Meeting of the Quality Council

Meeting Date	Meeting Time	Location
February 18, 2021	4:00 pm – 6:00 pm	Webinar/Zoom

Participant Name and Attendance

Quality Council		
Susannah Bernheim (new member)	Amy Gagliardi	Andrew Selinger (Co-Chair)
Rohit Bhalla	Karin Haberlin	Marlene St. Juste
Nettie Rose Cooley	Michael Jefferson	Brad Richards
Sandra Czunas	Nikolas Karloustsos	Carolyn (Cary) Trantalis
Stephanie DeAbreu	Joseph Quaranta	Steve Wolfson
Arielle Levin Becker, on behalf of Tiffany Donelson	Laura Quigley	Robert Zavoski (new member)
Lisa Freeman		
Others Present		
Michael Bailit, Bailit Health	Hanna Nagy, OHS	Jeannina Thompson, OHS
Deepti Kanneganti, Bailit Health	Kelly Sinko, OHS	
Members Absent:		
Steven Choi	Mark DeFrancesco	Robert Nardino
Alan Coker (Co-Chair)	Syed Hussain	Christine (Chrissy) Tibbits
Elizabeth Courtney	Paul Kidwell	Orlando Velazco

Meeting Information is located at: https://portal.ct.gov/OHS/SIM-Work-Groups/Quality-Council/Meeting-Materials

	Agenda	Responsible Person(s)
1.	**Welcome and Introductions**	**Andy Selinger**
	Andy Selinger called the meeting to order at 4:03 pm.	
2.	**Public Comment**	**Andy Selinger**
	Andy Selinger welcomed public comment. None was voiced.	
3.	**Approval of January 21, 2021 Meeting Minutes**	**Andy Selinger**
	Nettie Rose Cooley motioned to approve minutes of the Quality Council's January 21st meeting. Rohit Bhalla seconded the motion. Lisa Freeman abstained from approving the meeting minutes. The motion passed.	
4.	**Continue Annual Review of the Core Measure Set**	**Michael Bailit/Deepti Kanneganti**
	Michael Bailit provided a recap of the January 21st meeting, including the Council's preliminary decision to retain Plan All-Cause Readmission and Breast Cancer Screening, remove Annual Monitoring for Patients on Persistent Medications and revisit PCMH CAHPS. He explained that Bailit Health, at the Council's request, conducted an equity review since the last meeting to identify inequities in performance related to race/ethnicity, language, disability status and other social determinants of health. He also reminded the Council of the metrics against which Bailit Health was evaluating each measure, including alignment with national measure sets of interest, use by Connecticut payers, alignment with Connecticut state health priorities/needs, opportunity for improvement and alignment with the Council's measure selection criteria. Joe Quaranta asked whether insurance carriers specified how they are using quality measures when reporting using a measure, noting that measures may not be widely used across value-based programs. Michael agreed with Joe and said the Council could consider measures to be in wide use if they're used by several payers as opposed to only one payer. Susannah Bernheim asked whether there is a goal to have parsimony of measures when evaluating individual measures or the measure set as a whole. Michael acknowledged that there is a tension between parsimony and inclusiveness of the measure set; he explained that it is easiest to have a general awareness of parsimony while reviewing measures initially, then to step back to look at the overall size of the set after reviewing the individual measures. Michael summarized the Council's previous discussion on 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; and Person-Centered Primary Care Measure (PCPCM) developed by Ertz et al., and suggested by Brad Richards for consideration. Andy Selinger asked Michael for his thoughts on the chances of successful implementation of PCPCM. Michael responded that there would need to be initial conversations with payer and provider organizations to establish consensus on whether to adopt the PCPCM. Michael shared that his instinct was to not switch over to the PCPCM immediately, but to have conversations between now and next year's annual review to see whether there is interest in making the change. Michael invited Brad Richards' comments. Brad said he liked the patient-centered nature of PCPCM, but acknowledged that there could be challenges with implementation and buy-in. Michael shared that the Council could also recommend	

