Quality Improvement Committee (QIC)

Meeting Summary

Thursday, February 10, 2022 (Meeting held virtually)

Members Present: Steve Jacobson, Premera (Chair)
Rick Hourigan, Cigna (Vice-Chair)
Mary Anderson, The Polyclinic
Edwin Carmack, Confluence Health
Kavita Chawla, Virginia Mason Franciscan Health
Nancy Fisher, Region 8, 9 & 10, CMS
Kim Herner, UW Valley
Matt Jaffy, UW Neighborhood Clinics
Cat Mazzawy (sub for Darcy Jaffe), WSHA
Larry McNutt, Northwest Administrators; WHA Board Member (guest)
Dan Monahan, Novartis (guest)
Mike Myint, Embright
Komal Patil-Sisodia, Evergreen Healthcare
Paul Sherman, Community Health Plan of Washington
Hugh Straley, The Robert Bree Collaborative
Judy Zerzan-Thul, HCA

Staff Present: Jim Andrianos (WHA Consultant), Teresa Battels, Leslie Bennett, Sharon Eloranta, Denise Giambalvo, Nancy Giunto, Mark Pregler

Introductions, approval of meeting minutes

Members introduced themselves and we welcomed our guests; reminded the group of the executive session to follow.

Actions

The QIC meeting summary from December 2021 was approved with no changes; the committee also approved the advancement of a prospective QIC member, Jennifer Graves, to the Board for final approval.

General Alliance Updates

Steve mentioned Nancy's upcoming retirement (effective July 8, 2022); Nancy thanked the QIC for their work; how impressive and interactive the team is; essentially a group without peer in Washington State; she also mentioned her retirement plans. Steve then invited Denise Giambalvo, Director of Purchaser Strategies, to introduce herself to the group.

Proposal from the Chair and Vice Chair

Steve mentioned that he and Rick would like to do brief 1:1 meetings with each QIC member over the course of this year; members were encouraged to include their contact information in the Chat.

Diversity, Equity and Inclusion Moment

Sharon introduced the practice of having a DEI "moment" as a standard element of Alliance internal meetings as well as Committee meetings. The moment is being piloted at this QIC meeting and feedback is welcome. We will be asking QIC members to volunteer to share a quote, work of art, video, piece of music, or other brief (5 minute) presentation by or related to historically marginalized communities. We then shared a video suggested by Steve, called "Lift While You Climb." Many QIC members shared positive comments after the video. We will plan to continue this in future meetings and called for volunteers.
Video link: Want to truly succeed? Lift others up while you climb | The Way We Work, a TED series - YouTube

Community Checkup refresh discussion

Leslie and Sharon discussed the upcoming release of the next Community Checkup report. They reviewed efforts that have been made in the past to draw attention to metrics (e.g., eye exams for people with diabetes and others) for which Washington State's performance perennially score below the HEDIS national 25th percentile. Despite these efforts, the list of metrics that underperform remains similar year-over-year. Leslie and Sharon reminded the QIC that their survey data indicated that they'd like to lead some initiatives – in addition to responding ongoing efforts – and asked the group if and how they might like to choose a metric or two to focus on for implementation of improvements. There was great discussion; the group agreed that doing this would be a good idea and that at this point in the year, we'd be looking to influence work to be done in 2023 as most systems have already prioritized their 2022 improvement targets. Judy Zerzan-Thul called attention to chlamydia screening and adolescent well care visits, in light of increasing STD rates during COVID. General discussion appeared to support this idea (generalized improvement in STD screening rates and rates of adolescent well care), and the group agreed to talk more at the April meeting.

Obesity Roundtable Takeaways

Sharon reported briefly on major content points and takeaways from a purchaser-group roundtable hosted by NovoNordisk regarding obesity. The list of takeaways was included in the presentation file sent to all QIC members in preparation for this meeting. In brief, the presenters discussed obesity as a disease and described the evidence for utilizing not only wellness benefits and bariatric surgery but also the 'middle ground' of pharmacotherapeutics in addition to wellness.

Total Cost of Care Initiative Medical Group Level Reporting (Executive Session)

Jim Andrianos reviewed the methodology and release timeline for the medical-group level TCOC report. There were three main points:

1) Per Patient Per Month presents a communications challenge. WHA will be responsible for communicating this clearly – so not an issue for QIC
2) For QIC and subsequent Board committees: should high cost patients be included, excluded or both (pts with costs greater than 3 Standard Deviations above average)
3) For QIC and subsequent Board committees: should there be a minimum number of attributed patients for medical group reporting (balance between accuracy and comprehensiveness

Jim noted that these questions had been posed to the Health Economics Committee and that he would share their recommendations during the discussion.

With regard to high cost, Hugh asked if there were more high cost patients in certain areas or if they were spread out. Answer: at the medical group level, although there are huge differences for some- sometimes related to particular specialties, across the whole population, the distribution is remarkably predictable. Hugh thought perhaps these patients should be excluded.

HIGH-COST PROPOSAL: for high cost patients, include for the "all-in" spend view and exclude to enable comparisons between medical groups.
ATTRIBUTED PATIENTS PROPOSAL: 2 options

1) No minimums
2) Set a fixed threshold minimum (e.g., at WHA we use 80 patients; MNCM uses 600, which is the option chosen by HEC)

Conversation included comments on how MN arrived at the 600 figure and whether our data will give a similar result (answer: there has not been direct comparison but we are likely not too dissimilar).

Jim then showed some of the real data and explained the meaning of the red and green shading and also that the report does not address the "why" of varying costs – is it utilization or price.

Mike M stated that it is important to call our whether risk adjusted or not in the display.
Kavita asked if there would be a minimum number of high cost patients for the group to count or not. Answer: a rule like this would eliminate many groups.

There was more conversation about how risk adjustment worked in the setting of many high cost patients; also, we can't use the report to drill down to levels of detail e.g., which specific surgeries or vendors providing services account for certain costs due to the fact that there are 20,000 statistics that underlie the report; but we would consider pulling special request reports.

After the review of the real data, Jim then reviewed the HEC's approach, which he was asking the QIC to move on.
On the first question regarding inclusion of high cost patients:

1) HEC said that for all-in, high cost patients would be included by default

2) HEC said that for medical group comparisons, high cost patients would be EXCLUDED by default and truncated by a pre-set amount
3) It was noted that the default conditions include privacy minimums.

The motion was made, seconded and the QIC voted to accept the HEC approach to this question (inclusion/exclusion of high cost patients) with one objection.

On the question of minimums:

1) HEC recommended that we use 600 patient minimum for medical group reporting, even though we know that some use much larger minimums for contracting purposes. The default case would be to exclude groups with fewer than 600 attributed patients.

The motion was made, seconded and the QIC voted to accept the HEC approach to this question (minimum patient counts) unanimously.

Edwin suggested that the groups with fewer than 600 might be rolled up into one.

Open Information Exchange/Journal Club

The group reviewed an article by David Lansky on the potential for patient outcomes to lay atop the claims-based systems that we currently use to evaluate performance. We decided to add this as a topic for future discussion.

Dan suggested a webinar including several states' approach to TCOC and Nancy agreed.

Regarding approach to low-performing metrics, we will default this discussion to April and will be focusing on 2023 strategies; Steve suggested also that we look at the metrics with wide variations in performance and create a network of best practices to share.

2022 meeting dates: 2:00 – 4:00pm 2nd Thursday of every other month:

- February 10
- April 14
- June 9
- August 11
- October 13
- December 8