AGENDA

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

June 11th, 2019

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

I. Call to Order.............................................................. Dr. John Vinson, Stand-In Chair

II. Approval of May Minutes................................................ Dr. John Vinson, Stand-In Chair

III. Wasteful Services Follow-Up............................ Elizabeth Montgomery & Mike Motley, ACHI

IV. Catapult Update.......................................................... Lee Dukes & Dr. Tim Church, Catapult

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

VI. Adjournment............................................................ Dr. John Vinson, Stand-In Chair

Upcoming Meetings

July 16th, 2019, August 13th, 2019, September 10th, 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
June 11, 2019

Date | time 06/11/2019 1:00 PM | Meeting called to order by Dr. John Vinson, Stand-In Chair

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Attendance

<table>
<thead>
<tr>
<th>Members Present</th>
<th>Members Absent</th>
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<tbody>
<tr>
<td>Dr. Terry Fiddler</td>
<td>Michelle Murtha - Vice-Chair</td>
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<td>Zinnia Clanton</td>
<td>Margo Bushmiaer - Chair</td>
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<td>Dr. Arlo Kahn</td>
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<td>Pam Brown</td>
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<td>Dr. John Vinson</td>
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<td>Cindy Gillespie</td>
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<td></td>
<td>Teleconference</td>
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<tr>
<td>Chris Howlett, EBD Executive Director, Employee Benefits Division</td>
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Others Present:
Rhoda Classen, Shalada Toles, Theresa Huber, Sharon Parker, Eric Gallo, Cory Walker, Lanita Wasson, Kriste Grafe, EBD; Elizabeth Montgomery, Mike Motley, ACHI; Takisha Sanders, Jessica Akins, HA; Micah Bard, Dwight Davis, UAMS; Ronda Walthall, Wayne Whitley, ARDOT; Jason Treece, HA; Lee Dukes, Dr. Tim Church, Catapult; Nima Nabavi, Amgen

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Approval of Minutes by: John Vinson, Stand-In Chair

MOTION by Brown

I motion to approve the May 14, 2019 minutes.

Clanton seconded. All were in favor.

Minutes Approved.

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Wasteful Services Follow-Up by: Elizabeth Montgomery & Mike Motley, ACHI

Montgomery and Motley provided a brief update of the wasteful services.

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Catapult Update by: Lee Dukes & Dr. Tim Church, Catapult

Howlett provided a brief recap of the March meeting that had several questions regarding the presentation that were unable to be answered.

Discussion:
Patient Satisfaction
Dr. Kahn: From my point of view, this committee is charged with looking at the quality of programs that are supplied to beneficiaries. When we see a slide that says this is patient satisfactory, we would like to see the data on how you arrived at the conclusions not just the conclusions.

Dukes: Ironically, that is a question that Jenni Abisror could have answered. From a clinical perspective, we don’t monitor those numbers. It is a survey that is sent out via email after the patient leaves.

Blood Sugar

Dr. Kahn: Just because you say newly assessed with Diabetes instead of diagnosed with Diabetes. Those are just words.

Dukes: With the patient, we don’t say assessed or diagnosed.

Dr. Kahn: If you’re saying what I think you are, it should say patients with elevated blood sugar. When you say newly assessed with Diabetes, from my point of view, you’re saying these people have Diabetes. This is public information and I am not sure which part of this you are giving to the patients, but if they have access to this information then they are thinking they have Diabetes. I think you should really relook at your words because they are confusing.

Dr. Church: I agree, that is well stated.

Dr. Kahn: What do you mean by not effectively managing Diabetes? Are you meaning that on this one occasion their blood sugar was elevated?

Dukes: Their A1c was elevated.

Dr. Kahn: Once again, I don’t think that is a fair way to say that someone is not effectively not managing their Diabetes.

Dr. Church: I don’t disagree with any of that, but we are talking about a roll up for a company where a CFO is trying to figure how much they should or should not invest into this particular condition. We are really trying to show them which direction their oil tanker is going. At an individual level, it is a very different conversation. A lot of times, it is the first time this company has ever found out how high risk they are.

