AGENDA

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

May 14th, 2019
1:00 p.m.

EBD Board Room – 501 Building, Suite 500

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

II. Approval of April Minutes..................................................Margo Bushmaier, Chair

III. Health Waste Update.................................Elizabeth Montgomery & Mike Motley, ACHI

IV. Director’s Report..................................................Chris Howlett, EBD Executive Director

V. Adjournment.................................................................Margo Bushmaier, Chair

Upcoming Meetings

June 11th, 2019, July 16th, 2019, August 13th, 2019

NOTE: All material for this meeting will be available by electronic means only ASE-PSE BOARD@dfa.arkansas.gov. Please silence your cell phones. Keep your personal conversations to a minimum.
State and Public School Life and Health Insurance Board
Quality of Care Sub-Committee Minutes
May 14, 2019

Date / time 05/14/2019 1:00 PM | Meeting called to order by Margo Bushmiaer, Chair

Attendance

<table>
<thead>
<tr>
<th>Members Present</th>
<th>Members Absent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michelle Murtha - Vice-Chair</td>
<td>Dr. Terry Fiddler</td>
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<tr>
<td>Margo Bushmiaer - Chair</td>
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<tr>
<td>Dr. Arlo Kahn</td>
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<tr>
<td>Pam Brown – Proxy – Nikki Wallace</td>
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<tr>
<td>Dr. John Vinson</td>
<td></td>
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<tr>
<td>Cindy Gillespie</td>
<td></td>
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<tr>
<td>Zinnia Clanton</td>
<td></td>
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<tr>
<td>Chris Howlett, EBD Executive Director, Employee Benefits Division</td>
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</tr>
</tbody>
</table>

Others Present:
Rhoda Classen, Theresa Huber, Sharon Parker, Eric Gallo, EBD; Elizabeth Montgomery, Mike Motley, ACHI; Takisha Sanders, Jessica Akins, HA; Micah Bard, UAMS; Ronda Walthall, ARDOT; Nikki Wallace, AHA

Approval of Minutes by: Margo Bushmiaer, Chair

MOTION by Clanton

I motion to approve the April 9, 2019 minutes.

Dr. Kahn seconded. All were in favor.

Minutes Approved.

Health Waste Update by: Elizabeth Montgomery & Mike Motley, ACHI

Montgomery and Motley provided a brief update of the 2018 top 8 low-value services in EBD.

Discussion:

Bushmiaer: Do we know how much money was saved? Did you add it up, because some of them had increased use which is disappointing?

Motley: We didn’t get into an aggregate calculation. This is a pre-period to the recommendations that were adopted this year, so this is preintervention period.

Dr. Vinson: What is our overall annual plan spend?
Howlett: We have roughly $619 million in funding. As of last plan audit, around $550 million in spend on claims experience. Of that total spend, about $130 million gross is in pharmaceutical.

Gillespie: Do you have any way of looking to see the use of a heart monitor? It has been interesting to see those coming to work with those on. Is there a way to see if it was that type of screening versus a traditional EKG?

Motley: I think we can look into the claims and if it is possible, yes, we can look into that.

Dr. Vinson: Is it possible to see, in theory, who those patients were to do a chart review to see if it was a mistake and shouldn’t have been on the tool?

Howlett: We could probably capture that with a random audit of services.

Gillespie: Do you ever look at these to see whether or not they are within any particular group of practitioners? Or is it just widespread?

Howlett: You can pick some of it up on the claims audit. We could use a combination of claims audit and chart audit.

Dr. Vinson: Do we participate in medical side either patient centered medical home, comprehensive primary care plus, or any other initiatives with this particular patient population? I’m just trying to figure out if there are any other quality parameters out there that are being measured on this patient population with regard to any of these measures, especially cervical or colon cancers screenings. The higher those rates, in theory, with this little churn we have in this patient population, the return on investment.