the PCPCM for introduction in a future year to allow payers and providers sufficient time to implement the measure. Joe Quaranta asked the Council to think about whether it would rely on insurers and provider groups to collect data or an independent entity; if it is the latter, he shared that it would be simpler to pick a standardized survey mechanism, and if it is the former, he shared it would be a very heavy lift and impossible for some smaller groups to utilize the PCPCM. Lisa Freeman added that surveys need to be meaningful to the people expected to fill them out. Robert Zavoski asked whether the creators of PCPCM will continue to maintain the survey. Susannah Bernheim said that this measure was developed by American Board of Family Medicine and was recently reviewed by the Measure Application Partnership (MAP), which provides guidance to CMS. Susannah explained that the MAP supported inclusion of the PCPCM in MIPS program, so it may be more feasible for the Council to recommend the measure for inclusion in a year or two. Andy Selinger suggested that everyone review the questions in the measure, and Michael proposed that the group spend time discussing this again at the next meeting.

Next Steps: The Quality Council will review the measure specifications for the PCPCM and revisit the measure during the March meeting.

The Quality Council continued its review of the Core Measure Set.

- Cervical Cancer Screening
  - Marlene St. Juste advocated for retaining this measure as an important measure for women's health.
  - Andy Selinger, Amy Gagliardi, Steven Wolfson, and Lisa Freeman also voiced agreement to retain this measure.
  - Andy Selinger asked why performance seemed to differ considerably between commercial and Medicaid populations in Connecticut, but not by race and ethnicity. Michael noted that the Council did not have access to CT Medicaid data that are stratified by race and ethnicity and it is possible that there is greater variation in performance by race/ethnicity in California and Michigan. Michael explained that some patterns are consistent across states but that there is a lot of variation across states as well.
  - **Decision**: Retain measure.
- Chlamydia Screening
  - Marlene St. Juste agreed with retaining this measure.
  - Rohit Bhalla advocated for retaining this measure and commented that this is the only measure in the measure set that pertains to sexually transmitted diseases (STDs).
  - **Decision**: Retain measure.
- Colorectal Cancer Screening
  - Joe Quaranta asked how the data for commercial population are collected. Michael explained that this is a hybrid measure that uses a combination of claims and clinical record data. Joe asked whether the Council would recommend whether plans and providers should use a hybrid or claims-based data collection method. Michael Bailit responded that the Council is agnostic because it is picking a menu of measures from which payers and providers can select based on their data collecting capabilities. Michael noted that the future of quality measurement is moving towards electronic data collection, but most states have not yet developed this infrastructure. Michael shared that he believed it is okay to have some hybrid measures in the Core Measure Set, understanding that they won't be operationally viable for all advanced networks and payers today.
  - Andy Selinger advocated for retaining this measure for now and recommended circling back to identify which cancer screening measures to prioritize when conducing a second pass of the measures.
  - Robert Zavoski confirmed that the Medicaid data presented were specific to CT.
  - Michael advocated for including measures that rely on clinical record data in the Core Measure Set to serve as a bridge towards electronic data collection for providers to report as they develop the capacity to collect and report using these data.
  - **Decision**: Retain measure.
- Immunizations for Adolescents
  - Andy Selinger confirmed that Combo 1 contains Meningitis and Tdap and Combo 2 contains Meningitis, Tdap, and HPV.
  - Marlene St. Juste advocated to retain this measure.
  - Michael Bailit asked whether the group preferred adopting Combo 2.
  - Marlene St. Juste explained that adopting Combo 2 might push providers to speak with families about HPV, which might encourage greater uptake of the vaccine. Andy Selinger added that it might increase the opportunity for improvement and stated his preference to adopt Combo 2.
  - Rohit Bhalla asked if HPV is mandatory for schools, noting that performance for Meningitis and Tdap may be higher because they are required whereas HPV may be optional. Marlene St. Juste confirmed that HPV is not mandatory for schools.
  - Joe Quaranta strongly supported retaining the measure and adopting Combo 2 specifically.

- **Decision**: Retain measure and adopt Combo 2 specifically.