Dr. Kahn: I’m not saying that this isn’t worth saying, I’m saying that it is the words that you are using. To say that somebody wasn’t effectively managing their Diabetes because on one occasion they have an elevated hemoglobin A1c without knowing what the rest of that person’s management has been, is not really accurate. I would say that 37.9% had a hemoglobin A1c above 7, considered to be an optimal level.

Dr. Vinson: If it’s greater than 9, they clearly are not effectively managing their Diabetes. If it’s somewhere between 6 and 9, well that depends on how old they are and what their history of high blood sugar is. What is the number, 7?

Dukes: Yes

Dr. Kahn: There is data available that says if you control certain people too tightly, then you are not only not effectively managing them, but putting them in harm’s way because their blood sugars get low which is the worst thing you can do to a Diabetic. So, just using one measurement of a hemoglobin A1c to say they are not effectively managing their Diabetes is not the right terminology.

Dukes: We agree with patient level absolutely that conversation is a back and forth.

Dr. Kahn: I don’t think for a director level. He doesn’t know about this. You’re presenting this to the director of EBD, I don’t think that is the right terminology for him. He needs to know that
37% had a hemoglobin A1c that were slightly higher than ideal, but there are extenuating circumstances where you don’t even want the hemoglobin A1c to be below 7. He doesn’t know that; he doesn’t have medical training. He is a very smart person, but I don’t think this is appropriate language for directors of programs either.

Howlett: How I also understand there is engagement with the data that’s presented with the practitioner. Is any of this the raw data or is it comingled with some of the interaction that happens during the review?

Dukes: This is pretty much raw data.

Howlett: Yes, I am the director of EBD and am not clinically trained, I am a reasonable person, so in the same respect to what Dr. Kahn is saying, with the opposite holding true what do we expect to assume? I can’t assume that the person is Diabetic, but am I to assume that they are managing?

Dr. Kahn: I think with the group that says 618 with newly assessed with Diabetes, had the report come to you stating 618 had blood sugars indicating there may be a problem, then you would know as the director maybe there is something we need to do to alert our employees that they may have a problem.

Howlett: If I’m to say that they aren’t newly assessed because of where they measure, how can I come back from a plan perspective and tell them that they are or are not effectively managing based on the number not being at a certain threshold?

Dr. Kahn: You have to do that with consultations with medical people who can tell you what to do next.

Howlett: That can get costly.

Dr. Kahn: I think what we really want to know is what they found at Catapult.

Howlett: But I think we are questioning what they found at Catapult.

Dr. Fiddler: The question was, is that what actually you found at Catapult? The doctors first statement was, “we’re not diagnosing, we’re assessing our numbers and facts.” Nobody could tell us that, because it said in the presentation that we have diagnosed because we have newly assessed with Diabetes. There was a better way of stating this.

Dr. Vinson: This particular group in an ideal circumstance would have claims level data and be able to see what our HEDIS measures were. We as a committee, right now, can’t see that. For us, selfishly, since you have this kind of data with this population, it would be interesting to know what percent were greater than 7, greater than 9, and if we had have claims level data from HEDIS; it would be interesting to see what it is across the whole population versus what it was in the worksite screening.

Dr. Church: It would be nice to have, that is a great point.

Dr. Kahn: What would really be helpful to advise Mr. Howlett, if we could tell you, 20% of your population is really badly controlled.”

Dukes: I would like to ask you what numbers you want or what threshold you want? We would be happy to get those numbers for you.

Howlett: If this committee will provide to me and the board secretary a list of all the questions with the ranges along with everything you want; we will get those sent to Catapult for answers.

**Blood Pressure**

Dr. Kahn: The important thing here is, increasingly the JNC and everybody else points out that it is how you measure blood pressure that’s really important. Anecdotally, from one of my colleagues, the way the blood pressure was measured when she was checked out by
Catapult, was not according to the recommendations about how blood pressure should be measured. I would be surprised if the setup would have allowed for blood pressure to be measured the way it was supposed to be measured. I would love to hear from you that it was, but you know that white coat hypertension is present in probably 25% of people. To say anything about hypertension or whether it is being affectively managed based on one blood pressure reading in an artificial setting right after people had their blood drawn in a noisy room with a lot of other people in it. Those blood pressure readings are barely probably acceptable by anybody’s definition, but they certainly shouldn’t be used to make a decision about what a person’s blood pressure really is. They could be used to alert the patient that they need follow-up on their blood pressure.