Howlett: We were spending about $2.5 million a year in every one of the categories and kept going up just on PCMH alone. The rates were too high. I don’t believe it was being facilitated properly and other mechanisms have proven that with the decrease in the services through adopting other means.

Dr. Vinson: If we don’t have access, moving forward, it would be nice to see where we are and how we are trending. I think it would be valuable to have some other thought about what we want to look at above and beyond wasted services.

Murtha: Maybe we could take these one at a time, educate, and send out information that says BlueCrossBlueShield will not pay for EKG’s or cardiac screening just for surgery, no complications, etc. It should not fall on the patient but back to the clinic, hospital,
providers, whoever is ordering this, especially if they have been given information. Is that a possibility?

Howlett: I don’t know that it is Health Advantage’s responsibility. They’re administering the benefits offered by the plan. It’s the plan’s decision whether to cover services and they are the instrument by which we are doing that. They might cover it routinely and this plan adopt not to and vice versa. Overall, it is going to be an education piece. We are trying to do peer-to-peer reviews.

Gillespie: One of the values of being inside a PCMH network has always been that they can see the information as to what their peers are doing.

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

Howlett stated that Catapult and their medical director and team will be back in June to present and answer questions.

**MOTION** by Dr. Vinson

Move to adjourn.

Gillespie seconded. All were in favor.

**Meeting adjourned.**
AGENDA

- Review 2018 updates of top 8 low-value services in EBD
2018 UPDATES: TOP 8 LOW-VALUE SERVICES
### TOP 8 LOW-VALUE SERVICES WITHIN EBD (2017)

<table>
<thead>
<tr>
<th>Low-Value Service</th>
<th>Distinct Members with Low-Value Service</th>
<th>Number of Low-Value Services</th>
<th>Low-Value Dollars*</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>9,118</td>
<td>13,060</td>
<td>$4,028,766</td>
</tr>
<tr>
<td>2. Don’t order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.</td>
<td>9,643</td>
<td>10,274</td>
<td>$1,612,932</td>
</tr>
<tr>
<td>3. Don’t routinely order imaging tests for patients without symptoms or signs of significant eye disease.</td>
<td>8,187</td>
<td>12,875</td>
<td>$1,236,098</td>
</tr>
<tr>
<td>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.</td>
<td>7,676</td>
<td>7,762</td>
<td>$740,322</td>
</tr>
<tr>
<td>5. Don’t perform coronary angiography in patients without cardiac symptoms unless high-risk markers are present.</td>
<td>202</td>
<td>205</td>
<td>$372,219</td>
</tr>
<tr>
<td>6. Don’t do imaging for uncomplicated headache.</td>
<td>557</td>
<td>584</td>
<td>$258,925</td>
</tr>
<tr>
<td>7. Don’t perform population-based screening for 25-OH-Vitamin D deficiency.</td>
<td>2,925</td>
<td>3,050</td>
<td>$193,703</td>
</tr>
<tr>
<td>8. Don’t prescribe oral antibiotics for members with upper URI or ear infection (acute sinusitis, URI, viral respiratory illness, or acute otitis externa).</td>
<td>24,853</td>
<td>32,503</td>
<td>$186,219</td>
</tr>
</tbody>
</table>
# TOP 8 LOW-VALUE SERVICES WITHIN EBD (2018 UPDATES)

