Meeting of the Quality Council

Meeting Date	Meeting Time	Location
June 17, 2021	4:00 pm – 6:00 pm	Webinar/Zoom

Participant Name and Attendance

Quality Council		
Susannah Bernheim	Karin Haberlin	Alison Vail
Rohit Bhalla	Michael Jefferson	Jeannette Weiss
Elizabeth Courtney	Paul Kidwell	Steve Wolfson
Sandra Czunas	Joe Quaranta	Rob Zavoski
Stephanie De Abreu	Laura Quigley	
Tiffany Donelson	Andy Selinger (Chair)	
Amy Gagliardi	Marlene St. Juste	
Others Present		
Michael Bailit, Bailit Health	Krista Moore, OHS	Jeannina Thompson, OHS
Deepti Kanneganti, Bailit Health	Hanna Nagy, OHS	
Amanda Tran, Bailit Health	Kelly Sinko, OHS	
Members Absent:		
Syed Hussain	Lisa Freeman	Nikolas Karloustos
Robert Nardino	Doug Nichols	Brad Richards
Chrissy Tibbits	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 4:02pm.	
2.	**Public Comment**	**Andy Selinger**
	Andy Selinger welcomed public comment. • Dashni Sathasivam offered a public comment on behalf of Health Equity Solutions (HES). She thanked the Council for its intentional efforts to ensure that health equity is embedded within the quality measure conversations and decisions. She asked the Council to consider amending its recommendation to adopt a race, ethnicity, language and disability status (RELD) measure to also assess RELD data completeness, as the ability to stratify by RELD is only as good as the quality and completeness of the RELD data being collected. She shared that the Health Equity Data Analytics (HEDA) team published a 2020 report that noted that from 2012-2018, commercial insurers had primary race data for only nine percent of the 1.4M unique individuals, secondary race data for six percent of individuals and primary ethnicity data for ten percent of individuals. She shared that HES' request is aligned with the HEDA team's recommendations to "assess, track, and publicly report the existing baseline completeness" of REL data. Dashni cited Rhode Island's RELD measure as an example of a measure that strives to benchmark the completeness of RELD data while simultaneously stratifying performance. She thanked the Council for the opportunity to comment and welcomed any questions. • Michael Bailit shared that the legislature recently passed Senate Bill 1, which directs OHS to establish standards for the collection of REL data. He noted that providers generally have more complete REL data compared to insurers, but insurers typically have more information on disability status. He added that Medicaid typically has more complete data compared to commercial insurers. • Andy Selinger commented that it sounds intuitive to assess data completeness and expressed interest in seeing the implementation of Senate Bill 1. • Michael recommended discussing Dashni's request when discussing the RELD measure later in the agenda.	
3.	**Approval of May 20, 2021 Meeting Minutes**	**Andy Selinger**
	Steve Wolfson motioned to approve minutes of the Quality Council's May 20th meeting. Paul Kidwell seconded the motion. No one objected or abstained from approving the meeting minutes. The motion passed.	
4.	**Finalize Recommendations for 2022 Core Measure Set**	**Deepti Kanneganti**
	Deepti Kanneganti provided a recap of the May 20th meeting, noting that the Council recommended adding three substance use-related measures, one social determinants of health (SDOH) screening measure and one measure focused on stratifying measures by race, ethnicity, language and disability status (RELD).	

Deepti noted that the only SDOH screening measures available today have been developed by state agencies. NCQA, however, is developing two measures for implementation in 2023 – one focused on SDOH screening and another on referrals to community services after a positive screen. Deepti recommended delaying adoption of an SDOH screening measure until the 2022 annual review so that the Council could consider the NCQA measure. Deepti invited comment from the Council.

- Andy Selinger asked if there was a reason to not wait and adopt the NCQA SDOH measure.
- Deepti replied that is it useful to use a nationally-endorsed measure because it has been tested and validated, it will facilitate alignment across states, and there is a greater likelihood of having robust benchmark data. She said one disadvantage could be that the NCQA specification may not include a screening tool that is in wide use in CT. The likelihood of this occurring, however, is low. Deepti shared that NCQA will request public comment on the measure in February 2022.
- Marlene St. Juste asked if the Council could review the homegrown screening measures developed by RI, MA, and NC. Deepti shared that the specifications were distributed with the May meeting materials.
    - **Post meeting note**: The specifications can also be found here: https://www.shvs.org/wp-content/uploads/2020/10/Developing-a-SRF-Screening-Measure_Appendix.pdf
- Michael disclosed that Bailit Health helped RI develop its measure. He stated that another benefit to using a nationally-endorsed measure is that the steward will maintain it over time. He shared that many states will likely gravitate towards using the NCQA measure.
- Andy Selinger and Steve Wolfson agreed with waiting to consider NCQA's measure.
- Deepti added that Bailit Health is maintaining a list of topics for the Council to revisit in the future. She agreed to add consideration of NCQA's measure to the list.