Dr. Church: That was worrisome to me because we do put a lot of work into this. A reminder is that when we say blood draw, it is just a finger stick, not phlebotomy. That’s a big difference and it’s generally a benign finger stick. We have put a lot of thought into that when creating that. What we are really going after here, full disclosure, I’m really worried about that person who is 182/98, that is what I care about. I get white coat hypertension, I get it. It is those undiagnosed 180-190 plus where more than likely it isn’t white coat hypertension. They don’t have a doctor, they are usually a 46-year-old male. Let’s get them in the care. That’s what we are going to prioritize in the nurse practitioner exam.

Howlett: From a plan perspective, aside from someone going back to their physician and running up a claim to still have white coat syndrome and still present the same numbers. How is it referring them back to their physician going to alleviate that?

Dr. Kahn: Their physician knows how to deal with it. Catapult’s goal has never been and never claimed it was to take care of these patients. They are wanting to identify patients who may have a problem, so they can get them back to their physicians. This would have been perfectly fine if it had said 11,148 patients had blood pressures that were above ideal or who had a blood pressure above 140/90, 150/100, or 160/ so that they could see how bad it really looks. You could even classify them as mildly elevated or severely elevated. What they are doing with them makes perfect sense. When they see people with elevated blood pressures they are referring them back to their physician, and if they are really bad, they are referring them for emergency treatment. I don’t think anything they are doing with the data with the individuals is problematic. I’m saying that we could get the reports with a little bit more specific and granular information that would help the plan.

Howlett: Are we dealing with semantics and the words being used, basically?

Dr. Kahn: Do you keep data about whether those interventions actually helped? And on the EBD members?

Dr. Church: We do, it is in our published paper.

Dr. Kahn: We would like to see that data.

Dr. Church: I am happy to provide that.

Brown: You said that a lot of times you are able to work with patients who aren't taking their medications and get them back in to their physician. In the collection of data when you find a population of those that you screen that have a blood pressure outside the normal limits, you also identify if they are on blood pressure medication. Do you have data to support that? What would be interesting to me, was having a patient get notified by their health plan to let them know that their medications had not been refilled.
Dukes: A service that we have just added in January of this year and only applies to your employees who we have seen since January. We probably did it, last year as well. We have access to a national database of prescriptions that have been filled in the last 12 months. The nurse practitioner, once given permissions by the patient gives consent, clicks a button and can see, in real time, across several categories of drugs if they had a prescription written, had it filled, and with the prescription they have now, they check to see if it was past due. They then counsel them about their medications and the reason behind it.

Dr. Vinson: There may be other initiatives that this board or committees recommend, either in the physician’s office or in the community pharmacy setting or in another potential touchpoint where patients get care coordination. It would be interesting and helpful to see in the screenings what percent would be 120/80, 130-139/80-89 range, and what is over 140/90. Also, how many of them were greater than 180/120. It would be interesting to know if those numbers hold true over time and whether or not we need to aggressively look at other options to better coordinate that care.

Dukes: That is actually in our standard reports and we would be happy to make that available to you.

Dr. Kahn: Can you also report the information about compliance and noncompliance?

Dr. Church: It is in there. We have self-reports as well.

Depression

Dr. Kahn: Do you provide any information back to the employee about that depression?

Dukes: Yes, the nurse asks them if they are seeing a counselor or working with a therapist and we know then to refer them back to them.

Preventive Care

Dr. Kahn: I don’t understand why you have clinical breast exam there at all.

Dukes: It is a part of the discussion between the nurse practitioner.

Dr. Kahn: There was also a statement that said that so many percent were overdue for clinical breast exam, but they aren’t even recommended, so you can’t be overdue for it.

Dukes: We will pull it out of the report, because it is for plan design analysis not diagnoses or preventive care recommendations.

Howlett: How can that be phrased from a semantic standpoint? Is there no value in that data?

