Quality Council
March 18, 2021

OHS
CONNECTICUT
Office *of* Health Strategy

Agenda

Time	Topic
4:00 p.m.	Call to Order
4:05 p.m.	Public Comment
4:15 p.m.	Approval of February 18, 2021 Meeting Minutes
4:20 p.m.	Continue Annual Review of Core Measure Set
4:55 p.m.	Break
5:00 p.m.	Continue Annual Review of Core Measure Set
5:20 p.m.	Gaps Analysis of the Core Measure Set
5:50 p.m.	Wrap-up & Next Steps
6:00 p.m.	Adjourn

Call to Order

Public Comment

Approval of February 18, 2021 Meeting Minutes

Continue Annual Review of the Core Measure Set

Reminders!

- **Alignment with national measure sets of interest (max score: 7)**
  - CMS Electronic Clinical Quality Measures (eCQMs)
  - CMS Medicaid Child Core Set
  - CMS Medicaid Adult Core Set
  - CMS Merit-based Incentive Payment System (MIPS)
  - CMS Medicare Shared Savings Program ACO and Next Generation ACO
  - Core Quality Measures Collaborative Core Sets
  - NCQA HEDIS
- **Use by Connecticut payers (max score: 8)**
  - Dept. of Social Services (DSS) Patient-Centered Medical Home Plus (PCMH+)
  - Office of State Comptroller (OSC) State Employee
  - Responses from six surveyed commercial insurance carriers (Aetna, Anthem, Cigna, ConnectiCare, Harvard Pilgrim Health Care, UnitedHealthcare)

OHS CONNECTICUT Office *of* Health Strategy

Reminders! (Cont'd)

- **CT Health Priorities/Needs**

1. chronic conditions
   - hypertension: 30%
   - asthma: 15%
   - diabetes: 10%
2. access to substance use disorder (SUD) treatment
   - 29.9 drug deaths per 100,000 (*CT ranks 42nd*) and 30.7 drug poisoning deaths (*CT ranks 41st*) in 2018
3. childhood obesity
   - 17% of children are obese and 15% are overweight
4. behavioral health treatment
   - suicide is the leading cause of intention injury and death in the state.
5. lead screening/prevention
   - 26.6% of housing stock has a lead risk (*CT ranks 46th*)
6. low birthweight racial gap
   - increased 19% from 5.4 to 6.4 (2017-18)
7. emergency room (ER) use
   - 22% of individuals received care in an ER one to two times in the last year

Sources include: 2020 America's Health Rankings, 2020 Commonwealth Fund's Scorecard, 2019 CT State Health Assessment, Healthy CT 2025 and DataHaven.

Reminders! (Cont'd)

- **Opportunity for Improvement**
  - Commercial: weighted average plan performance from Quality Compass 2020
  - Medicaid: PCMH+ performance from DSS (PCMH+) for 2019 and statewide performance from CMS (CMS) for FFY 2019

Key:				
<25th	Between 25th and 50th	Between 50th and 75th	Between 75th and 90th	≥90th

- **Alignment with the Quality Council's Measure Selection Criteria**
  - The criteria are meant to aid the Council in recommending measures for inclusion in the Core Measure Set.
  - Measures do not need to satisfy all the criteria to be recommended.
  - See the first two slides of the Appendix or the Word document distributed with the meeting materials for the list of criteria.

OHS CONNECTICUT Office of Health Strategy

Reminders! (Cont'd)

- **Equity review** to identify inequities in performance related to race/ethnicity, language, disability status, and other social determinants of health using the following sources:
  - Connecticut Health Foundation's "Health Disparities in CT" 2020 Report
  - Connecticut Department of Public Health's "Healthy CT 2025: State Health Assessment"
  - A literature review conducted by the MA Department of Public Health
  - Performance data provided by MA health systems and ACOs
  - State disparities research (focusing on data from CA, MI, and MN)
  - Buying Value's "disparities-sensitive" measure status, based on NQF's 2017 Disparities Project Final Report
  - AHRQ's National Healthcare Quality and Disparities Report (2018)
  - A literature review conducted by Bailit Health to supplement the above data sources

Note: Not all results are displayed on each slide. All information can be found in the Crosswalk distributed with the meeting materials.

ACO: Accountable Care Organization
AHRQ: Agency for Healthcare Quality and Research
NQF: National Quality Forum

Recap of the February 18, 2021 Meeting

- The Council **continued its review** of the Core Measure Set, making the following decisions:
  - **Retain (8)**: Cervical Cancer Screening, Chlamydia Screening, Colorectal Cancer Screening, Immunizations for Adolescents (Combo 2), Developmental Screening in the First Three Years of Life, Well-Child Visits in the First 30 Months of Life, Child and Adolescent Well-Care Visits, Prenatal & Postpartum Care
  - **Remove (3)**: Weight Assessment and Counseling for Children/Adolescents, BMI Screening and Follow-up, Tobacco Use: Screening and Cessation Intervention
  - **Revisit (2)**: PCMH CAHPS/CG CAHPS/PCPCM, Screening for Clinical Depression & Follow-up Plan

CG CAHPS: Clinician & Group Consumer Assessment of Healthcare Providers and Systems (a patient survey instrument)
PCMH: Patient-Centered Medical Home PCPCM: Patient-Centered Primary Care Measure

Follow-up from the February 18, 2021 Meeting: 1. Revisit PCCMH CAHPS/CG CAHPS/PCPCM

- The Quality Council discussed three patient experience surveys:
  - Clinician and Group **(CG) CAHPS**, a widely used survey;
  - **PCMH CAHPS**, a supplemental item set that can be added to CG CAHPS; &
  - Person-Centered Primary Care Measure (**PCPCM**) developed by Ertz et al., suggested by Brad Richards for consideration
- The Council favored the patient-centered nature and overall goals of the PCPCM, but expressed concern about uptake and implementation if organizations are still primarily using the CAHPS surveys.

