WASHINGTON HEALTH ALLIANCE

Quality Improvement Committee (QIC)
Thursday, June 13, 2019

Committee Members Present:
Mary Anderson, *The Polyclinic*
Lydia Bartholomew, *Aetna* (phone)
Peter Dunbar, *Foundation for Health Care Quality* (phone)
Sharon Eloranta, *CHI Franciscan Health*
Bruce Gregg, *MultiCare Health System* (phone)
Matt Handley, *Kaiser Permanente Washington* (phone)
Kim Herner, *Valley Medical Center*
Matt Jaffy, *UW Neighborhood Clinics*
Dan Kent, *UnitedHealthcare Community Plan (Chair)*
Gary Knox, *MultiCare Rockwood Clinic* (phone)
Bob Mecklenburg, *Virginia Mason Medical Center*
Randal Moseley, *Confluence Health*
Michael Myint, *Swedish Health Services*
John Sobeck, *Cigna*
Julie Stroud, *Northwest Physicians Network*
Judy Zerzan, *WA State Health Care Authority*

Committee Members Absent:
David Buchholz, *Premera Blue Cross*
Nancy Fisher, *Region 8, 9 & 10, CMS*
Frances Gough, *Molina Health Care*
Darcy Jaffe, *WA State Hospital Association*
Drew Oliveira, *Regence Blue Shield*
Terry Rogers, *Emeritus member (ex-officio)*
Hugh Straley, *The Robert Bree Collaborative*
John Vassall, *Qualis Health*
Lynette Wachholz, *The Everett Clinic*

Staff Present:
Susie Dade, *Washington Health Alliance*
Nancy Giunto, *Washington Health Alliance*

Guests:
Cody Gillenwater, *Regence Blue Shield* (for Drew Oliveira)
Dan Monahan, *Novartis*
Dylan Oxford, *WA State Health Care Authority*
Charlie Peterson, *Proliance Surgeons*
Rick Rubin, *OneHealthPort*
Emily Tsiao, *Premera Blue Cross* (for David Buchholz)
Shaun Wilhelm, *WA State Health Care Authority*

WASHINGTON HEALTH ALLIANCE

I. INTRODUCTIONS, APPROVAL OF MEETING MINUTES, NEW MEMBER RECOMMENDATIONS

The QIC welcomed new members Dr. Matthew Jaffy (UWNC) and Darcy Jaffe (WSHA).

ACTION - The QIC reviewed and approved the QIC meeting minutes from April 11, 2019.

Updates: Ms. Dade provided several updates for the QIC.

- The **WA State Choosing Wisely Task Force** has been discontinued. The work of the CWTF, specifically oversight of reporting based on the Health Waste Calculator, will shift to the QIC. Ms. Dade reported that the Alliance is working hard to produce results that attribute results from the Health Waste Calculator to medical groups.
- State oversight of the **state managed APCD** (WA-APCD) is shifting from the Office of Financial Management (OFM) to the Health Care Authority (HCA), effective 1/1/20. Oregon Health Sciences University will discontinue as WA-APCD Lead Organization, effective 12/31/2019
  - Transition planning is currently underway between OFM and HCA.
  - The HCA will release an RFP for a new Lead Organization. The Alliance intends to bid on the RFP,
  - The enabling legislation requires that the Lead Organization have: (1) experience in health care data collection, analysis, analytics and security, and (2) experience in convening and effectively engaging stakeholders to develop reports, especially among groups of health providers, carriers and self-insured purchasers.
- Ms. Dade noted that a work group has been formed to develop a quality composite scoring methodology. Recommendations are expected to come back to the QIC in Fall 2019 for action.
- Ms. Dade also noted that a small work group is in the early stages of exploring a method for cost efficiency composite scoring.

II. STATUS REPORT: WASHINGTON STATE CLINICAL DATA REPOSITORY (CDR)

OneHealthPort serves as the Lead Organization for Health Information Exchange (HIE) in Washington state. The CDR is a service of the HIE and is operated and managed by OneHealthPort, with the Washington State Health Care Authority as the sponsor. Rick Rubin (OneHealthPort) and Shaun Wilhelm (Health Care Authority) joined the QIC to provide a status report on the development of the state's CDR.