Dr. Kahn: Yeah, hopefully we’re using the national guidelines that are most evidence based and most accepted by the most number of practitioners, agencies, and we used to do clinical breast exams every year on women and we though that it was valuable. When it was actually studied it was found that there was no evidence that it was valuable or that it adds anything to mammograms. Many, many years ago that recommendation was removed and a physician was keeping up with that had that conversation with their patients. The idea to put it in a report that it is the same as mammograms, pap smears, and colorectal exams, all of which are supported by evidence, just doesn’t make sense.

Dr. Church: He makes an excellent point and that will likely get removed.

Howlett: I understand that some of it is self-reported, but we make million-dollar decisions on this plan with HRA data and it is self-reported. Coming from a perspective where we have a fragment, caption, or component of data that we may not have ever had before, albeit self-reported or not. This plan hasn’t always operated like that, so what can we do with the data?
Brown: Even if it is low, you can't make any decisions because it's not recommended. If it is high, you can't make any decisions because it just means people are doing it and it's not recommended.

Dr. Vinson: I also worry about potential harm. There are certainly different guidelines, some may support it and others do not, but USPSTF, for example, recommends against self-exams and if you're asking the question, then you may have patients thinking they need to go.

Dr. Church: We need to relook this. You've had new cholesterol guidelines come out and new blood pressure guidelines. I was part of the sprint trial and understand the blood pressure guidelines extremely well. I wasn't convinced they were going to stick, so we had to make some strategic decisions.

Dr. Fiddler: Those individuals with the most information can make the best decisions. The physicians and those surrounded in the medical field have looked over this and evidence based says it's not a necessity to do that. It is not political or religious-based.

Smoking
Dr. Kahn: The problem here is that the numbers don't add up. In Arkansas, 25% of adults smoke. What percent did you say admitted to smoking or using tobacco?

Dukes: It depends. 13.4% are for ASE and 7.3% for PSE.

Dr. Kahn: Unless all these employees covered under our plan are way different from Arkansans, and there is not really a great reason to think they are, then their self-reports are not accurate.

Dukes: Well the self-reports are the ones that we administered the cotinine tests to.

Dr. Kahn: Then you admitted a cotinine test to it, so you should have picked up another 10-12% that should have been positive. So, there is one of two things happening here, either we aren't screening, a lot of those people aren't getting screened and are not even applying for the discount, and you have told us in the past that something like 90% were applying for the discount, isn't that what you said?

Howlett: With last year, it was just under 90%. I don't know that I agree with your summation.

Dr. Kahn: If those 10% who were smokers and didn't admit or show up for the screening.

Howlett: 10% didn't qualify for the wellness benefit period.

Dr. Kahn: But maybe those were the 10% who didn't show up because they knew they were going to be found out and didn't want to be found out as smokers.

Dr. Church: This is a common phenomenon, not just for smoking but also for other things. An employer population will often not match national norms or state norms, because the norms will have both the retired population and older population and, of course, unemployed which is also going to be higher risk.

Dr. Kahn: Chris, I think if there only getting less than 1% on the cotinine testing, I think a good question would be, is it even worth doing? How much is it costing and is it worth continuing?

Howlett: It was a provision of the wellness committee that took 20 years to get to, so I don't know that we are at that point. The plan had no mechanism prior to May of 2016 to actually assess anything, so we were giving away free money to meet something that wasn't required and that was not relying upon any subcommittee's assistance or recommendation. From that standpoint, I would not want to have the explanation to be that 1% is going to trump anything positive that could have come from the program. Dr. Vinson was the chair of the wellness committee and they brought the recommendation
through this committee as well as the benefits subcommittee and to the board for final approval. I think that was the time to probably evaluate that. Going forward, we can look at it with the tangible data, but I would also like to base administrative decisions on actual data outcome than self-reported.

Dr. Vinson: I’m relieved that the data is not drastically different than what was on the self-report and I think at least now we have an idea from the first round that it is only a 0.8% delta of what somebody may say it is versus what it really is.

Dr. Kahn: A good argument to keep doing it would be that those 10% that aren’t showing up for the screenings, you’re not giving them the discount, and maybe they aren’t showing up because they know they are going to get the cotinine test. Maybe if you weren’t doing the cotinine test, they would show up and say they weren’t smokers.