1. Revisit PCMH CAHPS/CG CAHPS/PCPCM (Cont'd)

- Susannah Bernheim noted that the Measure Application Partnership is supporting inclusion of the PCPCM in the MIPS program, which *could* promote measure adoption and make it more feasible for implementation in the future.
- The Council agreed to review the questions in the PCPCM before deciding whether to recommend the PCMH CAHPS, the CG CAHPS, or the PCPCM for inclusion during the March meeting.

Survey Comparisons

	CG CAHPS	PCMH CAHPS	PCPCM
Number of Questions	Adult: 31 Child: 39	Adult: 6 Child: 10	11
Domains	Accessibility of Care, Communication with Providers, Care Coordination, Interactions with Staff	Access, Communication, Coordination of Care, Comprehensiveness, Information, Self-Management Support, Shared-Decision Making	Accessibility, Advocacy, Community Context, Comprehensiveness, Continuity, Coordination, Family Context, Goal-Oriented Care, Health Promotion, Integration, Relationship
Validated/ Psychometrically Tested?	Yes	Yes	Yes

Survey Comparisons (Cont'd)

	CG CAHPS	PCMH CAHPS	PCPCM
Advantages	• Most commonly used survey among providers • Scientifically designed and trusted to reliably assess patient experience • Provided by many survey vendors	• Easy to add onto CG CAHPS without requiring additional validation • Provides more tailored questions related to access, care coordination, etc.	• Developed with parsimony in mind, i.e., may be less burdensome to the patient • Effectively captures primary care-focused experience
Disadvantages	• Focused on consumer experience of care delivery rather than primary care • Survey length (31-39 questions)	• Survey length (37-49 questions when combined with CG-CAHPS)	• Not as widely used as the CAHPS survey • May be harder to encourage adoption among ANs

CAHPS PCMH Survey

Summary of Major Specification Changes	None	
Alignment with National Measure Sets of Interest	**0**	
Use by Connecticut Payers	**4** (DSS PCMH+ [Scoring], 3 of 6 commercial insurers)	
Addresses State Health Priorities/Needs?	No	
Opportunity for Improvement	**Commercial performance:** N/A	**Medicaid performance (2019):** N/A

CG CAHPS

Race/Ethnicity	Language	Disability Status
• A MA health system found that **all racial/ethnic minorities performed lower than Whites** on: Care Coordination, Provider Communication, and Provider Rating. Asians had lower patient experience on all ambulatory composite [MA Health System, 2018-2019].	• A MA health system found that **non-English-speaking patients are more likely to recommend their provider**. **Non-English-speaking patients have lower patient experience scores** in the areas of Care Coordination, Provider Communication, and Provider Rating [MA Health System, 2018-2019].	• Dual eligible beneficiaries with a **disability were more likely to report being unable to get needed health care** compared to beneficiaries without a disability (14% versus 10%) [CMS 2019].
Other		
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).		

Follow-up from the February 18, 2021 Meeting: 1. Revisit Screening for Depression and Follow-up Plan

- Several members of the Quality Council agreed that depression screening was important. A few members also highlighted challenges associated with access to treatment following a positive screen.
- The Council is revisiting this measure because it ran out of time on 2/18 before making a final decision on whether to retain or remove the measure.
- Based on our experience, states typically retain this (or a similar) measure because of its focus. However, there is wide variation in how payers and providers interpret "follow-up plan," resulting in performance ranging from low single digits to nearly 100 percent.

Screening for Depression and Follow-Up Plan

Summary of Major Specification Changes	MY 2020: Revised the numerator to also include patients screening for depression up to 14 days prior to the date of the encounter (used to only include screens performed on the date of the encounter). Measure lost NQF endorsement in September 2020 because CMS did not seek re-endorsement due to resource priorities.	
Alignment with National Measure Sets of Interest	**6** *(CMS eCQM, CMS Medicaid Adult Core Set, CMS Medicaid Child Core Set, CMS MSSP/Next Gen ACO, CMS MIPS, CMS Core Quality Measures Collaborative)*	
Use by Connecticut Payers	**1** (1 of 6 commercial insurers)	
Addresses State Health Priorities/Needs?	Yes - the 2019 CT State Health Assessment and Healthy CT 2025 Framework includes suicide rate as a surveillance measure.	
Opportunity for Improvement	**Commercial performance (2019):** N/A	**Medicaid performance (2019):** N/A

Screening for Depression and Follow-Up Plan

Race/Ethnicity	Disability Status
• Medicaid-covered Latinx, Asian/Pacific Islander, and Black youth were **less likely to have a depression diagnosis** than white counterparts. After a new diagnosis, Native American and Latinx youth were **less likely than white youth to have received an antidepressant or a mental health specialty visit** (Richardson et al., 2003). • Black and Asian adults were **less likely to be screened for depression** than white adults. Latinx adults were **more likely to be screened** for depression. Post-screening, Black adults, Latino males, and Asian adults were less likely to receive mental health care than their white counterparts (Hahm et al., 2015).	• The estimated **prevalence of depression in adults with disability (24.9-41%) is higher than that of adults without disability** (22.8-27.5%). Individuals with physical disability reported more pain, depression, and anxiety and a lower quality of life (Shen et al., 2017).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Depression Remission at Twelve Months

Summary of Major Specification Changes	MY 2019: Revised the age range to include adolescent patients 12-17 years (used to only be 18+). Revised the time frame to look at remission 12 months (+/- 60 days) after an index event (was +/- 30 days). Included patients with schizophrenia, psychotic disorder or pervasive developmental disorder to the exclusions. Included the PHQ-9M. MY 2018: Added telehealth.	
Alignment with National Measure Sets of Interest	**3** *(CMS eCQM, CMS MSSP/Next Gen ACO, CMS MIPS)*	
Use by Connecticut Payers	**0**	
Addresses State Health Priorities/Needs?	Yes - the 2019 CT State Health Assessment and Healthy CT 2025 Framework includes suicide rate as a surveillance measure.	
Opportunity for Improvement	**Commercial performance (2019):** N/A	**Medicaid performance (2019):** N/A

