Quality Improvement Committee (QIC)

Meeting Summary

Thursday, April 14, 2022 (Meeting held virtually)

Members Present: Steve Jacobson, Premera (Chair)
Rick Hourigan, Cigna (Vice-Chair)
Lydia Bartholomew, Aetna
Edwin Carmack, Confluence Health
Kavita Chawla, Virginia Mason Franciscan Health
Frances Gough, Molina
Jennifer Graves, KPWA
Kim Herner, UW Valley
Matt Jaffy, UW Neighborhood Clinics
Mike Myint, Embright
Komal Patil-Sisodia, Evergreen Healthcare
Wayne Rawlins, WellSpark Health
Paul Sherman, Community Health Plan of Washington
Hugh Straley, The Robert Bree Collaborative
Judy Zerzan-Thul, HCA

Guests: Mark Friedberg, MD; Gabriella Silva, PhD, Blue Cross Blue Shield of Massachusetts

Staff Present: Teresa Battels, Sharon Eloranta, Denise Giambalvo, Nancy Giunto, Mark Pregler

Introductions, approval of meeting minutes

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

Actions

The QIC meeting summary from February 2022 was approved with no changes; the committee also approved the advancement of a prospective QIC member, Wayne Rawlins, to the Board for final approval.

Diversity, Equity and Inclusion: building our culture

Sharon shared the following quote on peace from Dr. Martin Luther King, Jr.
"Peace is not merely a distant goal that we seek, but the means by which we arrive at that goal."

Update on Low Back Pain Implementation Collaborative
Denise Giambalvo described the work thus far on the Low Back Pain Implementation Collaborative. She mentioned the stakeholder-specific sessions held in March and the upcoming all-stakeholder meetings; described progress on the LBP pathway; also the good response to our request for action updates from participants.

Health Equity Guest Speakers: Mark Friedberg, MD, MPP, and Gabriella Silva, PhD, Blue Cross Blue Shield of Massachusetts

The guests from BCBSMA described their work towards being able to stratify quality metrics by race, ethnicity and language in order to identify potential equity issues at the health plan. The work starts with being able to identify REL**. (NOTE: please refer to BCBSMA slide presentation for detailed information – the notes are not nearly as complete).**

1) The gold standard is to have self-reported REL information from members, plus end-to-end documentation of the data collection processes, which include:
    a. Information on employees from employment files
    b. Information from providers back to BCBSMA
    c. Imputation based on RAND's free Bayesian method; uses first-and last-name plus geocoding. This method requires SAS programming. BCBSMA compared information they obtained from this imputation vs the gold standard, and believe that the imputation does offer probabilistic RE values.
2) They note that all data collection means – imputed, vended and provider-obtained have some degree of error, and pointed out that all of these data will be compared against the gold standard (once there is sufficient self-reported data obtained) and the various levels of error will be calculated.
3) With regard to self-reported data, BCBSMA is using multi-modal means of collection – using the current level one FHIR categories (with plans to move to Level two):
    a. By mail: everyone on the BCBSMA rolls receives hard copy letter requesting REL data for everyone on the policy
    b. In the "My Blue" app – all who open the app see a request for the data
    c. Whenever an account changes (enrollment, etc.), enrollee is asked for data for everyone on the policy

    At this point, through these means, more than 10% of covered persons have REL self-reported data.

BCBSMA plans to stand up equity measures in their plan incentives, once they have sufficient data to identify candidate metrics. They already publish certain metrics using their imputed data in a report **(see slides for QR code to download the report).**

They offered the following suggested approach to plans/others wanting to collect/impute RE information:

1) Collect a gold standard sample (they collected data on a sufficient sample – several hundred)
2) Use the gold standard to evaluate the error in data from imputed and other sources
3) For each member, identify most accurate possible ethnicity and race; then retain the information about how you arrived at that conclusion for that person
4) Compute most accurate possible estimates

A Q&A session followed the presentation.
Q: Sharon asked: What is your opinion on NCQA's requirement that health plans have REL data on 80% of patients by measurement year 2024?
A: Mark F suggested that an approach might be to share the data a plan has, and then NCQA could quality check it using CAHPS data.

