending too much of their time doing paperwork versus taking care of

patients. I think provider education will be a better first resort, and patient education is also needed. Patients will be told from the doctor why it is not needed, and they will have reasonable expectations. I would only use more extreme measures like prior authorization if that didn't work. In the end, if there are providers not coming in line with reasonable, non-wasteful practices, then one way or another, I think we need to not pay them or require them to do prior authorizations.

Dr. Vinson I have a few questions. **First, about the MedInsight Health Waste calculator that you used, did we have to pay for it? Is it something you already have and did you just use their framework and applied it to your data? Operationally, how did you get this data?**

Motley We had to pay a little for this and to implement it, but now it is a lot quicker than doing it ad hoc.

Montgomery This was an investment that our organization paid for through ACHI.

Dr. Vinson We see 2017 data. **How hard or how labor intensive is it to see a trend line?** The reason I am asking that is I think back to the pap smears, cervical cancer screenings, and low back pain and imaging. Just from 101 Smart Goals, specifically, what are we doing, how are we measuring it, is it relevant, and actionable, and what is the time frame to see was it effective or not? Also, did it make any difference in what implemented or discussed in this meeting? If we decide to do something with these, then I would love to be able to say for how many months will we educate providers and then what does the data look like. Did it impact it at all?

Howlett Hopefully, as we get through the top eight, we can tee up a motion or recommendation from this Committee to the Board. As relevant to 2017, they were working on more previous data, and I asked them to look at the closer years. I can amend the ask and get aggregate data.

Motley I can at least go back to 2015 and 2016 and have a couple of tests. I am eager to get to the pap tests. I think you can see some change after the policy was aligned with the recommendation.

Murtha We are in the world of prevention, but we tell everyone to go for well check. They get a lipid panel, and they weigh them and draw blood to make sure they are not anemic. I can't quote them, but I know there are measures out there with meaningful use and patients in medical homes things that they require these patients to have. The first two we talked about, anesthesia will require things with education a lot of times. I agree with keeping the unnecessary testing down to a certain amount, but maybe some of this is done in the world of prevention to prevent excessive issues in the future.

- Dr. Kahn There are things that accidentally happen where things are revealed, but these kinds of recommendations and preventive measures the US Preventive Services Task Force look at harm vs. benefit. Basically, we are relying on the people that do the evidence searches to tell us which is more beneficial than harmful. Generally, those criteria line up with Choosing Wisely or US Preventive Services Task Force. It is our job to educate the hospitals. There are some hospitals in rural areas that don't get the word right away. This will take some time to accomplish. I think what EBD does has an impact on people, and as long as we stick with the evidence, we will be seen as a leader in the State.
- Murtha The US Prevention Task Force should line up with this, but there are so many that do not line up. I also want to be respectful to the providers who do that and not cause them a lot of conflict. If I go for an annual and they just weigh me and check my blood pressure but do not do a lipid panel, even though I am not at risk, then it doesn't seem like they are following with the age of prevention.
- Dr. Kahn At this point, you should know what your cholesterol is. If you are in a low-risk category, you should probably never have your cholesterol checked again. Those are the guidelines that pretty much everyone is living by. If you are in a high-risk category, you should get started on statins, and then once you get that stabilized you are through. The idea of annual lipids never made sense, but now we have evidence to support that.
- Montgomery Something that the Choosing Wisely Initiative is, is a campaign about awareness and to encourage these discussions to happen between the providers and patients, but overall these guidelines are aimed at reducing waste. It is awareness, consumer education on the specialty guidelines along with Preventive Services Task Force.
- Howlett As we make these decisions from a clinical perspective and from your respective fields, it is important that EBD trust in that process and try to arm EBD or arm the process of how we get around those that hide behind prescriptive authority versus evidence and the fact. I think education can come along the side and readdress or repoint people in proper directions. We are dealing with population management as a whole. We care about everybody on the plan, but the individuals, looking at paps, were specific to an individual's history versus the population. We tailor to them after we deal with the population decision. As we go through, that would help us from an administrative standpoint, to execute what comes from this committee and the Board and provide information to propel the right decision and make the best sound decision for the plan.
- Dr. Kahn I think that is necessary. You need to know what to do with appeals. The other thing is people have the idea that if you put limitations on what the doctors want to do, they will resent that. Many of these doctors are doing tests in a defensive manner because they don't want someone to come back and say you missed something. When you give doctors guidelines, they are very relieved because

they have been practicing defensive medicine. They are grateful to have the professional recommendations to back them up. The low back imaging is the perfect example.