Depression Response at Twelve Months - Progress Towards Remission

Summary of Major Specification Changes	MY 2019: Revised the age range to include adolescent patients 12-17 years (used to only be 18+). Revised the timeframe to look at remission 12 months (+/- 60 days) after an index event (was +/- 30 days). Included patients with schizophrenia, psychotic disorder or pervasive developmental disorder to the exclusions. Included the PHQ-9M. MY 2018: Added telehealth.	
Alignment with National Measure Sets of Interest	**1** *(CMS Core Quality Measures Collaborative)*	
Use by Connecticut Payers	**0**	
Addresses State Health Priorities/Needs?	Yes - the 2019 CT State Health Assessment and Healthy CT 2025 Framework includes suicide rate as a surveillance measure.	
Opportunity for Improvement	**Commercial performance (2019):** N/A	**Medicaid performance (2019):** N/A

Equity Assessment

- See “Screening for Clinical Depression and Follow-up Plan” for an equity assessment for the following measures:
  - Depression Remission at Twelve Months
  - Depression Response at Twelve Months - Progress Towards Remission

Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment

Summary of Major Specification Changes	MY 2018: Added telehealth.	
Alignment with National Measure Sets of Interest	**2** *(CMS eCQM, CMS MIPS)*	
Use by Connecticut Payers	**0**	
Addresses State Health Priorities/Needs?	Yes - the 2019 CT State Health Assessment and Healthy CT 2025 Framework includes suicide rate and high school students who experienced sexual violence as surveillance measures.	
Opportunity for Improvement	**Commercial performance (2019):** N/A	**Medicaid performance (2017):** N/A

OHS CONNECTICUT Office of Health Strategy

Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment

Overview of CT Demographics	Disability Status
Percentage of High School Students who Seriously Considered Attempting Suicide • By **race**: Hispanic (14.7%), Black (14.1%), White (12.8%) • By **grade**: 9 (14.8%), 10 or 12 (14.1% or 13.7%)*, 11 (10.9%) • By **sex**: female (16.8%), male (10.3%) *Report lists Grade 10 twice Source: 2025 CT State Health Assessment	• Analyses using 2012 survey data from WI found that **youth in each disability category were 3-9 times more likely to report suicide attempts(s) (SA) relative to peers**, and having **multiple disabilities tripled the risk** of SA relative to youth reporting a single disability. • Some disability sub-groups, including youth reporting **autism spectrum disorder and hearing and vision impairments reported surprisingly high rates** of SA. **Disability status added unique risk for suicidal behavior** (Moses, Tally 2018).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Behavioral health screening (pediatric, Medicaid-only, custom measure)

Summary of Major Specification Changes	None	
Alignment with National Measure Sets of Interest	**0**	
Use by Connecticut Payers	**1** (DSS PCMH+ [Challenge])	
Addresses State Health Priorities/Needs?	Yes - the 2019 CT State Health Assessment and Healthy CT 2025 Framework includes suicide rate and drug overdose deaths as two surveillance measures.	
Opportunity for Improvement	**Commercial performance (2019):** N/A	**Medicaid performance (2017 – PCMH+):** 45.9% (no benchmark, as measure is homegrown)

OHS CONNECTICUT Office of Health Strategy

Behavioral health screening

Race/Ethnicity	Disability Status	Income
• From 2015 to 2017, nearly all racial/ethnic groups and age groups experienced significant increases in opioid-involved overdose death rates, **particularly Blacks aged 45–54 years (from 19.3 to 41.9 per 100,000) and 55–64 years (from 21.8 to 42.7)** in large central metro areas (AHRQ, 2018).	• Adults with disabilities were **significantly more likely than adults without disabilities to experience past year prescription opioid use** (52.3% with disabilities vs. 32.8% without), misuse (4.4% vs. 3.4%), and use disorders (1.5% vs. 0.5%) [Lauer et al., 2019]. • Substance abuse **among persons with disabilities is more prevalent than among other persons for most substances** (Glazier and Kling, 2013).	• In 2005, the rate of ED visits involving opioid-related diagnoses was 104.9 per 100,000 for poor people, and in 2016, the rate increased to 314.3. **Data from 2005 to 2016 show disparities widening between high-income and low-income people** (AHRQ, 2018).
Other		
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).		

Slides 38, 43 and 73 contain equity-related assessments for the “Tobacco Use: Screening and Cessation Intervention,” “Screening for Clinical Depression and Follow-up Plan” and “Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment” measures that may be relevant for “Behavioral Health Screening.”

Follow-Up Care for Children Prescribed ADHD Medication

Summary of Major Specification Changes	MY 2020: Added telehealth to the numerator for both rates.	
Alignment with National Measure Sets of Interest	**5** *(CMS eCQM, CMS Medicaid Child Core Set, CMS MIPS, CMS Core Quality Measures Collaborative, NCQA HEDIS)*	
Use by Connecticut Payers	**3** (DSS PCMH+ [Reporting Only], 2 of 6 commercial insurers)	
Addresses State Health Priorities/Needs?	No	
Opportunity for Improvement	**Commercial performance (2019):** **Continuation & Maintenance:** 51.3% **Initiation:** 43.7%	**Medicaid performance (2019 - CMS):** 44.4%

OHS CONNECTICUT Office *of* Health Strategy

Follow-Up Care for Children Prescribed ADHD Medication

Race/Ethnicity	Income
• **African-American and Latino children, compared with White children, had lower odds of having and ADHD diagnosis and taking ADHD medication**, controlling for sociodemographic, ADHD symptoms, and other potential comorbid mental health symptoms. Among children with an ADHD diagnosis or symptoms, African-American children had lower odds of medication use at fifth, seventh, and 10th grades, and Latino children had lower odds at fifth and 10th grades (Coker et al., 2016; Morgan et al., 2013).	• Overall, **children living in families at less than 100% of the federal poverty level (18.7%) were more likely to be diagnosed with ADHD** or a learning disability compared with children living in families at 100% or more of the federal poverty level (12.7%) and were more likely to be White and Black (CDC, 2020).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Metabolic Monitoring for Children and Adolescents on Antipsychotics