Q: Hugh asked which racial/ethnic groups have had higher/lower response rates to BCBSMA's data collection efforts?
A: It differed with electronic vs paper collection, but white, non-Hispanic populations had lower response rates

Q: Matt asked who else is working on best practices in data collection?
A: BCBSMA is partnering with IHI, but there is no empirical proof re best practices; Press Ganey is working on this and may have some useful data

Q: Sharon asked in which languages were the surveys offered?
A: Spanish and English; it is a double-stuffing experiment with the mailed surveys, includes a cover letter

Q: Steve asked regarding other resources that we could consult?
A: RAND BISG has literature.

Composite Score/TCOC dimension discussion (Executive Session)
Jim Andrianos reviewed the four recommendations that were put forward by the expert panel regarding the ways a pricing domain could be presented in the context of the composite score report.

Timeline: TCOC by medical group has been covered by all committees; but conditional approval of a composite expansion is already done by the Board so the QIC needs to approve.

Update on Expert Panel recommendations (with partial Board approval) contingent on our approval:
Original expert panel (QIC and HEC volunteer representatives) met on 1/7 and recommended NOT expanding the current QCS to include cost, and came up with alternate proposals.
They also chose to use the risk-adjusted TCOC in the recommendations.

1) Display cost measures separately but alongside the quality scores, enable sorting
2) Show a scatterplot of the QCS versus the cost performance
3) Present a column of "V= Q/C" or calculate this, enable sorting
4) Expect demand by audiences for ways to combing cost and quality, and provide ways to do so

Then Jim reviewed the sample scatterplot. For TCOC, there needed to be at least 600 attributed patients in order for a medical group to be included.

Of the four recommendations above, the Board approved #s 1 and 2. The QIC was asked to concur (or not).

Edwin (who was on the panel) stated that 1 and 2 are the most important anyway; Hugh stated that he felt the Board's choice made sense; Hugh and Jennifer voiced approval for the scatterplot; Kim approved of 1 and 2 but wanted to be sure about inclusion of risk adjustment in the scatterplot (Jim confirmed that the MARA risk adjustment IS included in the TCOC at the medical risk level and excludes the high-cost, catastrophic patients). It is not adjusted for race or SDOH.

Matt and Jennifer moved to vote; Kavita seconded; ***approval of recommendations 1 and 2 was passed; the QIC concurred with the Board's support of these.***

Jim then reviewed recommendations 3 and 4.

Aim is to build consensus on these; Board was not prepared to accept them; Jim reviewed the Board's reasoning: scatterplot visually serves the same end; Q/C is not meaningful to purchasers; need to see real results to reconsider.

Regarding 3, Jim noted that using actual data for Q/C in this instance resulted in nonsensical results or resists interpretation for various reasons.

Item 4: Jim tried some tactics to address this need; one includes a composite score that then allows a user to weight the cost score to result in a percentile. When cost weight is set to zero, the results are just the QCS: when weighted at 100, the result is just the TCOC. Using real data, he demonstrated the impact of changing the cost weight, for instance to 20%. As the cost weight increases, groups that migrate DOWN the list may be competing primarily on quality; groups migrating UP the list, they may be competing primarily on cost. Remaining toward the top may indicate competing primarily on VALUE.

Next steps that are recommended:

1) Drop #3; let scatterplot stand in for Q/C
2) Focus on developing #4; show some examples (need QIC input on this weighting approach, reviewing with HEC and then get more employer input by getting views from the Purchaser Advisory Group. (The expert panel had no purchaser members).

3) Compile proposal and data illustrations for Board review.

Discussion on these recommendations included Kim asking about unintended consequences and supporting getting feedback from added stakeholders; Hugh wondered what PAG will say; some concerns about access and quality. There were comments in approval of Jim's "slider" approach to weighting. Would seem to be valuable for purchasers – which groups remain in the top.

Following the discussion, Steve asked for a motion, second and vote; the recommendations re Items 3 and 4 were passed.

The meeting was then adjourned by Steve.

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