Rick reported that, currently:

- The CDR includes Medicaid Managed care lives only – approximately 2.3M lives in the Master Person Index (MPI)

WASHINGTON HEALTH ALLIANCE

- There are about 10 Million total CCD[1]s in the CDR.
- Approximately 1M lives have at least one CCD.
- This includes current medical, dental, medication claims (clinical info only, no financial data).
- Behavioral health data is not yet included in CDR.
- Currently, based on HCA policy, access to CDR is limited to portal access only, but this will be changing soon.

Rick discussed how rapidly the health information market place is changing, e.g.,

- Changing incentives - demand for info grows, personal/population health pushed together, increasing emphasis on measurement, cost savings
- Currency of exchange - evolving from claims & ADT to include clinical info - emerging interest in social determinants of health, consumer generated data, etc.
- Standards - are maturing, promise of APIs/FHIR - data quality, patient matching problems abound
- Consolidation - creates differentials in capabilities, rates of progress among provider organizations
- Crowded space - vendors, enterprises, national networks, disruptors - competitive advantage vs. commodity, what's the role of a "utility?"

OneHealthPort and the state are actively seeking ways to increase the value of the CDR and health information exchange; Rick and Shaun discussed a variety of tactics including adding more data (and different types of data), improving data quality (including patient matching), expanding access and methods of access, and deploying tools and services that providers and others will find helpful.

QIC members asked a number of questions on a variety of topics, e.g.,

- What efforts are underway to improve data quality in the CDR?
- Is there a way to get zip code+4 for each patient to enable "hot spotting" QI techniques and more granular analyses of social determinants of health?
- Will the CDR help us measure emerging quality indicators such as shared decision-making, clinical appropriateness and return-to-function?
- How will state policy respond to demand for expanded access to data in the CDR to support transparency, quality improvement, evaluation of delivery system performance, etc.?

[1] Continuity of Care Document: an electronic document exchange standard for sharing patient summary information

WASHINGTON HEALTH ALLIANCE

III. HOSPITAL INPATIENT QUALITY MEASURES

At its April 2019 meeting, the QIC asked a small ad hoc work group to review the hospital inpatient quality measures currently reported on the Community Checkup website and make recommendations about measures that should be discontinued or added. A group of five clinician leaders met to complete this review, including:

- Sharon Eloranta, MD, Division Director, Clinical Effectiveness and Quality, CHI Franciscan
- Jennifer Graves, RN, MS, Vice President, Quality and Safety and Regional Nursing Executive, Kaiser Permanente Washington
- Darcy Jaffe, BSN, MN, Senior Vice President, Safety and Quality, Washington State Hospital Association
- Michael Myint, MD, Medical Director, Population Health, Swedish Health Services
- John Vassall, MD, Physician Executive for Quality and Safety, Comagine Health

On June 5th, the work group reviewed the following: (1) all hospital inpatient quality measures on the Community Checkup website; (2) all measures on the quality website for the Washington State Hospital Association; and, (3) all measures currently included in CMS Hospital Compare.

The work group recommended that the following two measures be **removed** from Community Checkup reporting:

1. **Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus Aureus (MRSA) Bacteremia (NQF-endorsed measure, #1716)**
   Rationale: The rate of hospital acquired MRSA is low and has been for some time now (current state average = .03 per 1000 patient days). There are few gains to be made based on hospital interventions and so this measure is not thought to be meaningfully actionable.

2. **Early Elective Deliveries (NQF-endorsed measure, #0469)**

   Rationale: Significant progress has been made in Washington state and the current state average is now 1.7%. Not much room for improvement remains in a majority of hospitals (0% - 2%) and systems are in place to review/adjudicate with feedback loops to keep the rate low. Five hospitals have a rate of 3% - 4% and one hospital, Mid-Valley Hospital in Omak, has a current rate of 14%.

WASHINGTON HEALTH ALLIANCE

ACTION: The QIC approved removing these two measures from the Community Checkup effective 2019.

The work group recommended that the following two measures be **added to** Community Checkup reporting:

1. Heart Failure 30-day Readmission, NQF-endorsed measure, #0330

Definition: The measure estimates a hospital-level 30-day risk-standardized readmission rate (RSRR) for patients discharged from the hospital with a principal diagnosis of heart failure (HF). The outcome is defined as readmission for any cause within 30 days of the discharge date for the index hospitalization, excluding a specified set of planned readmissions. The target population is patients aged 18 years and older. The current state average is 21.2%. The data source for Alliance reporting will be WSHA/CMS Hospital Compare.

