Meeting of the Quality Council

Meeting Date	Meeting Time	Location
July 15, 2021	4:00 pm – 6:00 pm	Webinar/Zoom

Participant Name and Attendance

Quality Council		
Rohit Bhalla	Karin Haberlin	Brad Richards
Elizabeth Courtney	Michael Jefferson	Andy Selinger (Chair)
Sandra Czunas	Nikolas Karloustos	Marlene St. Juste
Stephanie De Abreu	Paul Kidwell	Jeannette Weiss
Lisa Freeman	Doug Nichols	Steve Wolfson
Amy Gagliardi	Joe Quaranta	Rob Zavoski
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:		
Susannah Bernheim	Robert Nardino	Alison Vail
Tiffany Donelson	Laura Quigley	Orlando Velazco
Syed Hussain	Chrissy Tibbits	

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 4:01pm.	
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 addressing completeness of the race, ethnicity, language, and disability status (RELD) in addition to stratification of specific measures by RELD. She noted that while RELD collection must include an 'decline-to-answer' option, there are evidence-based ways to improve completeness of these fields (e.g., tailoring how questions are asked, explaining why questions are asked). She also commented on the language used in the slide deck and stated that equity measures should never exclusively focus on "best-performing" and "worst-performing race/ethnicity." Equity means reducing gaps between minoritized and majoritized groups. The phrasing of the slide language implies that racial/ethnic groups are "performing better or worse," when the healthcare system's performance is the issue. In addition, she recommended incorporating an approach similar to Minnesota's Healthcare Disparities Report, which uses the overall state average to benchmark disparities. Finally, she recommended measures included in the Medicaid Transparency Board report be considered as health equity health status measures, including, for example, life expectancy. • Pareesa Charmchi Goodwin offered a public comment on behalf of Connecticut Oral Health Initiative (COHI). She thanked the Council for exploring oral health inclusion in the Quality Benchmarks. She highlighted that while the CT rate of adults visiting the dentist in a year is 76.5% (BRFSS), the adult dental utilization rate for the CT Medicaid population is about 36%. She noted that the slide deck stated that Dental Quality Alliance (DQA) measures could not be included because there are no baseline data available. Pareesa recommended contacting Dr. Donna Balaski at the Department of Social Services to discuss the DQA measures that CT collects for the Medicaid population, how these data could be shared with the Quality Council for review, and how these measures could be included in Quality Benchmarks. She added that the measures could be implemented beyond the Medicaid population because they use administrative claims data, adding the DQA measures were well supported by a wide range of stakeholders including oral health policy experts and CT-based consumer advocates.	
3.	**Approval of June 17, 2021 Meeting Minutes**	**Andy Selinger**
	Steve Wolfson motioned to approve minutes of the Quality Council's June 17th meeting. Brad Richards seconded the motion. No one objected or abstained from approving the meeting minutes. The motion passed.	
4.	**Continue Discussion of Quality Benchmarks**	**Michael Bailit/Deepti Kanneganti**

Michael Bailit, as a follow up to the public comment, asked the Council if it would like to take action on any of the recommendations it just heard from the public comments.

- Marlene St. Juste commented that the Medicaid oral health statistic stuck out to her.
- Nikolas Karloustos commented about the importance of collecting accurate REL data from patients, which also applies to collecting accurate patient experience data too.
- Michael replied that REL data are currently limited by what is available. He noted that we know nothing about how the methods for how REL data are collected at present. He also stated that the Council will revisit REL data collection later in the meeting.
- Rohit Bhalla stated that he supported looking at REL data completeness. He stated that so much of what is publicly reported in Connecticut is listed as unknown, which was the case when analyzing COVID-19 data. He said it is very important to be cognizant of what proportion is unknown because it compromises the integrity of what conclusions can be drawn about the quality of care.
- Michael agreed with Rohit. He stated that it is not possible to turn data completeness into a quality benchmark because there are no pre-existing data on REL data completeness. He shared that the Council could revisit this topic in the future as it has consistently expressed the importance of advancing health equity.
- Steve Wolfson commented that historically, the standard was focused on delivering care that is blind to a person's race, ethnicity and language.

