WASHINGTON HEALTH ALLIANCE

Quality Improvement Committee (QIC) Meeting Summary

Thursday, April 9, 2020
(Meeting was held virtually)

Members Present:
Mary Anderson, *The Polyclinic*
Drew Baldwin, *Virginia Mason Medical Center*
Lydia Bartholomew, *Aetna*
Nancy Fisher, *Region 8, 9 & 10, CMS*
Frances Gough, *Molina Health Care*
Bruce Gregg, *MultiCare Health System*
Matt Handley, *Kaiser Permanente Washington*
Kim Herner, *Valley Medical Center*
Matt Jaffy, *UW Neighborhood Clinics*
Dan Kent, *UnitedHealthcare Community Plan (Chair)*
Bob Mecklenburg, *Virginia Mason Medical Center*
Randal Moseley, *Confluence Health*
Drew Oliveira, *Regence Blue Shield*
Charles Peterson, *Proliance Surgeons*
Paul Sherman, *Community Health Plan of Washington*
Hugh Straley*, The Robert Bree Collaborative*
John Vassall, *Comagine Health*
Judy Zerzan, *Washington State Health Care Authority*

Members Absent:
Darcy Jaffe, *Washington State Hospital Association*
Gary Knox, *MultiCare Rockwood Clinic*
Aileen Mickey, *EvergreenHealth Medical Group*
Jessica Schlicher, *CHI Franciscan Health*
Julie Stroud, *Northwest Physicians Network/The Everett Clinic*

Staff Present:
Nancy Giunto, *Washington Health Alliance*
Karen Johnson, *Washington Health Alliance*
Mark Pregler*, Washington Health Alliance*
Jim Andrianos, Calculated Risk

Guests:
Kathy Lofy, *Washington State Department of Health*

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

INFORMATION SHARING – Dr. Kent welcomed new committee members: Drs. Drew Baldwin (Virginia Mason, to replace Bob Mecklenburg), and Paul Sherman (Community Health Plan of Washington), and Jessica Schlicher (CHI Franciscan Health).

Dr. Kent and Ms. Giunto expressed their appreciation to Dr. Bob Mecklenburg for his years of service and many contributions to the work of the QIC and the Alliance.

ACTION – The QIC reviewed and approved the QIC meeting minutes from February 2020.

II. QUALITY COMPOSITE SCORING

INFORMATION SHARING/DISCUSSION – During the February 2020 meeting, the QIC reviewed and approved recommendations from an ad hoc workgroup (expert panel) formed to finalize recommendations to the QIC on the quality composite scoring methodology. The QIC approved specific recommendations in the following areas.

1. Four Domains and Weighting for each Domain
   a. Prevention and Screening – 35%
   b. Chronic Disease Care – 35%
   c. Coordinated, Cost-Effective Care – 20%
   d. Appropriate, Cost-Effective Care – 10%
2. Quality measures within each domain (based on quality measures already available within the Community Checkup)
3. Graphic representation of the quality composite score on the Community Checkup website

Alliance staff is offering a "catch-up webinar" on this topic for new committee members or those that missed previous meetings where the methodology was reviewed/approved and were asked to contact Adria Moskowitz if they are interested in participating.

At the February QIC meeting, the committee asked Alliance staff to give the QIC an opportunity to review draft results and do a basic "sniff test" or face-validity review of the method. Draft results were shared during this meeting, but not distributed electronically to committee members.

Jim Andrianos presented the draft results based on the methodology approved at the February meeting, as well as incorporating the following three recommendations made by Alliance staff.