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
  - Andy Selinger suggested the metric does not produce very useful outcomes, as Deepti Kanneganti indicated.
  - Brad Richards stated that he would favor not measuring it, as it does not seem very helpful to be capturing this.
  - Marlene St. Juste agreed with Brad and expressed interest in finding a different measure to help prevent obesity in children in the future.
  - Steven Wolfson shared that his wife is a pediatrician and that obese children tend to have obese parents who regard obesity as normal.
  - Deepti Kanneganti explained that Bailit Health had been trying to find a better measure for measuring and reducing obesity in children and adults, but had not found one in the last five years. Deepti committed to performing another search and reporting back if she finds an appropriate measure.
  - Lisa Freeman wondered whether there is another target that would indicate the poorer health that results from obesity. Andy Selinger offered that maybe it could be something akin to food deserts or other community-based metrics.
  - Deepti confirmed that consensus was to drop this measure and committed to looking further into other measure options for the future, potentially as part of the Council's gaps analysis.
  - **Decision**: Drop measure.
  - **Next Steps**: Bailit Health will research if there are any alternate obesity-focused measures for the Council to consider, potentially as part of the gaps analysis.
- BMI Screening and Follow-Up
  - Andy Selinger advocated to be consistent with the design made regarding the previous measure and drop this measure too. Steven Wolfson, Lisa Freeman, Marlene St. Juste, and several others agreed to drop this measure.
  - **Decision**: Drop measure.
- Developmental Screening in the First Three Years of Life
  - Lisa Freeman advocated to retain this measure. She shared that she believed that developmental screening is critical and shared that some of the problems with assessing non-English-speaking children is because people may not be familiar with non-English-speaking tools that exist. Steven Wolfson and Marlene St. Juste agreed with Lisa.
  - Marlene asked whether there are data to track whether children are being referred to a provider after receiving a positive screen. Amy Gagliardi agreed that this is an important question because screening without engagement does not lead to the desired outcome. Lisa Freeman confirmed that one of the equity review sources notes that referrals because of a positive screen is reducing disparities.
  - Deepti Kanneganti added that the measure steward is in the process of testing and validating a version of this measure that looks at screening and follow-up. She committed to bringing the measure to the group for consideration when it is available.
  - **Decision**: Retain measure.
  - **Next Step**: Bailit Health will bring Developmental Screening and Follow-up in the First Three Years of Life to the Quality Council for consideration when the measure is available.
- Well-Child Visits in the First 15 Months of Life
  - Lisa Freeman asked for clarification about extension to 30 months of life, specifically whether the steward altered the number of visits a child should have within the time frame. Deepti explained that there are several sub-measures, each of which focuses on the number of visits child has in the first 30 months (0, 1, 2…up to 6+ visits).
  - Joe Quaranta said that there has been some consolidation within NCQA on the pediatric measure sets for well visits. This measure is the infant/pre-toddler measure. He stated that this measure is not particularly different from the previous measure and he did not believe there was a reason to move away from using the measure due to the change to 30 months.
  - Marlene St. Juste advocated for retaining the measure and adopting the updated specifications (30 months). Steven Wolfson, Michael Jefferson, Susannah Bernheim, and Brad Richards agreed with Marlene.
  - Susannah confirmed that the steward also updated the measure specifications to include telehealth.
  - **Decision**: Retain measure and adopt the updated specifications (30 months).
- Adolescent Well-Care Visits
  - Marlene St. Juste advocated for retaining this measure and supported adopting the updated specifications (which include child and adolescent well-care visits).

- Michael Jefferson stated that specification change supports the move towards primary care, and Lisa Freeman agreed.
- Andy Selinger asked to confirm whether this measure and the Well-Child Visits in the First 30 Months of Life measures were complementary to one another.
- **Decision**: Retain measure and adopt the updated specifications (child and adolescent well-care visits).