2. Brain Scan Results in 45 Minutes, NQF-endorsed measure #0661

Definition: Emergency Department Acute Ischemic Stroke or Hemorrhagic Stroke patients who arrive at the ED within 2 hours of the onset of symptoms who have a head CT or MRI scan performed during the stay and having a time from ED arrival to interpretation of the Head CT or MRI scan within 45 minutes of arrival. The target population includes all ages. The current state average is 67%. The data source for Alliance reporting will be WSHA/CMS Hospital Compare.

ACTIONS: (1) The QIC approved adding "Brain Scan Results in 45 Minutes" to the Community Checkup, effective 2019; (2) The QIC tabled action on the measure, "Heart Failure 30-day Readmission," until September 2019.

Discussion: Dr. Handley mentioned a recent article in the New England Journal of Medicine, "The Hospital Readmissions Reduction Program: Time for a Reboot." This article discussed whether the Hospital Reductions Readmission Program may have had unintended consequences, particularly for patients with heart failure. Dr. Handley suggested that QIC members have the opportunity to review the article prior to making a decision to add the "Heart Failure, 30-day Readmission" measure to the Community Checkup. Ms. Dade will distribute a link for the article (https://www.nejm.org/doi/full/10.1056/NEJMp1901225) and the topic will be brought back in September.

IV. POTENTIALLY AVOIDABLE ER VISITS MEASURE

At its April 2019 meeting, the QIC asked a small ad hoc work group to review the specifications for the Potentially Avoidable ER Visits measure currently reported on the Community Checkup website and make recommendations about updating those diagnostic codes that are included

in the numerator (i.e., potentially avoidable). A group of six clinician leaders met to complete this review, including:

- David Buchholz, MD, Medical Director of Provider Engagement, Premera Blue Cross
- Cameron Buck, MD, ED Medical Director, Valley Medical Center; Quality & Patient Safety Committee, AECP
- Bruce Gregg, MD, Primary Care Medical Director, MultiCare Health System
- Kim Herner, MD, Chief Quality Officer, Valley Medical Center
- Tonya Owens, Provider Engagement Manager, Premera Blue Cross
- John Sobeck, MD, Market Medical Executive, Cigna

On May 29th, the group reviewed detailed data provided by Premera Blue Cross on the top 100 ER visits diagnosis categories. Twenty diagnosis categories were identified for further investigation (deep dive on additional ICD-10 codes that roll-up to that category). Next steps including having the ad hoc work group review the results of the deep dive and agree upon which additional ICD-10 codes should be added to the numerator. The group may also recommend some ICD-10 codes to remove from the numerator. Final recommendations will be available for action at the September QIC meeting.

V. MAPPING CANCER CARE DISPARITIES IN WASHINGTON STATE

Dr. Veena Shankaran, Co-Director of the Hutchinson Institute for Cancer Outcomes Research (HICOR), joined the QIC as a guest presenter. HICOR recently released results from their analyses on whether they see differences in cancer stage at diagnosis, insurance type, survival and quality of cancer care – based on social determinants of health. In this case, they defined social determinants of health as: (1) race, (2) neighborhood socioeconomic disadvantage, (3) rurality of residence, and (4) travel time to oncologist.

Below is a brief summary of what they learned. The full slide deck is available upon request.

Survival: What did they learn?

- Across all cancer stages at diagnosis:
    - Persons with low income insurance fare worse than those with commercial and Medicare insurance
    - Persons who live in the most disadvantaged neighborhoods fare worse, regardless of their insurance

WASHINGTON HEALTH ALLIANCE

- Factors related to socioeconomic disadvantage are likely responsible for observed lower survival in the low income insurance group:
    - Our society sorts people into insurance plans based on their age and socioeconomic status
    - Quality of initial cancer treatment is generally high for all insurance types

Quality of Care: What did they learn?

- Patients living in the most disadvantaged neighborhoods visit the ED more during treatment and end of life
- Black patients and those with long travel times to their oncology provider have more stays in the ICU at end of life
- Patients living in rural areas are less likely to have inpatient hospital stays during treatment and at end of life
- Appropriate care measures are less likely to be impacted by social determinants of health

The next QIC meeting will be Thursday, September 12, 2019 from 2:00 – 4:00 at the Alliance.