Deepti described two questions the Council must answer in order to develop a measure that stratifies performance by RELD: (1) which Core Measure Set measure(s) should payers and advanced networks (ANs) stratify by RELD and (2) what is the data source for the measure? Deepti then explained that NCQA is requiring plans to stratify performance on select HEDIS measures by race/ethnicity in 2022. Deepti noted that which measures the Council recommends stratifying is dependent on whether ANs or plans are responsible for generating stratified performance. If ANs stratify performance, it will be easier, timelier, more likely to have accurate patient-reported RELD data and would use the same data source for measure performance and RELD information. However, AN-reported data may not be entirely accurate because ANs do not have access to claims data and can only report performance for patients seen vs. all patients attributed to the AN. If plans stratify performance, data would be more accurate of actual performance because plans have access to clinical and claims data. Data, however, would take longer to report and it may be more challenging to identify the "source of truth" if there are differing RELD data between plans and ANs. Deepti invited comment from the Council on which measures and data source it recommended using.

- Rohit Bhalla asked if OHS knew to what extent a) ANs and plans had complete RELD data for their patients/members and b) RELD data collected by ANs and plans differed. Deepti shared that OHS does not have this information.
- Michael added that Bailit Health issued a survey to accountable care organizations in MA to ask about RELD data completeness. He shared that a physician executive in Rhode Island found that his organization had a lot of inaccurate patient-level REL data.
- Rohit Bhalla shared that he was more inclined to use data from the ANs data because 1) it is more complete and 2) there is a greater likelihood for providers to update RELD data because patients interact with their provider on an ongoing basis.
- Michael replied that a third reason to use data from ANs is because ANs ultimately will be taking action to address disparities.
- Steve Wolfson commented that he hesitated to recommend using only claims data because they are used primarily for monetary purposes rather that for promoting patient care.
- Rob Zavoski noted that an individual's language preference may change over time. He added that it is very challenging to identify disability status using claims data because it is not always related to a specific diagnosis. Rob also shared that how a provider asks for RELD data is important. He said Medicaid found that patients were more likely to share their race and ethnicity when they were asked by a Medicaid enrollment officer than if they were self-reporting it on a form. Rob highlighted the importance of identifying why an organization is asking for a patient's RELD information. Finally, Rob advocated for using whatever RELD data are available because it will take many years before data are perfect.
- Deepti stated that Rob's points were important and highlighted the need for cultural competency training around how to ask RELD-related questions. She added that Bailit Health recommended using data from ANs because it will allow CT to begin stratifying performance and motivate improved data collection over time.
- Susannah Bernheim asked OHS which data source would be more consistent with Senate Bill 1. Kelly Sinko replied that OHS was in the beginning stages of identifying how to implement Senate Bill 1 and did not have a specific recommendation about a data source at the present time.
- Susannah Bernheim asked if ANs or plans would be responsible for stratifying performance for the RELD measure. Deepti responded that the Core Measure Set includes measures that are intended to be applied in contracts between

ANs and plans. She said if the Council recommended using AN EHR data, then ANs would be responsible for stratifying performance. If the Council recommended using AN EHR and plan claims data, then either plans or ANs could stratify performance.