- Tobacco Use: Screening and Cessation Intervention
  - Andy Selinger said that Connecticut may get more "bang for the buck" focusing on other measures if one of the Council's criterion is to be parsimonious.
  - Deepti explained that Rhode Island removed this measure from its patient-centered medical home recognition program due to consistently high performance. Brad Richards asked whether Rhode Island found any changes in performance when adopting the revised measure specifications, which include three stratified rates, one of which is focused on cessation intervention. He added that perhaps Rhode Island could have realized a reduction in performance with the specification changes because cessation counseling is not always conducted. Deepti replied that Rhode Island removed the measure in 2018, right before the steward made the change. She added that stakeholders in Rhode Island's noted that high performance was because this was a check-the-box process measure that providers learned how to code for, rather than a true indication of whether cessation counseling was effective.
  - Brad Richards advocated for removing the measure, even though tobacco use is important to address. Marlene St. Juste and Lisa Freeman agreed with Brad. Marlene advocated for finding another way to address tobacco use. Lisa noted that the Council may need to consider a measure that is more broadly inclusive as the state legislature considers legalizing marijuana.
  - Deepti committed to keeping tobacco use on the list of topics of interest for the Council to consider during the gap analysis.
  - **Decision**: Drop measure.
  - **Next Steps**: Reconsider tobacco use during the gap analysis.
- Prenatal & Postpartum Care
  - Steven Wolfson noted that NQF cited that this measure could lead to "unintended consequences" when it removed its endorsement in 2016 and asked for further clarification on this topic. Deepti explained that the measure previously had a narrow window of when a postpartum visit could occur, which could lead to unintended consequences. The measure steward has expanded this window and made several other major revisions to the measure since 2016. Amy Gagliardi added 30% of maternal deaths happen from 40 days to one year after delivery. Screening within the postpartum period could pick up a lot of conditions related to postpartum depression, high blood pressure, and family planning to prevent unwanted subsequent pregnancies.
  - Marlene St. Juste asked if there is any part of this measure that differentiates between postpartum visits that occur between 7 and 84 days, noting that this seems like a very wide duration of time. Amy explained that standard practice is a postpartum visit within two weeks, with some visits within one week if a mother had a cesarians. Amy added that the large window encourages providers to continue to outreach with women to conduct a postpartum visit until the 84th day, rather than closing their chart earlier.
  - Susannah Bernheim said that it would be ideal to replace this measure with an outcomes-focused measure if available. She noted that the Joint Commission is working to develop one focused on maternal mortality, but it is still in development.
  - Amy Gagliardi noted that there is an enormous health disparity issue around prenatal care and birth outcomes and advocated for considering such measures.
  - Andy Selinger supported retaining this measure. Brad Richards and Steven Wolfson agreed.
  - **Decision**: Retain measure.
- Screening for Clinical Depression and Follow-Up Plan
  - Andy Selinger asked if this measure uses claims data to assess follow-up. Deepti responded that this measure primarily uses clinical data to assess follow-up. There are G codes which can capture follow-up, but practices rarely use these.
  - Marlene St. Juste stated that this measure is important but emphasized that there is an issue with access to behavioral health care especially for Medicaid patients. She emphasized the importance of addressing access to behavioral health care, especially to a psychiatrist, and focusing on whether follow-up is conducted.
  - Michael Jefferson agreed with Marlene. He asked whether the adoption of telehealth could temper the volatility of access to care and added that it could potentially exacerbate disparities in access to care.

	○ Lisa Freeman also agreed with Marlene, noting that there are two issues at hand: 1) retaining the measure to screen for depression and identify who needs care, and 2) working on how to expand access to behavioral health care. ○ Karin Haberlin agreed there is a dearth of providers available to the Medicaid population. She wondered whether the Council could look at referral data, particularly federally qualified health centers (FQHCs) and FQHC-lookalikes that have many behavioral health providers, such as Intercommunity in East Hartford and BHcare in Ansonia. ○ Steven Wolfson asked if there is any way to screen for behavioral drug intervention, such as whether patients who are depressed are on antidepressants. Karin Haberlin said this information can be found using prescription claims in Medicaid data. Rob Zavoski noted that it is challenging to identify whether the patient is on the antidepressant due to a specific behavioral health intervention, or because of a separate intervention, depending on how the data are structured. ○ Karin Haberlin separately noted that there are other behavioral health screens the Council can consider, such as the Screening, Brief Intervention and Referral to Treatment (SBIRT) screen. ○ Deepti proposed to continue discussion of this measure in next meeting in the interest of time. Brad Richards suggested grouping other mental health measures for consideration together. ○ **Next Steps**: Revisit measure during the March meeting with other mental health measures.	
5.	**Adjourn**	**Andy Selinger**
	Steve Wolfson made a motion to adjourn the meeting. Robert Zavoski seconded the motion. There were no objections. The meeting adjourned at 6:00 pm.	