Summary of Major Specification Changes	None	
Alignment with National Measure Sets of Interest	**3** *(CMS Medicaid Child Core Set, CMS Core Quality Measures Collaborative, NCQA HEDIS)*	
Use by Connecticut Payers	**1** (DSS PCMH+ [Challenge])	
Addresses State Health Priorities/Needs?	Yes - the 2019 CT State Health Assessment and Healthy CT 2025 Framework includes suicide rate as a surveillance measure.	
Opportunity for Improvement	**Commercial performance (2019):** 37.5%	**Medicaid performance (2019 – PCMH+):** 40.4%

OHS CONNECTICUT Office *of* Health Strategy

Metabolic Monitoring for Children and Adolescents on Antipsychotics

Disability Status
• Children with intellectual difficulty/autism were **more likely to be prescribed antipsychotics** (2.8% have been prescribed an antipsychotic [75% with autism] compared with 0.15% of children without intellectual difficulty). Those with intellectual disabilities/autism were **prescribed antipsychotics at a younger age and for a longer period**. Antipsychotic use was associated with a higher rate of respiratory illness for all (PERR of hospital admission: 1.55 [95% CI: 1.51–1.598] or increase in rate of 2 per 100 per year in those treated) [Brophy et al., 2018].
Other
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).

Medication Management for People with Asthma

Summary of Major Specification Changes	MY 2020: Retired the measure because there are new recommendations for controller combination therapy and recent evidence suggests the measure is not coordinated with improved outcomes. Measure lost NQF endorsement in August 2016 due to concerns around the 50% and 75% thresholds and the ability of the measure to track outcomes.	
Alignment with National Measure Sets of Interest	**1** *(CMS MIPS)*	
Use by Connecticut Payers	**2** (DSS PCMH+ [Scoring], 1 of 6 commercial insurers)	
Addresses State Health Priorities/Needs?	Yes - America's Health Rankings ranks CT as 41 out of 50 states on this indicator as 10.5% of adults have asthma. According to DataHaven, 15% of individuals had asthma in 2018.	
Opportunity for Improvement	**Commercial performance (2019):** 58.5%	**Medicaid performance (2019 - PCMH+):** 43.7%

Medication Management for People with Asthma

Race/Ethnicity
• In CT, **Black and Hispanic children are 5.5x and 4.5x, respectively, more likely to go to the ED** because of asthma than White children (CT Health Foundation, 2020). • In CT, **Black and Hispanic children are 4.5x and 3x, respectively, more likely to be hospitalized** because of asthma than White children (CT Health Foundation, 2020). • In 2016, 1 in 12 children ages 0-17 had asthma. Among them, asthma **disproportionately affected males, non-Hispanic Black children, and children from low-income households** (AHRQ, 2018). • CA Medicaid managed care performance was 9.1 percentage points **higher for Whites than it was for Blacks** (state disparities research).

Medication Management for People with Asthma (Cont'd)

Disability Status	Housing	Income
• **Individuals with physical disabilities and cognitive disabilities experienced more asthma than those without.** Age-adjusted prevalence rates of asthma (per 1,000) without disabilities: 7.6%; cognitive limitations: 17%; physical disabilities: 71% (Reichard et al., 2010).	• **Substandard housing conditions** have been associated with poor health outcomes related to asthma (MA DPH Literature Review; Taylor, Lauren 2018).	• Even after controlling for other traditional measures of socioeconomic status, children are **more likely to have asthma the closer their family is to the federal poverty line** (MA DPH Literature Review; Taylor, Lauren 2018).

Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)

Summary of Major Specification Changes	MY 2020: Removed the restriction that only one of two eligible visits can be via telehealth. MY 2018: Added telehealth.	
Alignment with National Measure Sets of Interest	**6** *(CMS eCQM, CMS Medicaid Adult Core Set, CMS MSSP/Next Gen ACO, CMS MIPS, CMS Core Quality Measures Collaborative, NCQA HEDIS)*	
Use by Connecticut Payers	**3** (3 of 6 commercial insurers)	
Addresses State Health Priorities/Needs?	Yes - 10 percent of CT residents in 2018 had diabetes according to DataHaven.	
Opportunity for Improvement	**Commercial performance (2019):** 27.0%	**Medicaid performance (2019 - CMS):** 36.9%

OHS CONNECTICUT Office of Health Strategy

Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)

Race/Ethnicity	Disability Status
• In CT, **Black and Hispanic residents are more than 2x more likely than Whites to have diabetes** and have severe complications from it. Blacks are **>2x more likely than Whites to die from diabetes** (CT Health Foundation, 2020). • Prevalence of diabetes is **77% higher among Blacks and 66% higher among Hispanic** adults compared to Whites (MA DPH Literature Review; Piccolo, Rebecca et al., 2016). • MA Health System performance showed **highest control for Asians** (75%) and **lowest for Blacks or African Americans** (65%) [MA Health System, 2020). • Rate of HbA1c poor control is **6 percentage points worse for Black patients compared to White patients** in CA's Medicaid program (state disparities research).	• **Individuals with physical disabilities and cognitive disabilities experienced more diabetes than those without**. Age-adjusted prevalence rates of diabetes (per 1,000) without disabilities: 3.7%; cognitive limitations: 18%; physical disabilities: 15% (Reichard et al., 2010).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing

Summary of Major Specification Changes	MY 2020: Removed the restriction that only one of two eligible visits can be via telehealth. MY 2018: Added telehealth.		
Alignment with National Measure Sets of Interest	**2** *(CMS Core Quality Measures Collaborative, NCQA HEDIS)*		
Use by Connecticut Payers	**6** (DSS PCMH+ [Scoring], OSC, 4 of 6 commercial insurers)		
Addresses State Health Priorities/Needs?	Yes - 10 percent of CT residents in 2018 had diabetes according to Data Haven.		
Opportunity for Improvement	**Commercial performance (2019):** 92.2%	**Medicaid performance (2019):**	
		PCMH+: 89.2%	**CMS:** 87.0%

OHS CONNECTICUT Office of Health Strategy

Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing

Race/Ethnicity	Disability Status
• In CT, **Black and Hispanic residents are more than 2x more likely than Whites to have diabetes** and have severe complications from it (e.g., death). (CT Health Foundation, 2020). • A MA health system's performance showed **higher performance for Hispanics (82%) than for Black or African Americans (78%)** [MA Health System, 2020]. • Michigan Medicaid managed care performance was 6% **higher for Whites than it was for Blacks** (state disparity research).	• Compared to adults without disability, **those with physical disabilities and those with cognitive limitations experienced more diabetes** (Reichard et al., 2010).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Comprehensive Diabetes Care: Eye Exam

Summary of Major Specification Changes	MY 2020: Removed the restriction that only one of two eligible visits can be via telehealth. MY 2018: Added telehealth.	
Alignment with National Measure Sets of Interest	**4** *(CMS eCQM, CMS MIPS, CMS Core Quality Measures Collaborative, NCQA HEDIS)*	
Use by Connecticut Payers	**6** (DSS PCMH+ [Reporting Only], 5 of 6 commercial insurers)	
Addresses State Health Priorities/Needs?	Yes - 10 percent of CT residents in 2018 had diabetes according to Data Haven.	
Opportunity for Improvement	**Commercial performance (2019):** 65.7%	**Medicaid performance (2019):** N/A

OHS CONNECTICUT Office of Health Strategy

Comprehensive Diabetes Care: Eye Exam

Race/Ethnicity	Disability Status
• In CT, **Black and Hispanic residents are more than 2x more likely than Whites to have diabetes** and have severe complications from it (e.g., death). (CT Health Foundation, 2020). • The Michigan Medicaid managed care performance on this measure was 6.4 percentage points **higher for Whites than for Blacks** (state disparity research). • A MA health system's performance showed eye exam rate of 39% for Black/African Americans and 32% for other race/multi-racial people (MA Health System, 2020).	• Compared to adults without disability, **those with physical disabilities and those with cognitive limitations experienced more diabetes** (Reichard et al., 2010).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Comprehensive Diabetes Care: Medical Attention for Nephropathy

Summary of Major Specification Changes	MY 2020: Replaced the measure with "Kidney Health Evaluation for Patients with Diabetes" because the measure is not precise enough to meet the needs of kidney health evaluation as an aspect of diabetes management.	
Alignment with National Measure Sets of Interest	**3** *(CMS eCQM, CMS MIPS, CMS Core Quality Measures Collaborative, NCQA HEDIS)* *Of note – NCQA includes the newer HEDIS measure*	
Use by Connecticut Payers	**5** (DSS PCMH+ [Reporting Only], OSC, 3 of 6 commercial insurers)	
Addresses State Health Priorities/Needs?	Yes - 10 percent of CT residents in 2018 had diabetes according to Data Haven.	
Opportunity for Improvement	**Commercial performance (2019):** 88.4%	**Medicaid performance (2019):** N/A

Comprehensive Diabetes Care: Medical Attention for Nephropathy

Race/Ethnicity	Disability Status
• In CT, **Black and Hispanic residents are more than 2x more likely than Whites to have diabetes** and have severe complications from it (e.g., death). (CT Health Foundation, 2020). • The Michigan Medicaid managed care performance on this measure is **not significantly different between Whites and Blacks** (state disparity research). • The rate of **end-stage renal disease due to diabetes is higher for Blacks and Hispanics compared to Whites** (AHRQ, 2018).	• Compared to adults without disability, **those with physical disabilities and those with cognitive limitations experienced more diabetes** (Reichard et al., 2010).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Controlling High Blood Pressure

Summary of Major Specification Changes	MY 2020: Revised the time frame to identify a diagnosis of hypertension. Eased telehealth requirements. Removed the requirements for remote monitoring devices and the exclusion of member-reported BP readings. MY 2018: Incorporated telehealth. Removed the requirement to confirm hypertension and the diabetes indicator.	
Alignment with National Measure Sets of Interest	**6** *(CMS eCQM, CMS Medicaid Adult Core Set, CMS MSSP/Next Gen ACO, CMS MIPS, CMS Core Quality Measures Collaborative, NCQA HEDIS)*	
Use by Connecticut Payers	**6** (6 of 6 commercial insurers)	
Addresses State Health Priorities/Needs?	Yes - this measure addresses medication for cardiovascular conditions. 30 percent of CT residents in 2018 had high blood pressure/hypertension.	
Opportunity for Improvement	**Commercial performance (2019):** 61.1%	**Medicaid performance (2019 - CMS):** 60.3%

Controlling High Blood Pressure

Overview of High Blood Prevalence in CT Adults (2025 CT State Health Assessment)	
• By **race**: Black (36%), White (32%), Hispanic (25%), Other (22%) • By **income**: <$25K (39%), $25K+ (28%) • By **age**: 55+ (51%), 35-54 (24%), 18-34 (10%) • By **education**: high school or less (35%), more than high school (28%)	
Race/Ethnicity	**Disability Status**
• The Medicaid managed care performance on this measure was **higher for Whites than for Blacks** by 4% in California and 9% in Minnesota, as well as for a MA ACO (state disparity and MA ACO research, 2021).	• **Individuals with physical disabilities and cognitive disabilities experienced more blood pressure than those without.** Age-adjusted prevalence rates of high blood pressure (per 1,000) without disabilities: 16.1%; cognitive limitations: 27.5%; physical disabilities: 67.3% (Reichard et al., 2010).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Use of Imaging Studies for Low Back Pain