Michael Bailit noted that during June 17th meeting, the Council recommended adding a new guiding principle: prioritize measures that are not receiving attention from national entities. Michael observed that this new guiding principle six and guiding principle four, "draw from the Core Measure Set whenever possible," are in direct conflict with each other. He highlighted that the Core Measure Set measures are almost all from national measure sets. He added that the only measures that the Council can use for benchmarks are ones that are receiving attention from national entities because they have publicly available data. Therefore, guiding principle six is not feasible.

- Joseph Quaranta commented that the Council previously discussed guiding principle six in relation to inpatient hospital-based measures. He stated that there was no debate between choosing measures that are nationally recognized or from national stewards. Rather, the Council expressed a preference for selecting measures that are receiving less attention when choosing measures among that group.
- Michael confirmed Joseph Quaranta's clarification and recommended that the Council remove the phrase "from national entities" from guiding principle six because the Council wants to prioritize measures that are not receiving a lot of attention already.
- Andy Selinger, Steve Wolfson, and Joseph Quaranta supported Michael's recommendation.
- **Next Step**: Bailit Health will revise guiding principle six to read "Prioritize measures that are not receiving attention."

The Council continued its review of candidate measures for the Quality Benchmarks. Michael noted that the Council previously tentatively added "Adults who had an appointment for routine health care in the last 6 months who sometimes or never got appointments for routine care as soon as wanted (Medicaid)."

Michael introduced the following healthcare measures from the CAHPS 5.0H survey for the commercial population focused on access to care, in response to the Council's previous request to consider other survey measures from NCQA's Quality Compass database.

- *Getting Care Quickly Composite*
- *Getting Needed Care Composite*
- *How often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?*
- *How often did you get an appointment to see a specialist as soon as you needed?*

Michael invited comments from the Quality Council on these access-focused measures.

- Paul Kidwell asked if there were Medicaid data available in addition to commercial data for these measures. Michael shared that there were no Medicaid data because Quality Compass collects data from health plans and there is no Medicaid managed care in the state.
- Paul Kidwell commented that these commercial-focused measures may miss measuring access to care for the Medicaid population, where access is an especially important consideration.
- Michael asked Brad Richards to confirm whether DSS administers the CAHPS survey. Brad Richards said DSS historically ran the survey, but did not do so in 2020 due to COVID-19. He said DSS tentatively will no longer continue to administer the survey for its PCMH+ program.

- Deepti Kanneganti noted that the Council previously recommended a Medicaid access measure, which uses data from the Agency for Healthcare Research and Quality (AHRQ).
- **Post-meeting Note**: AHRQ obtains data from the Medicaid access measure from DSS. If DSS is discontinuing the survey moving forward, data for the Medicaid access measure will no longer be available.
- Marlene St. Juste advocated for the "How often did you get an appointment to see a specialist as soon as you needed?" measure. She shared that as a provider, she has seen Medicaid patients wait for up to six months to see an orthopedist. Michael Bailit noted that information on that question won't be available if DSS no longer administers the related survey.
- Andy Selinger said he preferred considering other measures instead.
- **Recommendation**: Do not add any commercial-focused access measures.

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

- *Weight classification by Body Mass Index (BMI)*
- *Obesity Equity Measure – Weight Classification by BMI*
    - Michael highlighted that the absolute rate of obesity is high in Connecticut. He described a potential obesity equity measure focused on reducing the gap in obesity rates between the minoritized and majoritized race/ethnicity groups.

Michael introduced two additional health status measures focused on obesity. The following measures can be modified to be obesity equity measures as well.

- *Consumed vegetables less than one time per day*
- *Consumed fruits less than one time per day*

Michael invited comments from the Quality Council on these obesity-focused measures.

- Andy Selinger agreed with Michael's observation about Connecticut's high absolute rate of obesity. He said the obesity rate is shockingly divergent between the White population and the Hispanic/Latino population and Black population. He said the Council absolutely needs to include two measures: an obesity health equity measure and an overall obesity state prevalence measure.
- Brad Richards, Steve Wolfson and Lisa Freeman agreed with Andy Selinger's recommendation. Lisa added that fruits have a high sugar content and therefore fruit consumption is not a great measure.
- Rob Zavoski commented that the BRFSS survey is administered annually, but some questions are asked every other year. He said the Council should consider this when selecting benchmarks.
    - Deepti confirmed that obesity rate is measured annually, but the fruit and vegetable consumption rates are measured every other year.
- Steve Wolfson commented that the consumption of fruits and vegetables varies depending on their availability. He said there is a significant opportunity for improvement, particularly in Black, indigenous and other people of color (BIPOC) communities. He confirmed that the measure excluded consumption of fruit drinks.
- **Recommendation**: Tentatively add *Weight classification by BMI* and *Obesity Equity Measure – Weight Classification by BMI*.

