Quality Improvement Committee (QIC)
Meeting Summary
Thursday, February 13, 2020

Committee Members Present:	Mary Anderson, *The Polyclinic* (phone) Peter Dunbar, *Foundation for Health Care Quality* Nancy Fisher, *Region 8, 9 & 10, CMS* (phone) Frances Gough, *Molina Health Care* Bruce Gregg, *MultiCare Health System (*phone) Matt Handley, *Kaiser Permanente Washington* Kim Herner, *Valley Medical Center* Darcy Jaffe, *Washington State Hospital Association* Matt Jaffy, *UW Neighborhood Clinics* Dan Kent, *UnitedHealthcare Community Plan (Chair)* Bob Mecklenburg, *Virginia Mason Medical Center* Aileen Mickey, *EvergreenHealth Medical Group* Randal Moseley, *Confluence Health* (phone) Drew Oliveira, *Regence Blue Shield* (phone) Julie Stroud, *Northwest Physicians Network/The Everett Clinic* Judy Zerzan, *Washington State Health Care Authority*
Committee Members Absent:	Lydia Bartholomew, *Aetna* Gary Knox, *MultiCare Rockwood Clinic* Charles Peterson, *Proliance Surgeons* Hugh Straley, *The Robert Bree Collaborative* John Vassall, *Comagine Health*
Staff Present:	Susie Dade, *Washington Health Alliance* Nancy Giunto, *Washington Health Alliance* Mark Pregler, *Washington Health Alliance* Theresa Tamura, *Washington Health Alliance*
Guests:	Jim Andrianos, Calculated Risk Pam Sheffield, Aetna (phone) (for Lydia Bartholomew)

I. INTRODUCTIONS, APPROVAL OF MEETING MINUTES, QIC MEMBERSHIP CHANGES

ACTION – The QIC reviewed and approved the QIC meeting minutes from November 2019.

ACTION – The QIC reviewed and approved a recommendation to add Drs. Jessica Schlicher (CHI Franciscan Health), Drew Baldwin (Virginia Mason, to replace Bob Mecklenburg), and Paul Sherman (Community Health Plan of Washington).

Ms. Dade and Dr. Kent also expressed their thanks to Dr. Peter Dunbar (Foundation for Healthcare Quality) and Dr. John Sobeck (Cigna), both of whom stepped down from the QIC due to retirement and a job change, respectively.

II. QUALITY COMPOSITE SCORING

ACTIONS –

The QIC approved a proposal to regarding (a) the number and types of measure domains to be used in the quality composite score; (b) which measures should do in which domain; (c) the weighting for each domain; and, (3) plans for visualizing the results on the Community Checkup website.

Following the November 2019 QIC meeting, a small ad hoc workgroup (expert panel) was formed to accomplish the four tasks outlined below. This workgroup included Drs. Matt Jaffy (UW), Christopher Chen (HCA) Mike Myint (MultiCare), Angie Sparks (KP-WA) and Randy Moseley (Confluence Health).

The workgroup was asked to finalize recommendations to the QIC on the following:

1. Number and types of measure domains
2. Quality measures within each domain (based on quality measures already available in the Community Checkup)
3. Weighting for each domain (must total 100)
4. Graphic representation of the quality composite score on the Community Checkup website

Domains, Measures, Weighting

The workgroup recommended and the QIC approved the following four measure domains with the accompanying weighting and measures within each domain (shown on page 4). The distribution of measures includes the 31 measures that are currently included in the Community Checkup and for which the Alliance has robust results for medical groups/clinics.

In forming this recommendation, the workgroup considered several points:

- Current payer/provider contracting tends to focus on measures that are included in the first two domains, Prevention and Screening and Chronic Disease Care. Most of these measures are NCQA HEDIS measures. A heavier weighting on these two domains helps to align messaging in the marketplace.

- There is a recognition that some purchasers emphasize prevention/screening (younger, healthier workforce) while others emphasize chronic disease care (older workforce with greater morbidity). By weighting these two domains the same (35%), we're giving a nod to each general type of purchaser, signaling both areas of focus are important.
- The third domain, Coordinated Cost-Effective Care, is weighted at 20%. This domain includes two measures that are focused on potentially avoidable care. Reductions in avoidable hospital readmissions and ER visits could both significantly reduce costs and improve quality. This domain is not weighted more than 20% because it's recognized that systemic solutions are essential, not just solutions implemented by medical groups.
- The fourth domain, Appropriate Cost-Effective Care, includes several measures where overall statewide performance is good (although there is still a lot of variation and room for improvement.