Summary of Major Specification Changes	MY 2017: Added telehealth. Measure lost NQF endorsement in May 2017 because NQF said the measure did not pass the validity criterion (patients with trauma/ neurological impairment were sometimes excluded from the measure when using claims data).	
Alignment with National Measure Sets of Interest	**2** *(CMS Core Quality Measures Collaborative, NCQA HEDIS)*	
Use by Connecticut Payers	**4** (DSS PCMH+ [Reporting Only], OSC, 2 of 6 commercial insurers)	
Addresses State Health Priorities/Needs?	No	
Opportunity for Improvement	**Commercial performance (2019):** 75.7%	**Medicaid performance (2019):** N/A

Use of Imaging Studies for Low Back Pain

Race/Ethnicity	Income
• Compared to White patients, **Asian and Hispanic patients are less likely to be prescribed opioids... Black patients and patients of other race are more likely to receive an opioid prescription** to treat their back pain even after accounting for socioeconomic status, health insurance status and general health status (King and Liu, 2020). • **Blacks are more likely to report having low back pain** and corresponding physical functioning compared to Hispanics and Caucasians (Safo, 2012).	• Low back pain patients with **lower socioeconomic status may have higher health care costs** due to smaller benefit packages. Individuals receiving workers compensation due to low back pain in states with lower median household incomes and higher unemployment rates typically had longer length of disability, which were frequently associated with higher medical costs (Shraim et al., 2017).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis *(previously Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis)*

Summary of Major Specification Changes	MY 2019: Expanded the age range to members 3 months of age and older. Changed the measure from a member-based denominator to an episode-based denominator. Revised the Negative Competing Diagnosis timeframe. Deleted cystic fibrosis from the Negative Comorbid Condition History test. MY 2018: Added telehealth.	
Alignment with National Measure Sets of Interest	**3** *(CMS MIPS, CMS Core Quality Measures Collaborative, NCQA HEDIS)*	
Use by Connecticut Payers	**4** (DSS PCMH+ [Scoring], OSC, 2 of 6 commercial insurers)	
Addresses State Health Priorities/Needs?	No	
Opportunity for Improvement	**Commercial performance (2019):** 34.1%	**Medicaid performance (2017):** 30.8%

Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis

Race/Ethnicity	Insurance Status	Housing
• Providers are **17% less likely to prescribe an antibiotic prescription for acute bronchitis when the provider and patient are of the same race** (Morgan et al., 2017). • The proportion of adults with acute bronchitis who received an antibiotic between 1996-2010 was relatively **similar for Whites and Blacks** (72% and 21%, respectively), but **significantly lower for Other** (51%), although the sample size was much lower (Barnett and Linder, 2014).	• The proportion of adults with acute bronchitis who received an antibiotic between 1996-2010 was **lower for Medicaid (63%), than for private (71%) and Medicare (74%)** [Barnett and Linder, 2014].	• Living in close proximity to high-volume roads / neighborhoods, or **areas with blight, increases rates of respiratory diseases.** Revitalizing abandoned lots can improve health (Taylor, Lauren 2018).

Appropriate Treatment for Upper Respiratory Infection *(previously Appropriate Treatment for Children with Upper Respiratory Infection)*

Summary of Major Specification Changes	MY 2019: Expanded the age range to members 3 months of age and older (previously ended at age 18). Changed the measure from a member-based denominator to an episode-based denominator. Removed the anchor date requirements. Removed the requirement to exclude episode dates where there was a diagnosis other than URI on the same data. Added the Negative Comorbid Condition History exclusion. Added telehealth.	
Alignment with National Measure Sets of Interest	**4** *(CMS eCQM, CMS MIPS, CMS Core Quality Measures Collaborative, NCQA HEDIS)*	
Use by Connecticut Payers	**4** (DSS PCMH+ [Reporting Only], OSC, 2 of 6 commercial insurers)	
Addresses State Health Priorities/Needs?	No	
Opportunity for Improvement	**Commercial performance (2019):** 80.6%	**Medicaid performance (2019):** N/A

Appropriate Treatment for Upper Respiratory Infection

Race/Ethnicity	Housing
• **White children were 1.5 to 2 times more likely than their minority counterparts to be prescribed unnecessary antibiotics** for viral respiratory infections. 3% of children discharged from pediatric EDs with a viral acute respiratory tract infection received antibiotics. This percentage was **higher among Whites** (4%), **lower among Blacks** (2%), and the **same among Hispanic and Other** (3%) [Bell et al., 2017].	• Living in close proximity to high-volume roads / neighborhoods, or **areas with blight, increases rates of respiratory diseases.** Revitalizing abandoned lots can improve health (Taylor, Lauren 2018).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Gap Analysis and Request for Measure Proposals

Gap Analysis

- Before the Council can conduct a gap analysis, it must first consider the **representativeness** and **balance** of the Core Measure Set as it relates to the following five variables:
  1. Domain
  2. Condition
  3. Measure type (i.e., process, outcomes, patient experience)
  4. Data source (i.e., claims, clinical data, claims/clinical data, survey data)
  5. Population (e.g., adult, pediatric)
- It must also consider how the Core Measure Set **aligns with its measure selection criteria**.

Gap Analysis (Cont'd)

- Based on our assessment of the Core Measure Set against the five variables, Bailit Health identified the following gaps (*see the Appendix for more detail*):
  - Equity
    - Infant mortality & low birthweight racial gap
    - Lead screening
  - Oral health
  - Hospital/inpatient care (inclusive of maternity care)
  - Substance use treatment

- **Are there any additional gaps that you've identified at this time?**

Gap Analysis (Cont'd)

- In addition, the measure set could be redistributed slightly to:
  - **replace some process measures with outcome measures**, where available alternatives exist, and
  - be more **evenly spread across conditions**.
- Finally, the Core Measure Set could **adopt a true core set**, or measures that are recommended for use in *all* contracts to better balance comprehensiveness and breadth with the need for parsimony.