Michael introduced the following healthcare measures focused on oral health. Of note, there were no identified health status focused measures on oral health for which data are publicly available.

- *Percentage of Eligibles Who Received Preventive Dental Services: Ages 1 to 20*
- *Percentage of Adults who Visited the Dentist or Dental Clinic within the Past Year*

Michael noted the Dental Quality Alliance (DQA) recommended several additional oral health measures for consideration. Bailit Health could not include them as there are no data currently available to assess opportunity for improvement or to set target values.

Michael invited comments from the Quality Council on these measures.

- Brad Richards stated that DSS was working on making its data publicly available, including oral health measures from the DQA, within the next year or so.
- Michael suggested that the Council consider the first measure, which was focused on children in Medicaid, the second measure, which was focused on the total population, and then a derivative of the second measure that looks only at Medicaid enrollees.
- Steve Wolfson commented that he advocated for oral health because it strongly correlates with employability.

- Michael commented that the Council can select a measure that is specific to Medicaid, but the Quality Benchmarks are not intended to be specific only to Medicaid. However, the Council may choose to select some measures that are Medicaid-focused, some that are commercial-focused, and some that are total population-focused.
- Deepti Kanneganti addressed one of Rob Zavoski's earlier points and stated the BRFSS survey question on adult dental visits is only administered every other year.
- Rob Zavoski commented that data for oral health measures are easier to obtain for Medicaid. Commercial payers do not have access to dental plan data and often do not cover dental services without a separate plan. He said another challenge with the BRFSS is that it is a survey, where most of the people being surveyed know what the right answer is.
- Steve Wolfson asked if selecting a dental services-focused measure services could help make dental insurance cheaper and more ubiquitous. Michael said this would not necessarily be the case.
- Rohit Bhalla asked how frequently the Council could obtain data for the first measure and what the target population was. Deepti Kanneganti confirmed that the data come from the CMS Medicaid Core Set, which obtains data from DSS and is published annually. Deepti added that the measure is specific to the Medicaid population.
- Rohit Bhalla supported the first measure specifically for the pediatric population because it addresses an important public health priority and it has been part of the Surgeon General's health priorities every decade.
- Rob Zavoski commented that he supported both oral health measures, even though the BRFSS data is flawed for the second measure. He said lack of access to dental care is a huge cause of chronic illnesses that are not properly treated, addressed, and controlled.
- Steve Wolfson, Amy Gagliardi, and Lisa Freeman supported Rob Zavoski's recommendation.
- **Recommendation**: Tentatively add *Percentage of Eligibles Who Received Preventive Dental Services: Ages 1 to 20* and *Percentage of Adults who Visited the Dentist or Dental Clinic within the Past Year*.

Michael introduced the following healthcare measures focused on patient experience. Of note, there were no identified health status focused measures on patient experience.

- *Adults who had a doctor's office or clinic visit in the last 6 months whose health providers sometimes or never listened carefully to them, Medicaid*
- *Rating of health care 0-6 on a scale from 0 (worst grade) to 10 (best grade) by adults who had a doctor's office or clinic visit in the last 6 months, Medicaid*

Michael noted that it had become apparent during the meeting that these two measures were not viable because DSS is considering to discontinue use of the CAHPS survey.

Michael introduced the following measures focused on patient experience that are from the CAHPS 5.0H survey and are specific to the commercial population.

- *Rating of All Health Care (Scores 9-10)*
- *Rating of All Health Plan (Scores 9-10)*
- *Rating of All Personal Doctor (Scores 9-10)*
- *Rating of All Specialist Seem Most Often (Scores 9-10)*

Michael invited comments from the Quality Council on these measures.