*Values in red reflect updates based on 2018 output.*

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<th>Low-Value Service</th>
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<tr>
<td>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.</td>
<td>9,118 <em>9,236↑</em></td>
<td>13,060 13,411↑</td>
<td>$4,028,766 $4,101,825↑</td>
</tr>
<tr>
<td>2. Don’t order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.</td>
<td>9,643 13,295↑</td>
<td>10,274 14,111↑</td>
<td>$1,612,932 $2,185,293↑</td>
</tr>
<tr>
<td>3. Don’t routinely order imaging tests for patients without symptoms or signs of significant eye disease.</td>
<td>8,187 8,748↑</td>
<td>12,875 13,619↑</td>
<td>$1,236,098 $1,394,676↑</td>
</tr>
<tr>
<td>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.</td>
<td>7,676 7,211↓</td>
<td>7,762 7,330↓</td>
<td>$740,322 $579,469↓</td>
</tr>
<tr>
<td>5. Don’t perform coronary angiography in patients without cardiac symptoms unless high-risk markers are present.</td>
<td>202 221↑</td>
<td>205 227↑</td>
<td>$372,219 $479,381↑</td>
</tr>
<tr>
<td>6. Don’t do imaging for uncomplicated headache.</td>
<td>557 437↓</td>
<td>584 450↓</td>
<td>$258,925 $215,339↓</td>
</tr>
<tr>
<td>7. Don’t perform population-based screening for 25-OH-Vitamin D deficiency.</td>
<td>2,925 2,344↓</td>
<td>3,050 2,424↓</td>
<td>$193,703 $127,342↓</td>
</tr>
<tr>
<td>8. Don’t prescribe oral antibiotics for members with upper URI or ear infection (acute sinusitis, URI, viral respiratory illness, or acute otitis externa).</td>
<td>24,853 21,589↓</td>
<td>32,503 26,869↓</td>
<td>$186,219 $73,498↓</td>
</tr>
</tbody>
</table>
UNNECESSARY PREOPERATIVE BASELINE LAB STUDIES

2016–2018 low-value service volume trends

- 2016: 14,077
- 2017: 13,060
- 2018: 13,411
ANNUAL EKGS AND OTHER CARDIAC SCREENINGS

2016–2018 low-value service volume trends

- **2016**: 10,606
- **2017**: 10,274
- **2018**: 14,111
2016–2018 low-value service volume trends

- 2016: 10,511
- 2017: 12,875
- 2018: 13,619
TOO FREQUENT CERVICAL CANCER SCREENING

2016–2018 low-value service volume trends

<table>
<thead>
<tr>
<th>Year</th>
<th>Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>10,347</td>
</tr>
<tr>
<td>2017</td>
<td>7,762</td>
</tr>
<tr>
<td>2018</td>
<td>7,330</td>
</tr>
</tbody>
</table>
CORONARY ANGIOGRAPHY

2016–2018 low-value service volume trends

- 2016: 173
- 2017: 205
- 2018: 227
IMAGING FOR UNCOMPLICATED HEADACHE

2016–2018 low-value service volume trends

<table>
<thead>
<tr>
<th>Year</th>
<th>Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>659</td>
</tr>
<tr>
<td>2017</td>
<td>584</td>
</tr>
<tr>
<td>2018</td>
<td>450</td>
</tr>
</tbody>
</table>
POPULATION-BASED SCREENING FOR VITAMIN D DEFICIENCY

2016–2018 low-value service volume trends

- 2016: 3,368
- 2017: 3,050
- 2018: 2,424
ANTIBIOTICS FOR ACUTE UPPER RESPIRATORY AND EAR INFECTIONS

2016–2018 low-value service volume trends

2016: 30,929
2017: 32,503
2018: 26,869
CONCLUSIONS

- 2018 data and trends over three years support previous recommendations for provider and member outreach for several of these services (unnecessary preoperative baseline labs, annual EKGs and other cardiac screenings, coronary angiography, antibiotics for URI, etc.)

- Findings reinforce need to revisit original wellness subcommittee guidelines to eliminate unnecessary repeat blood testing

- Findings reinforce previous recommendation to ensure specified eye imaging services are not paid for among patients without signs or symptoms of eye disease
CONCLUSIONS, CONTINUED

- Particular attention should be given to cervical cancer screenings because a high number of these are being paid for inappropriately.

- Provider and member outreach should be utilized to continue to decrease low-value services for uncomplicated headaches.

- Continue ongoing assessment of low-value services to assure trends continue in a positive direction.