The following is considered a starting point. The composite scoring method can easily accommodate the addition or deletion of measures and/or changes to the domains/weighting in the future. As measures are added or deleted from the Community Checkup, the QIC will need to revisit the assignment of measures to domains and the weighting of domains to ensure that the method still makes sense. The Alliance will want to track any/all changes carefully so we can understand and comment on changes to the quality composite results that are published on the Community Checkup over time.

The QIC noted that this method produces relative scoring (i.e., how clinics and medical groups score in relation to one another), not absolute scoring.

In addition, the composite scoring method can also easily be adapted to create a hospital quality composite score, should the Alliance choose to do so.

Domain and Measures	Weighting
Prevention and Screening 1. Well Child Visits – First 15 Months 2. Well Child Visits – Ages 3-6 3. Adolescent Well Care Visits 4. Chlamydia Screening for Young Women 5. Breast Cancer Screening for Women 6. Cervical Cancer Screening for Women 7. Colorectal Cancer Screening for Age-Appropriate Adults	**35%**
Chronic Disease Care 1. Follow-up Care for Children Prescribed ADHD Medications - 30 days 2. Follow-up Care for Children Prescribed ADHD Medications – 9 months 3. Staying on Antidepressant Medications – 12 weeks 4. Staying on Antidepressant Medications – 6 months 5. Managing Medications for People with Asthma 6. Comprehensive Diabetes Care – HBA1c Testing 7. Comprehensive Diabetes Care – Retinal Eye Exam 8. Comprehensive Diabetes Care – Medical Attention for Nephropathy 9. Taking Diabetes Medications as Directed 10. Monitoring Patients with High Blood Pressure 11. Statin Therapy for Patients with CVD 12. Taking Cholesterol Medications as Directed 13. Taking Hypertension Medications as Directed	**35%**
Coordinated, Cost-Effective Care 1. Potentially Avoidable ER Visits 2. Hospital Re-admissions within 30 days (All Cause)	**20%**
Appropriate, Cost-Effective Care 1. Appropriate Testing for Children with Sore Throat 2. Avoiding Antibiotics for Children with URI 3. Avoiding X-Ray, MRI and CT Scan for Low Back Pain 4. Avoiding Antibiotics for Adults with Acute Bronchitis 5. Generic Prescribing (ADHD) 6. Generic Prescribing (Antidepressants) 7. Generic Prescribing (ACE/ARB) 8. Generic Prescribing (PPIs) 9. Generic Prescribing (Statins)	**10%**

Data Visualization on the Community Checkup Website

In November 2019, the QIC viewed seven different graphic representation ideas and indicated that they favored three of the seven that included a *continuous* ranking. Continuous rankings calibrate observed results across the full, theoretical range of standardized performance. This reduces the chance of mistaking the top observed score with top performance, as might happen if there is a low average level of performance across all observations.

Alliance staff tested the three different graphic representations favored by the QIC and found that two of the three passed a Tableau feasibility test that would ensure full functionality on the Community Checkup website (Tableau is the software that is used to power the Community Checkup website).

The workgroup recommended and the QIC approved the following approach to graphic representation of the quality composite scoring results. The following uses fake data to illustrate the data visualization. In this example, an "entity" could be a clinic or a medical group.

Med Group	Percentile Rating	Quality Score
Entity 1	88%	1.170
Entity 2	75%	0.660
Entity 3	67%	0.450
Entity 4	60%	0.250
Entity 5	53%	0.070
Entity 6	52%	0.040
Entity 7	42%	-0.190
Entity 8	34%	-0.420
Entity 9	32%	-0.480
Entity 10	31%	-0.490
Entity 11	25%	-0.660
Entity 12	24%	-0.710

In this illustrative visualization, 12 medical groups (entities) have been sorted by their composite quality score (right hand column). The unit of measure for the composite score is standard deviations, which is abstract and harder to understand for some. So, we instead emphasize the shaded middle column, Percentile Rank. Each composite quality score can be mapped to a

percentile from the continuous range of theoretical performance. A composite score of 0.0 means an entity's performance is the same as the overall observed average performance.