- Susannah Bernheim suggested that the Council consider measures that will have sufficient denominator sizes when stratifying performance by RELD at the AN level.
  - **Post-meeting note**: Susannah shared her assessment that the following measures are more likely have sufficient denominator sizes: *Colorectal Cancer Screening*, *Child and Adolescent Well-Care Visits*, *Prenatal and Postpartum Care*, *Screening for Depression and Follow-up Plan*, *Comprehensive Diabetes Care: HbA1c Control*, *Controlling High Blood Pressure*, *Follow-up After Hospitalization for Mental Illness* and *Follow-up After ED Visit for Mental Health*.
- Andy Selinger advocated for selecting measures that capture activities that occur at the primary care site because ANs are more likely to have data on those activities.
- Joe Quaranta commented that every provider group will not be able to collect and report RELD data. He noted that payers are able to access data on a broader set of patients whereas ANs will only have data on patients seen within the network.
- Marlene St. Juste spoke in favor of stratifying *Prenatal and Postpartum Care* because of the disparities in outcomes for women by race. Deepti noted that NCQA is requiring plans to stratify performance on the measure in 2022.
- Michael emphasized that the RELD measure is not intended to be an all-inclusive set of measures. It is focused on making incremental progress in getting larger provider organizations used to routinely stratifying performance by RELD.
- Rohit Bhalla commented that the Council should consider how many interactions a patient has with an AN for each measure. For example, for *Child and Adolescent Well-Care Visits*, an adolescent may come in every year or once every two years. For *Controlling High Blood Pressure* or *Comprehensive Diabetes Care*, an individual may visit the practice anywhere from two to eight times a year. He said measures that focus on multiple visits provide more opportunities to update, correct, and capture RELD information.
- Michael proposed that Bailit Health develop a recommendation on which measures to include in the RELD measure for the Council to vote on after the meeting.
- **Next Steps**: Bailit Health will develop a recommendation for the RELD measure for the Council to vote on following the meeting. Bailit Health will incorporate Dashni Sathasivam's request into the proposal.

Deepti summarized how Bailit Health scored the Core Measure Set against the Council's measure selection criteria. Each measure could receive a maximum of 14 points when scored against the criteria to be applied to individual measures. Overall, measures received between 9-12. Deepti explained why seven measures received the lowest score of 9 points. Deepti noted that the Core Measure Set met four of the five criteria that are to apply to the measure set as a whole. The Core Measure Set did not meet criterion #3 – prioritizes health outcomes. Deepti asked the Council if it recommended (1) any changes based on the scoring results and (2) adopting a "true" core set for use by all payers in all AN contract.

- Andy Selinger asked how a "true" core set of measures differed from the Core Measure Set. Deepti explained that the Core Measure Set is a menu of options from which payers and ANs ideally should select when using measures in contracts. The true core set would be a small subset of measures (typically around 4-6 measures) recommended for use in all contracts. Michael added that a true core set is what really facilitates alignment across contracts.
- Andy Selinger, Marlene St. Juste, Steve Wolfson, Amy Gagliardi, Elizabeth Courtney (in the chat) and Karin Haberlin (in the chat) spoke in favor of adopting a true core set.
- Susannah Bernheim noted that claims-based measures are easier to calculate than EHR-based measures. She asked why plans and ANs didn't calculate performance for all claims-based measures. Deepti replied that the focus of the Core Measure Set is measures to use in contracts between ANs and plans. She said it would be challenging for providers to improve performance on multiple measures simultaneously even if performance was easy to calculate.
- Michael commented that there is currently not much alignment by insurers with the Core Measure Set. He shared that there is much greater insurer alignment with similar measure sets in RI (required of commercial payers by regulation) and MA (voluntary).
- Susannah Bernheim asked if there is an opportunity to have plan performance on the Core Measure Set published in the future. Deepti replied that a public scorecard could theoretically align with the Core Measure Set, but that was not the focus of the Council.
- **Next Steps**: The Council will select measures for a "true" core set beginning in fall 2021.

5.	**Continue Discussion of Quality Benchmarks**	**Michael Bailit/Deepti Kanneganti**

Michael Bailit reminded the Council that Quality Benchmarks are intended to ensure the maintenance and improvement of healthcare quality, be applied across all public and private payers, *may* include clinical quality, over- and under-utilization and patient safety measures and per the Governor shall become effective on January 1, 2022. Michael described how the use of Quality Benchmarks and Core Measure Set differ. Finally, Michael noted that the Council previously recommended including

health status measures (to be applied at the state and market levels) and healthcare measures (to be applied at the state, market, insurer and provider levels) and focusing on access to care, behavioral health (including tobacco), care coordination, obesity, oral health, patient experience, patient safety and SDOH/health equity. Michael asked the Council if it wished to focus on inpatient-related or outpatient-related patient safety measures. Finally, Michael invited comment from the Council.