- Andy Selinger commented that he thought that the previous survey measures and the Patient-Centered Primary Care Measure (PCPCM) were much more appropriate than these ratings metrics.
- Rohit Bhalla expressed concern about potential health literacy issues for the third and fourth measures. There are some people who do not have a personal doctor, particularly the younger age groups, and some respondents may not understand what a "specialist" is.
- Brad Richards stated that the third measure is doctor-centric and not provider-centric, which is problematic when considering providers with APRN and PA licenses.
- Lisa Freeman stated that she did not think the Council should consider these measures because focus should be on outcomes and quality of care, and not about whether a patient likes their doctor. She said the latter did not correlate with better outcomes.
- Andy Selinger seconded Lisa Freeman's comment.
- **Recommendation**: Do not add any patient experience measures.

Michael explained that there are several measures available through CMS focused on patient safety, including measures focused on complications and death, hospital-acquired infections, timely and effective care and transitions of care for inpatient psychiatric facilities. Michael noted that the measures, however, are (1) inpatient-focused and (2) already receive a lot of national attention because they are included in several CMS hospital-focused programs.

Michael introduced two additional healthcare measures focused on patient safety. The following measures are focused on medication management, a component of medication safety, for specific conditions. Of note, there were no identified health status focused measures on patient safety.

- *Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase*
- *Follow-Up Care for Children Prescribed ADHD Medication – Continuation & Maintenance Phase*

Michael invited comments from the Quality Council on these measures.

- Andy Selinger stated that these measures are proxies for patient safety for the pediatric population. He asked if the Council could obtain Adverse Childhood Experiences (ACEs) data as another proxy for patient safety.
- Michael replied that these data are most likely not publicly available. He questioned whether such measures would be appropriate because ACEs often have nothing to do with healthcare. Michael stated that state agencies typically have data on these social risk factors.
- Rob Zavoski stated that he did not like these measures because medication is the last step of a long process. He said a better measure would focus on the steps prior to medication, such as neuro-psych evaluations and other classroom and behavioral interventions. He added that the patient's ongoing care includes weight monitoring, the main side effect of ADHD medication, which is typically done in a school setting and therefore not associated with a claim.
- Steve Wolfson expressed his interest in considering transition-of-care measures. Deepti shared that the transition-of-care measures that CMS publishes regularly are specific to inpatient psychiatric facilities.
- Rohit Bhalla commented that the patient safety measures that CMS monitors have been publicly reported for years and therefore would be duplicative. Michael agreed with Rohit.
- Lisa Freeman commented that although hospital-acquired infections (HAIs) have been consistently measured, it still remains one of the biggest threats to patient safety. She noted that performance improves when the HAI is receiving attention, but otherwise declines. She stated that she thinks they are good measures and should be kept at the forefront because there is room for improvement. She noted that there are similar challenges related to sepsis, which accounts for the majority of readmissions into Connecticut hospitals.
- Michael commented that Bailit Health did consider six HAI measures. Connecticut performance for the catheter-associated infection measure was below the 25th percentile.
- Rohit Bhalla said the HAI measures are focused on highly specific infections and are already publicly reported. He agreed that HAIs are important but expressed uncertainty around which measures to choose. He added that there are no publicly available measures for sepsis. Rohit added that hospitals are exerting an extraordinary amount of energy into improving performance on these measures and infections overall are becoming very rare.
- Michael commented that hospitals already have strong incentives to address HAI measures.
- Rob Zavoski shared that, from his previous experience at a large payer, sepsis measures are highly susceptible to coding.
- **Recommendation**: Do not add any patient safety measures.

Deepti Kanneganti introduced the following two healthcare measures focused on readmissions. Both, however, are already receiving national attention. Of note, there were no health status-focused measures on readmissions.

- *Plan All-Cause Readmission (Observed-to-Expected Ratio)*
- *Hospital-wide Readmit (READM-30-HOSPWIDE)*

Deepti Kanneganti invited comments from the Quality Council on these measures.