Request for Measure Proposals

- Please consider where there are any additional measures you think the Quality Council should consider **adding**, **removing** and/or **replacing** to address the needs identified in the gap analysis.
- Please submit the following to Hanna Nagy (Hanna.Nagy@ct.gov) by **Friday, March 26th**:
  - Any **specific measure recommendations** (including the measure name and steward) for addition, removal or replacement, and your corresponding rationale ***or***
  - Any recommendations for any **domains**, **conditions**, **services** and/or populations that you think are missing, underrepresented or overrepresented and your corresponding rationale

Wrap-up & Next Steps

Meeting Wrap-Up & Next Steps

- Review the Quality Council's measure proposals for addition, removal and/or replacement to address the needs identified in the gap analysis (e.g., maternity care, oral health)

- Begin the final review of the Core Measure Set (which includes scoring the measures against the Quality Council's criteria) to identify whether any changes should be made
- Finalize recommended changes to the Core Measure Set

- Begin discussion of Quality Benchmarks

OHS CONNECTICUT Office of Health Strategy

Appendix

Gap Analysis – Detailed Assessment

- The following tables break down the composition of the Core Measure Set, following the February 18 meeting, as it relates to the previously discussed variables.

DISTRIBUTION BY DOMAIN

	Consumer Engagement	Care Coordination	Prevention	Acute & Chronic Care	Behavioral Health	Total Measures
# Measures	1	1	11	9	5	27

Bailit Health Assessment: Hospital/Inpatient Care (inclusive of maternity care) and Equity are two potential missing domains.

Gap Analysis – Detailed Assessment (Cont'd)

DISTRIBUTION BY CONDITION

	Cancer	Cardio-vascular	Diabetes	Infectious Disease	Mental Health
# Measures	3	1	4	2	7

	Musculo-skeletal	Patient Safety	Pregnancy	Respiratory	N/A*	Total Measures
# Measures	1	1	1	3	4	27

*Includes: CAHPS PCMH Survey, Developmental Screening in the First Three Years of Life, Well-Child Visits in the First 15 Months of Life, Adolescent Well-Care Visits

Gap Analysis – Detailed Assessment (Cont'd)

DISTRIBUTION BY MEASURE TYPE

	Process	Outcome	Patient Experience	Total Measures
# Measures	21	5	1	27

DISTRIBUTION BY DATA SOURCE

	Claims	Clinical Data	Claims/ Clinical Data	Survey Data	Total Measures
# Measures	9	3	14	1	27

Gap Analysis – Detailed Assessment (Cont'd)

DISTRIBUTION BY POPULATION

	Pediatric	Adolescent	Pediatric or Adolescent / Adult	Adult	All Ages	Total Measures
# Measures	7	2	4	13	1	27

COMPARISON TO OTHER STATES

	CT	RI	MA
# Measures	27	36 (7 core, 29 menu)	25 (4 core, 21 menu)

Gap Analysis – Detailed Assessment (Cont'd)

- Alignment with criteria to apply to the measure set as a whole:
  1. **Includes topics… to promote health equity…**
     - *Bailit Health assessment*: This is a current measure set gap.
  2. **Broadly address population health.**
     - *Bailit Health assessment:* The measure set, when looking at measures by domain and condition, is broadly representative of population health (although measures could be redistributed slightly between select conditions).
  3. **Prioritizes health outcomes…**
     - *Bailit Health assessment:* 5/27 (19%) of measures are focused on outcomes. The Council could replace some process measures with outcome measures where available alternative options exist.

Gaps Analysis – Detailed Assessment (Cont'd)

- Alignment with criteria to apply to the measure set as a whole (cont'd):
  4. **...advance[s] the delivery system toward the goals of safe, timely, effective, efficient, equitable, patient-centered (STEEEP) care.**
     - *Bailit Health assessment:* Measures advance the goals of STEEEP care if they meet the individual measure criteria of being correlated with improved patient health (criterion #4) and being valid and reliable (criterion #6).
  5. **Balances comprehensiveness and breadth with the need for parsimony...**
     - *Bailit Health assessment:* 27 measures overall. Smaller than RI and larger than MA, but lacks a true core measure set of measures that are recommended or required for use in all contracts. A true core set might better advance alignment.
  6. **Representative of the array of services... and the diversity of patients...**
     - *Bailit Health assessment:* The Core Measure Set overall lacks measures related to inpatient care and has few non-primary care measures. There are also opportunities to include additional measures to address statewide health priorities.

Gap Analysis – Detailed Assessment (Cont'd)
Potential Gaps Based on CT Inequities/Need

- We identified the following areas with inequities/need for which there are currently no measures in the measure set:
  - **Infant mortality & low birthweight racial gap**: Babies born to Black mothers in CT are >4x more likely to die before their 1st birthday than those born to White mothers.[1]
    - Babies born to Black women are nearly 2x as likely to be born at low birthweight than those born to White mothers[1]
  - **Lead screening**: Black children are at >2x the risk of lead poisoning compared to White children, which may account for part of the historical achievement gap among CT school children.[2]
    - 27% of CT housing stock has a lead risk[3]

[1] Health Disparities in CT 2020 Report
[2] Healthy CT 2025: State Health Assessment
[3] America's Health Rankings
[4] Commonwealth Fund Scorecard

Gap Analysis – Detailed Assessment (Cont'd)
Potential Gaps Based on CT Disparities

- **Oral health**: Dental decay remains one of the most common chronic diseases in CT, affecting 37% of children. Black, Hispanic and Asian children were 25% more likely to have dental decay than White children.[1]
- **Substance use**: There were 29.9 drug deaths per 100,000 in the state (CT ranks 42nd). Rates were highest for Whites (35.8), followed by Blacks (26.7) and Hispanics (23.5).[3] There were 30.7 drug poisoning deaths per 100,000 (CT ranks 41st) in 2018.[4]

[1] Health Disparities in CT 2020 Report
[2] Healthy CT 2025: State Health Assessment
[3] America's Health Rankings
[4] Commonwealth Fund Scorecard

Criteria to Apply to Individual Measures

1. Represents an opportunity to promote health equity, evaluated by performing an assessment of data and literature to identify disparities by race, ethnicity, language, disability status, economic status, and other important demographic and cultural characteristics.
2. Represents an opportunity for improvement in quality of care, inclusive of outcomes and of population health.
3. Accessible with minimal burden to the clinical mission, and:
    a. draws upon established data acquisition and analysis systems;
    b. is efficient and practicable with respect to what is required of payers, providers, and consumers, and
    c. makes use of improvements in data access and quality as technology evolves and become more refined over time.
4. Evidence demonstrates that the structure, process, or outcome being measured correlates with improved patient health.