- Marlene St. Juste asked about the Core Measure Set's intended use. Michael replied it is to inform contractual measures used by insurers and ANs. The Quality Benchmarks, in contrast, can be measured at the state, market, insurer and/or payer level.
- Steve Wolfson spoke in favor of including transition-of-care measures that assess what happens when a patient moves from inpatient to outpatient care and vice versa.
- Joe Quaranta noted that there is already a big focus on, and public reporting of, inpatient patient safety measures, but not outpatient patient safety measures. He recommended focusing on the latter.
- Rohit Bhalla commented that the inpatient safety measures have been around for a long time and are therefore becoming less relevant. He asked if there were outpatient patient safety measures the Council could consider.
- Susannah Bernheim stated that many outpatient patient safety measures are focused on medication safety.
- Rob Zavoski agreed with Susannah and Steve, noting that errors that occur at the transition of care are due to medication-related errors. Steve added that it could be because hospitals have different formularies than outpatient care settings.
- Michael stated, in response to a question from Susannah Bernheim, that the level of measurement and aspirational statewide targets are still to be defined. He emphasized the importance of working with stakeholders to improve performance on the Quality Benchmarks.
- **Next Steps**: Bailit Health will research measures focused on transitions of care and outpatient patient safety, inclusive of medication safety-related measures, for the July meeting.

Michael Bailit noted that the Council did not previously express any preference for which principles to use to aid selection of the Quality Benchmarks. Michael outlined five proposed guiding principles and invited the Council to provide any feedback on the proposal.

- Susannah Bernheim recommended selecting measures focused on healthcare areas that are not prioritized in other quality and patient safety programs. For example, she noted that the CMS is already focused on inpatient hospital safety and therefore the Council may not need to prioritize inpatient-focused measures for the Benchmarks.
- Rohit Bhalla asked how the Council would define measures that are not being prioritized and how it would select measures not from the Core Measure Set.
- Susannah Bernheim proposed that the Council identify non-prioritized measures as those that are not included in an existing national program. Michael shared that Bailit Health would look for measures outside of the Core Measure Set if there are no measures in the Set focused on a topic of interest (e.g., medication safety, racial inequities in obesity).
- Paul Kidwell confirmed with Michael that measures focused on promoting health equity would be focused on the healthcare setting and could include measures of healthcare quality or population health status.
- **Next Steps**: Bailit Health will add a guiding principle that specifies that the Quality Benchmarks should prioritize measures that are not already receiving attention from national entities.

Michael Bailit described how Bailit Health researched health status and healthcare measures for the Council to consider during the meeting. He noted that Bailit Health could only bring forth measures that have data available to set the aspirational targets for the state. He asked the Council to review the following measure options and identify whether it recommended proposing the measure be a Quality Benchmark. He shared that after the Council identifies a handful of measures, it will identify at which level the measure should be applied and set a target for each measure.

The Council discussed the following healthcare measures focused on access to care. Of note, there were no health status measures focused on access to care.

- *Adults who had an appt. for routine health care in the last 6 months who sometimes or never got appts. for routine care as soon as wanted* (Medicaid)
    - Andy Selinger spoke in favor of the measure unless a better measure comes along.
    - Steve Wolfson confirmed that the measure is focused on an insured population. He noted that uninsured individuals may have no access to care, and described a program created by Poverty Access New Haven focused on providing care for the insured.
    - Elizabeth Courtney expressed interest in the measure because she thought it could address equity. Deepti confirmed there were no data available to identify whether there were inequities in measure performance by race/ethnicity.
    - Deepti confirmed for Rob Zavoski that Bailit Health could only find data for the measure for the Medicaid population. She added that there is a similar measure for the Medicare managed care that looks at routine

health care in the last 6 or 12 months, which does not have opportunity for improvement. There were no publicly available data on commercial performance.
  - Michael noted there could be additional access-related healthcare measures available on Quality Compass.
  - **Recommendation**: Tentatively add *Adults who had an appt. for routine health care in the last 6 months who sometimes or never got appts. for routine care as soon as wanted*.
  - **Next Step**: Bailit Health will research additional healthcare access-to-care measures on Quality Compass.

Michael Bailit introduced five behavioral-health related health status measures:

- *Alcohol use disorder in the past year*
- *Substance use disorder in the past year*
- *Tobacco product use in the past month*
- *Drug overdose deaths involving any opioids per 100,000 resident population per year*
- *High School Students Who Seriously Considered Attempting Suicide*

Michael Bailit invited comments from the Quality Council on these measures.