Recommendation	Rationale
Adopt a two-measure requirement for domain #3: Coordinated, Cost-Effective Care for public reporting This domain includes two measures: - Potentially avoidable ER visits - Hospital Readmissions within 30 days (all cause)	These measures were originally in domain #4 as part of a 3-domain scheme. The workgroup felt these measures carried substantial financial & resource use impact along with clinical import. Thus, the measures were put into their own domain with increased weight. Requiring both avoids ever placing a 20% weighting on a single measure. The hospital readmission measure is the only measure that requires risk-adjustment.
Include "reportable" results only so that drilldowns to measure results tie out "Reportable" means results are not suppressed on the Community Checkup website because of privacy rules (numerator and denominator minimums).	This will align the measure count cited for each composite score, with what's visible to users when drilling down into detailed measure results for a medical group.
Exclude measures where statewide average is approaching perfection This results in two measures being excluded: - Generic prescribing for high-blood pressure medications - Generic prescribing for cholesterol-lowering medications	Average adherence for both measures is approaching 100% with a tiny standard deviation. Relative laggards still have very strong adherence rates, but receive very low z-scores, which could have undue influence on their domain and composite scores.

Un-blinded results were shared with the QIC and committee members were asked to use the results as a "face-validity review" – a means to answer the question, "Is the method working the way we thought it would when using real data?" Committee members were asked to set aside self-interest during the brief time allotted. It was also noted that today's results are draft, not comprehensive, and are subject to change, based on the following:

- Methods may change based on committee input or patient verification may alter results, etc.
- We only looked at commercial results, and for a subset of medical groups.

QIC committee members engaged in a robust discussion of the results and voted to accept all three recommendations made by Alliance staff outlined above. The discussion included several notable observations:

- The reliance upon the Community Checkup measures as the basis upon which the composite methodology is built adds to its validity based on:
  - The primary care measures upon which this is based have a strong "pedigree" and background beyond the Community Checkup; and,
  - The history that the Alliance has in conducting and sharing this validated measure set at the medical group level through the Community Checkup.
- The use of z-scores in the composite methodology is somewhat intuitive.
- The results met the "sniff test" for many in the room when considering their own organization's draft results.
- Regarding measures that are "topping out," it is important to celebrate what has been successful in the past and not be afraid to sunset it and move on when the time has come.

It was noted that one of the strengths of the quality composite methodology is that it can be modified over time as needed or desired. In terms of future opportunities to build and enhance this measure, the following were noted:

- Socio-economic/social determinants of health play a role in influencing results at the medical group level.
- The methodology change to require both measures in Domain #3 results in restricting the list of reportable medical groups to the larger ones. This could disadvantage smaller groups by withholding relative performance cues that could inform improvement efforts. The Alliance was encouraged to explore ways to include smaller groups in this work if possible.

Jim also shared the visual presentation of the results in the manner approved at the February QIC meeting. (Example shown in Appendix B). 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.

III. BRIEFING: COMMUNITY CHECKUP "HIGHLIGHTS"

INFORMATION SHARING/DISCUSSION The Alliance has produced two reports utilizing pricing data: (1) a Spending Trend Analysis that includes provider organization detail on key drivers of spending; and 2) a newly refreshed Hospital Value Report with results that combine quality, patient experience, and allowed price levels in a single analysis. During the ensuing general discussion, it was noted that allowed case price levels for inpatient treatments seemed to increase as performance on mortality and patient safety measures decreased. Jim Andrianos reviewed these two reports with the QIC. No action was required by the QIC.

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IV. QIC INFORMATION EXCHANGE: IMPACT OF COVID-19, CHALLENGES & STRATEGIES

Many thanks to Dr. Kathy Lofy, State Health Officer, Washington State Department of Health, who joined the QIC to share an update from the state and engage in a discussion with the clinical leaders that comprise the QIC on this important topic.

Notable highlights from the discussion include the following:

- It does appear that the curve is flattening in Washington state.
- The state is very focused on testing and PPE availability; while there is an immediate shortage, there is a strong inventory of both on its way.
- Microsoft has worked with the state to build a number of dashboards that are a useful mechanism for tracking on a daily basis: # patients, beds, PPE supplies, etc.
- There are many clinical trials happening – the state is looking for someone to take the lead on understanding "who's doing what" in this space.
- The Gates Foundation has been a strong partner in expanding testing.
- Considerations for lifting the ban on elective care were discussed; the availability of testing will be a factor in this discussion.

The next QIC meeting will be Thursday, June 11, 2020 from 2:00 – 4:00 at the Alliance, if conditions allow.