Criteria to Apply to Individual Measures (Cont'd)

5. Addresses the most significant health needs of Connecticut residents, with attention to areas of special priority, beginning with:
   a. behavioral health
   b. health equity
   c. patient safety, and
   d. care experience.
6. Measures and methods are valid and reliable at the data element and performance score level.
7. Useable, relevant and has a sufficient denominator size.

Criteria to Apply to the Measure Set as a Whole

1. Includes topics and measures for which there are opportunities to promote health equity by race, ethnicity, language and/or disability status.
2. Broadly address population health.
3. Prioritizes health outcomes, including measures sourced from clinical and patient-reported data.
4. Taken as a whole, high performance on the proposed measure set should significantly advance the delivery system toward the goals of safe, timely, effective, efficient, equitable, patient-centered (STEEEP) care.
5. Balances comprehensiveness and breadth with the need for parsimony to enable effective quality improvement.
6. Representative of the array of services provided, and the diversity of patients served, by the program.

Data Sources for the Five Considerations

1. **Have there been any major changes to the measure specifications?**
   - We reviewed major changes to the measure specifications by each measure's "steward" and the measure's endorsement status with NQF since 2016.
2. **What is the measure status in the national measure sets of interest?**
   - We identified whether the measure is currently in any of the following 7 measure sets that were previously indicated to be of interest to the Quality Council in 2016:
     - CMS Electronic Clinical Quality Measures (eCQMs)
     - CMS Medicaid Child Core Set
     - CMS Medicaid Adult Core Set
     - CMS Merit-based Incentive Payment System (MIPS)
     - CMS Medicare Shared Savings Program ACO and Next Generation ACO
     - Core Quality Measures Collaborative Core Sets
     - NCQA HEDIS

Data Sources for the Five Considerations (Cont'd)

3. **Is the measure currently utilized by Connecticut payers?**
   - We identified whether the measure is:
     - included in the DSS PCMH+ Measure Set,
     - in use by the state employee health plan, and/or
     - in use by commercial insurers (we surveyed 6 insurers – Aetna, Anthem, Cigna, ConnectiCare, Harvard Pilgrim Health Care and UnitedHealthcare).
   - The current max score for this field is 8.

4. **Does the measure address any of the state's health priorities?**
   - We identified the primary state health priorities using the following sources:
     - America's Health Rankings and Commonwealth Fund's Scorecard (2020)
     - 2019 CT State Health Assessment and Healthy CT 2025
     - DataHaven (2018)

CT State Health Priorities: Needs and Opportunities

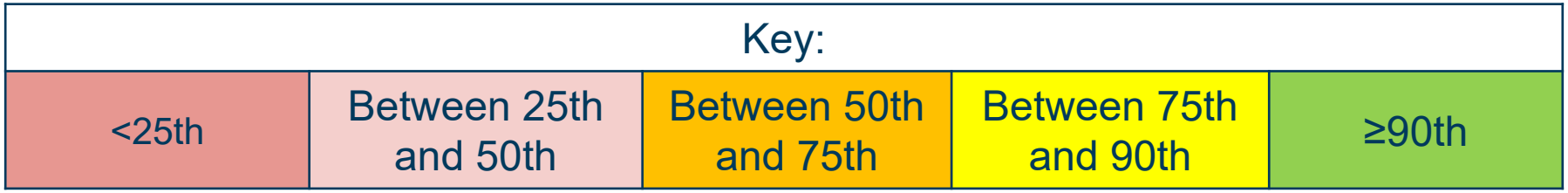
1. chronic conditions
   - hypertension: 30%
   - asthma: 15%
   - diabetes: 10%
2. access to SUD treatment
   - 29.9 drug deaths per 100,000 (*CT ranks 42nd*) and 30.7 drug poisoning deaths (*CT ranks 41st*) in 2018
3. childhood obesity
   - 17% of children are obese and 15% are overweight
4. behavioral health treatment
   - suicide is the leading cause of intention injury and death in the state.
5. lead screening/prevention
   - 26.6% of housing stock has a lead risk (*CT ranks 46th*)
6. low birthweight racial gap
   - increased 19% from 5.4 to 6.4 (2017-18)
7. ER use
   - 22% of individuals received care in an ER one to two times in the last year

Sources include: 2020 America's Health Rankings, 2020 Commonwealth Fund's Scorecard, 2019 CT State Health Assessment, Healthy CT 2025 and DataHaven.

OHS CONNECTICUT Office of Health Strategy

Data Sources for the Five Considerations (Cont'd)

5. **Is there opportunity for improvement?**
   - **Commercial**: We created a 2019 statewide average of the four largest CT payers using data from Quality Compass 2020.
   - **Medicaid**: We obtained 2019 data for DSS' PCMH+ program (PCMH+) and statewide data for FFY2019 from CMS for the Medicaid Core Sets.
   - We compared commercial and Medicaid performance to national 2019 percentile data obtained from Quality Compass.*



* "Developmental Screening for the First Three Year of Life" is a non-HEDIS measure and therefore national FFY 2019 data were obtained from CMS.