- Rob Zavoski shared that there are some standard questions from the Youth Risk Behavior Surveillance System that are administered every year, whereas other questions are administered every other year.
- Elizabeth Courtney advocated for the drug overdose deaths measure because it is huge problem in CT and because there are state-based resources OHS can use to track performance. She also spoke in favor of the suicide measure because children and teenagers have experienced a lot of stress in the past year due to COVID-19.
- Andy Selinger noted that if the Council were to only include six to eight measures in the Quality Benchmarks, inclusion of an access to care and two behavioral health measures would comprise of half of the allotted slots. Michael noted that the Council can pare down the list of recommended measures after the first pass through the measures.
- Andy Selinger, Amy Gagliardi and Steve Wolfson advocated for the suicide and drug overdose deaths measures.
- Amy Gagliardi added that the opioid measure is reasonable to include because it addresses all ages, there is room for improvement, and the difference between CT's performance and national performance is likely statistically significant.
- Rob Zavoski recommended including the alcohol use disorder and substance use disorder measures because they lead to drug overdose deaths. Steve Wolfson agreed with Rob.
- Karin Haberlin said all measures looked like reasonable ones to consider for the Quality Benchmarks. She advocated for the substance use disorder and alcohol use disorder because there have been increased rates of alcohol consumption during the pandemic.
- **Recommendation**: Tentatively add *Drug overdose deaths involving any opioids per 100,000 resident population per year*, *High School Students Who Seriously Considered Attempting Suicide* and *Substance use disorder in the past year.*

Michael Bailit introduced three behavioral health-related healthcare measures, all of which are from the Core Measure Set:

- *Follow-Up After Hospitalization for Mental Illness (7-Day)*
- *Follow-Up After ED Visit for Mental Illness (7-Day)*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics*

Michael Bailit invited comments from the Quality Council on these measures.

- Karin Haberlin commented in the chat that she was interested in the two follow-up measures.
- Marlene St. Juste, Andy Selinger, Steve Wolfson and Michael Jefferson agreed with Karin.
- Michael noted that while CT performance may be above the national 90th percentile, the absolute rate (which was 56-60 percent) is quite low. Susannah Bernheim confirmed that the Quality Council could set a target for these measures that was above the 90th percentile.
- **Recommendation**: Tentatively add *Follow-Up After Hospitalization for Mental Illness (7-Day)* and *Follow-Up After ED Visit for Mental Illness (7-Day)*.

Michael Bailit shared that there were no health status or healthcare care coordination measures that met the Council's parameters (e.g., have benchmark data on current CT performance).

- Steve Wolfson said the Council could look at hospital readmission data because that's where most care coordination occurs. Michael stated that hospital readmission can be, but is not always, an indication of poor care coordination.
- Michael added that CMS prioritizes readmission measures and therefore (based on the Council's newly adopted measure selection criterion) the measures may not be good candidates for the Quality Benchmarks.
- Andy Selinger stated ANs do prioritize having a follow-up visit post-discharge because CMS incentivizes it. He added that the referral loop is rarely closed because there is no robust health information exchange in the state. He did agree that the measure is being prioritized, and deferred to the Council about whether the measure should be included.

- Michael Jefferson spoke in favor of adopting a behavioral health-focused readmission measure, especially one that "inspires action." Michael said he was unsure if such a measure existed, and if there were publicly available data to calculate CT performance.
- Susannah Bernheim noted that CMS uses a readmission measure in its inpatient psychiatric hospital program.
- Rob Zavoski noted that hospital readmissions must consider observation stays to ensure that hospitals are not gaming the measure. He added that the measure should exclude required follow-up visits for kids receiving cancer care.
- Susannah Bernheim shared that CMS publicly reports data on the number of excess days a patient spends in acute care post-discharge.
- **Next Steps**: Bailit Health will research readmission measures for the Council to consider in July.

Michael Bailit introduced the following health status measures focused on obesity. Of note, there were no healthcare focused measures on obesity.

- *Weight classification by Body Mass Index (BMI)*
- *Consumed vegetables less than one time per day*
- *High school students who did not eat vegetables during the 7 days before the survey*
- *Consumed fruit less than one time per day*
- *High school students who did not eat fruit or drink 100% fruit juices during the 7 days before the survey*

Michael invited comment from the Council and noted that it would continue discussion during the July meeting given the limited remaining time in the June meeting.

- Andy Selinger, Steve Wolfson and Elizabeth Courtney noted that the differences in obesity rates by race/ethnicity were "jaw dropping" and "demanded action."
- Michael Bailit, Michael Jefferson and Steve Wolfson noted that that cause of obesity is multifactorial.
- Deepti shared that NQF was testing several obesity measures, but halted its review because the steward developing and testing the measure lost funding.

6.	**Adjourn**	**Andy Selinger**

Elizabeth Courtney made a motion to adjourn the meeting. Michael Jefferson seconded the motion. There were no objections. The meeting adjourned at 5:59 pm.