- Dr. Vinson            Going back to where you are getting more information on the data; are their specific procedures that are more common than others? Which providers?
- Motley                This is something we would need more direction on if there was a desire.
- Dr. Vinson            It would be interesting to on the EKG's, is it primary care, the hospitals, or specialists. Looking at categories, zip codes, or certain areas of the state where we see this.
- Motley                There may be some limitations around volume, but in terms of provider variation, certainly anonymously, we can show you that trend.
- Howlett               We will go back through the take aways and requests from today, and we can break down the data. We can look at the other states and what they have explored. We will come back as a whole and decide what to do as a committee.

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

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Just to provide an update on Catapult health, we are 58% met and 52% not met. Last year at this time, we were about 50/50, so we are tracking right along. We have 28,174 completed check-ups as of 9/4/2018, and there are 176 confirmed clinics out there until the end of October, with total of 77,000 appointments remaining. We have about 29,000 completed that went to their own PCP and took the form and took the HRA online. Projection by the end of October will be close to 38,000.

**MOTION** by Zohoori.

Move to adjourn.

Murtha seconded. All were in favor.

**Meeting adjourned.**

# September 2018 Quality of Care Presentation

**Mike Motley, MPH**

Assistant Director of Health Policy

**Izzy Montgomery, MPA**

Policy Analyst



# Objectives for Presentation

- Review updated Health Waste Calculator output using 2017 EBD data
- Review top two low-value services (based on cost)
- Discuss next steps for analyses and recommendations



# Choosing Wisely Initiative Background

- Aims to promote conversations between clinicians and patients by helping patients choose care that is:
  - Supported by evidence
  - Not duplicative of other tests or procedures already received
  - Free from harm
  - Truly necessary
- Recommendations are developed by provider specialty societies
- Intended to spark discussion about the need—or lack thereof—for many frequently ordered tests or treatments

Source: *Choosing Wisely Initiative Website, [About](#) Section.*



# Assessing Wasteful Services within EBD <sup>4</sup>

- MedInsight Health Waste Calculator is a tool which identifies low-value services and spending
- 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



# Findings within EBD (2017)

- Of the 42 common low-value services assessed, **8** measures account for **69 percent** of low-value services
- The top 8 low-value services (based on cost) represent **85 percent** (\$13 million) of the total low-value dollars
- Among all EBD members enrolled in 2017, **91,051** had at least one of the 42 low-value services



# Top 8 Low-Value Services within EBD (2017)

Low-Value Service	Low-Value Total Dollars	Number of Distinct Members with a Low-Value Service	Number of Low-Value Services
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/are expected to be minimal.	\$4,937,308	11,254	18,242
Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.	\$3,083,194	17,754	22,470
Don't routinely order imaging tests for patients without symptoms or signs of significant eye disease.	\$1,609,898	10,580	17,812
Don't perform coronary angiography in patients without cardiac symptoms unless high-risk markers present.	\$1,494,996	1,227	1,297
Don't order unnecessary cervical cancer screening (Pap smear and HPV test) in all women who have had adequate prior screening and are not otherwise at high risk for cervical cancer.	\$730,595	7,635	7,732
Don't perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.	\$672,102	2,445	2,585
Don't obtain EKG, chest X rays or Pulmonary function test in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery.	\$341,951	3,731	6,893
Don't perform population based screening for 25-OH-Vitamin D deficiency.	\$272,528	4,535	4,985



# Unnecessary Preoperative Baseline Lab Studies

# Unnecessary Preoperative Baseline Lab Studies<sup>8</sup>

- Measure is based on Choosing Wisely recommendations from two 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 – specifically complete blood count, basic or comprehensive metabolic panel, coagulation studies when blood loss (or fluid shifts) is/are expected to be minimal.*
- 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) & Choosing Wisely, [American Academy of Ophthalmology](#) (released February 21, 2013)



# Unnecessary Preoperative Baseline Lab Studies<sup>9</sup>

- 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
    - For example, individuals with diabetes should receive a blood glucose test

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<sup>10</sup>

- Some services are excluded 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<sup>11</sup>

- 2017 data from EBD population:

Year	Total Low-Value Dollars	Number of Distinct Members with a Low-Value Service	Number of Low-Value Services
2017	\$4,937,308	11,254	18,242



# Annual Electrocardiogram (EKG) and Other Cardiac Screenings

# Annual EKGs and Other Cardiac Screenings

- Measure is based on Choosing Wisely recommendation from one 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 screening 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)



- 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 screening exceed the potential benefits

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



- For these measures, 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
  - Inflammatory conditions such as arthritis, joint pains, or muscle inflammation



# Annual EKGs and Other Cardiac Screenings

- 2017 data from EBD population:

Year	Total Low-Value Dollars	Number of Distinct Members with a Low-Value Service	Number of Low-Value Services
2017	\$3,083,194	17,754	22,470

# 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