Howlett: With respect, I would disagree, because you didn’t have to jump through anything except go to a physician with a preventative code. We had people getting it for going to the eye doctor or their gynecologist. We had it based on code, and in doing that we still had 10% that didn’t get it and you didn’t have to do anything. We are still seeing the same 10% prior to tightening the program still exist within on average about a half of a percent deviation. I think it is something to review and look at, but for me to adjust my recommendation to the committee I would have to have some pretty convincing and compelling information or data that would change that outcome. I would like to see at some point that we go ahead and go full on with ACA and look at premium adjustments for those that tobacco positive on the health plan since that is a component that ACA allows us to deal with.

Dr. Vinson: If we are even going to even think about going down that road, I think we need to have a good, considering we know the real data at least in the population that screened and having a tobacco cessation program, robust set of options to help kick the habit.

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

Howlett requested that the committee send any additional questions/comments regarding Catapult be sent to him so that he could get it to Catapult for responses. It will help provide guidance for me and the plan administration to meet with Catapult and make sure that we provide the data that those questions and comments afford us.

**MOTION by Dr. Vinson**

Move to adjourn.

Gillespie seconded. All were in favor.

**Meeting adjourned.**
AGENDA

- Address follow-ups from last Quality of Care meeting
- Discuss next set of analyses for upcoming meetings
## TOP 8 LOW-VALUE SERVICES WITHIN EBD (2018 UPDATES)

*Values in red reflect updates based on 2018 output.

<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>
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<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&lt;br&gt;<em>9,236↑</em></td>
<td>13,060&lt;br&gt;13,411↑</td>
<td>$4,028,766&lt;br&gt;$4,101,825↑</td>
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<td>2. Don’t order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.</td>
<td>9,643&lt;br&gt;13,295↑</td>
<td>10,274&lt;br&gt;14,111↑</td>
<td>$1,612,932&lt;br&gt;$2,185,293↑</td>
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<td>3. Don’t routinely order imaging tests for patients without symptoms or signs of significant eye disease.</td>
<td>8,187&lt;br&gt;8,748↑</td>
<td>12,875&lt;br&gt;13,619↑</td>
<td>$1,236,098&lt;br&gt;$1,394,676↑</td>
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<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&lt;br&gt;7,211↓</td>
<td>7,762&lt;br&gt;7,330↓</td>
<td>$740,322&lt;br&gt;$579,469↓</td>
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<td>5. Don’t perform coronary angiography in patients without cardiac symptoms unless high-risk markers are present.</td>
<td>202&lt;br&gt;221↑</td>
<td>205&lt;br&gt;227↑</td>
<td>$372,219&lt;br&gt;$479,381↑</td>
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<td>6. Don’t do imaging for uncomplicated headache.</td>
<td>557&lt;br&gt;437↓</td>
<td>584&lt;br&gt;450↓</td>
<td>$258,925&lt;br&gt;$215,339↓</td>
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<td>7. Don’t perform population-based screening for 25-OH-Vitamin D deficiency.</td>
<td>2,925&lt;br&gt;2,344↓</td>
<td>3,050&lt;br&gt;2,424↓</td>
<td>$193,703&lt;br&gt;$127,342↓</td>
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<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&lt;br&gt;21,589↓</td>
<td>32,503&lt;br&gt;26,869↓</td>
<td>$186,219&lt;br&gt;$73,498↓</td>
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ANNUAL EKGs AND OTHER CARDIAC SCREENINGS

2016–2018 low-value service volume trends

- 2016: 10,606
- 2017: 10,274
- 2018: 14,111
ANNUAL EKGS AND OTHER CARDIAC SCREENINGS

**Question**: For this measure, how many of the low-value services are attributable to the use of heart monitors?

**Answer**: We reviewed CPT codes associated with wearable heart monitors and identified 38 total (out of 14,111 low-value services).

- Comprises about 0.3% of the overall low-value services for this measure.
NEXT STEPS

- Planning to revisit HEDIS quality measures related to diabetic population:
  - HbA1c measure
  - Eye exams
  - Statin use
- Low-value service assessment:
  - In future meetings, could consider additional HEDIS measures to look at plan quality alongside low-value services (such as cervical cancer screening, breast cancer screening, etc.)
  - Can incorporate provider variation information