In the example, Entity 1 has the highest composite score of 1.17, which translates into the 88th percentile of performance. So, we might expect only 12% of measured entities would exceed Entity 1's performance, were we to measure a large number of medical groups.

In contrast, Entity 9 has a negative composite score of (0.48), meaning its average performance is about half of a standard deviation below the expected overall performance. Scaled against the full range of possible performance, Entity 9 ranks in the 32nd percentile -- about 68% of measured entities could be expected to score higher.

Regarding color shading: A percentile ranking of >50% (composite score >0) is a better score, and is shown in grades of green, with darker green being better. A percentile ranking of <50% (composite score <0) is a worse score, and is shown in shades of red, with darker red being worse.

Quality composite scores will be published on the Community Checkup website following the release of new Community Checkup results for clinics and medical groups. The quality composite scoring will be published via "Highlight." These are brief "articles" that emphasize data visualization of results from the Alliance's work.

In the Highlight with quality composite scoring, we will show the domain scores that make up the composite, likely in a "dialogue box" that will appear when you hover over the entity's score.

In addition, in the Highlight with composite scoring, when you click on the name of a medical group or clinic (shown in the example as "entity"), it will take you directly to the detailed quality measure results for that organization.

III. REDUCING OPIOID PRESCRIBING

QIC members were asked to share information with the Alliance and with other QIC members regarding the following:

- Does your organization have one or more specific strategies in place to reduce opioid prescribing?
- What seems to be working? What is not working?

There was a robust, round-robin discussion, with each organization briefly sharing. Below is a summary composite of responses from the group (in no particular order). Most groups were using multiple methods, as shown below, to curb opioid prescribing.

1. **Provider education - Regular transmittal of information on appropriate prescribing**
    a. Promote Rx alternatives to opioids, especially targeting specialties/disciplines where acute use of opioids is common (e.g., perioperative)
    b. Acute use of opioids
    c. Chronic use of opioids
    d. Transitioning from acute to chronic
    e. Dangers of co-prescribing opioids with benzodiazepines
    f. Pain experts coaching/shadowing individual providers, with help on prescribing patterns and conversational skills with patients who are currently using or want opioids for pain relief
    g. Teach "mindfulness" as an alternative strategy to Rx
2. **Use transparency to track opioid prescribing**
    a. Track opioid prescribing by individual provider, including quantities, MME, MED
        i. Share results internally (un-blinded); provider "report cards"
        ii. Identify outliers and intervene with specific coaching from leadership
        iii. Track improvement over time
    b. Include aggregate opioid prescribing rates over time on organizational dashboards; share with leadership, including Boards
        i. Rates by specialties, departments, clinics, etc.
        ii. Inpatient versus outpatient
3. **Use of tools to support provider appropriate prescribing**
    a. All patients on chronic opioids must be on an annually-updated care plan that is routinely monitored via a registry and is available for other providers (interfacing with that patient) to refer to
    b. Develop and promote care pathways to standardize management of patients on chronic opioids
    c. Electronic health records: change order sets for acute and subacute pain management to curb prescribing at the point of care; eliminate provider "favorites" and require re-doing order sets (following education) to modify previous prescribing behaviors
    d. Promote the University of Washington Opioid Consult Line (1-800-520-PAIN); UW pain pharmacists and physicians are available Monday-Friday to provide clinical advice at no charge
    e. Embed pharmacists in care teams to enable a team-based approach to caring for patients with ongoing pain needs
    f. Implement Medication-Assisted Treatment (MAT), especially in ERs
    g. Implement and promote "drug take-back" programs
    h. Health plans: implement prescribing limits (coverage/payment)

IV. NEXT STEPS ON HEALTH WASTE CALCULATOR RESULTS

The QIC began a discussion regarding whether we should develop specific strategies to address one or more other areas identified as problematic in the Health Waste Calculator, similar to what we did with the "Drop the Pre-op" initiative. The two topics that were briefly discussed were (1) Vitamin D deficiency screening, and (2) annual cardiac screening for low-risk, asymptomatic individuals. Ms. Dade reviewed the results for these measures from the Health Waste Calculator.

Due to time limitations, the QIC did not reach a conclusion and the topic will be picked up again at a future meeting.

The next QIC meeting will be Thursday, April 9, 2020 from 2:00 – 4:00 at the Alliance.