- Rohit Bhalla asked if the measures would be reported at the hospital level or at the advanced network (AN) level. Deepti stated that the Council would identify the level of measurement after selects the measures. Michael added that the measures will minimally be reported at the state level.
- Andy Selinger confirmed with Deepti that NQF no longer endorses the first measure because the steward did not submit the measure for reindorsement.
- Rob Zavoski commented that the Medicare *Hospital-wide Readmit* measure incentivizes hospitals to admit patients for observation to avoid marking a readmission, which shifts costs to Medicaid. Therefore, if the Council chooses to adopt this measure, it should also consider hospital observation stays after admission.
- Rob Zavoski added that hospital readmissions measures are inappropriate for children because most children's readmissions are either staged surgeries or for cancer treatment. Deepti stated that both measures exclude the pediatric population – the first measure focuses on adults 18 and older and the second focuses on older adults 65 and older.
- Rohit Bhalla noted that the Medicare readmission program had been around since 2013. He said it was useful to assess readmissions by condition.

- Andy Selinger stated that he preferred not to adopt a readmissions measure as the topic is already receiving significant attention.
- **Recommendation**: Do not add any readmission measures.

Deepti Kanneganti noted that Bailit Health could not find any health status or healthcare measures with published results focused on Social Determinants of Health (SDOH) because of the lack of a reliable data source that publishes measure performance on an annual basis. Deepti reminded the Council that it will revisit the topic of SDOH-related measurement in 2022 once NCQA publishes its measure focused on SDOH screening and referral to services after a positive screen.

- Andy Selinger asked if the Council could use a state-specific SDOH screening measure if there are benchmark data available versus a national measure.
- Deepti confirmed that the Council could use any public data source. She noted that neither Rhode Island nor Massachusetts, both of which use state-specific SDOH screening measures, publish performance data. Therefore, the Council could not at the present time adopt either measure for the Quality Benchmarks.
- Amy Gagliardi asked if DSS had any SDOH-focused measures from its PCMH+ program. Deepti shared that Bailit Health would follow up with Brad Richards on this topic.
- **Next Steps**: Bailit Health will reach out to Brad Richards and inquire whether DSS collects data on SDOH measures.

Deepti reported that the only health equity-related health status measures Bailit Health could find were the obesity measures discussed earlier in the meeting. Bailit Health could not find any healthcare measures with published results focused on health equity. Deepti reminded the Council that there needs to be a reliable data source that publishes measure performance on an annual basis to be able to use a measure as a Quality Benchmark. Therefore, the Council could not adopt a health equity-related homegrown measure.

5. RELD Measure Follow-Up — **Deepti Kanneganti**

Deepti Kanneganti shared that OHS requested feedback from the Council on its proposal for the Race, Ethnicity and Language (REL) Measure for the Core Measure Set and received responses from 11 Council members. Deepti reminded the Council that the REL Measure is a "measure of measures," meaning that it identifies several measures within the Core Measure Set that should be stratified by REL. It is a measure that could be applied in contracts between Advanced Networks (ANs) and payers in Connecticut.

Deepti shared the following REL Measure Survey results.

- Data Source: All members agreed with OHS' proposal to use EHR data from ANs for the measure.
- Measures: All members agreed with OHS' proposal to stratify performance for Child and Adolescent Well-Care Visits, Comprehensive Diabetes Care: HbA1c Control, Prenatal and Postpartum Care and Screening for Depression and Follow-up Plan.
    - One member expressed hesitation about including Controlling High Blood Pressure as it was unclear how patient self-reported readings would be incorporated into the measure. OHS will include the measure and ensure that the specifications include language on how to incorporate patient self-reported readings that aligns with NCQA.
- One member expressed hesitation about including an additional component that asks ANs to identify the percentage of patients for which it has complete REL data. The member noted there are various reasons why patients may refuse to self-report REL information.
    - OHS agreed that there are many reasons why a patient may not report REL information. However, one commonly-used REL category is "patient refused to answer." This category is a valid data field that would count towards the overall data completeness rate. Also, this is proposed as a P4R measure, so there would be no negative provider consequences for performance. OHS will include this component in the measure specifications.

Deepti shared that OHS will develop a draft set of specifications for the REL Measure based on the Council's input. It will circulate the specifications for comment before including the specifications with the rest of the documentation for the 2022 Core Measure Set.

6. Adjourn — **Andy Selinger**

Elizabeth Courtney made a motion to adjourn the meeting. Rob Zavoski seconded the motion. There were no objections. The meeting adjourned at 5:33pm.