Meeting of the Quality Council

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

Participant Name and Attendance

Quality Council		
Susannah Bernheim	Tiffany Donelson	Laura Quigley
Rohit Bhalla	Amy Gagliardi	Andy Selinger (Co-Chair)
Alan Coker (Co-Chair)	Karin Haberlin	Marlene St. Juste
Elizabeth Courtney	Michael Jefferson	Steve Wolfson
Sandra Czunas	Nikolas Karloustsos	Rob Zavoski
Stephanie DeAbreu	Brad Richards	
Others Present		
Michael Bailit, Bailit Health	Grace Flaherty, Bailit Health	Jeannina Thompson, OHS
Deepti Kanneganti, Bailit Health	Hanna Nagy, OHS	
Members Absent:		
Steven Choi	Robert Nardino	Orlando Velazco
Lisa Freeman	Chrissy Tibbits	Jeannette Weiss
Syed Hussain	Cary Trantalis	
Paul Kidwell	Joe Quaranta	

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**	**Alan Coker**
	Alan Coker called the meeting to order at 4:02 pm.	
2.	**Public Comment**	**Alan Coker**
	Alan Coker welcomed public comment. None was voiced.	
3.	**Approval of March 18, 2021 Meeting Minutes**	**Alan Coker**
	Elizabeth Courtney motioned to approve minutes of the Quality Council's March 18th meeting. Steve Wolfson seconded the motion. No one objected or abstained from approving the meeting minutes. The motion passed.	
4.	**Continue Annual Review of the Core Measure Set**	**Deepti Kanneganti**
	Deepti Kanneganti reminded the Quality Council of the information shared with each measure, including alignment with national measure sets of interest, use by Connecticut payers, alignment with Connecticut health priorities/needs, opportunity for improvement and an equity review. Council members were reminded to consider whether a measure aligned with the Council's measure selection criteria. Deepti Kanneganti provided a recap of the March 18th meeting, including the Council's preliminary decision to retain five measures, remove four measures and replace one outdated measure with a more current measure. Deepti reminded the Council that it agreed to pursue a pilot of the Person-Centered Primary Care Measure (PCPCM) and asked if there were any payer or provider organizations that were interested in participating. Andy Selinger asked the Council if it would be reasonable for Eastern Connecticut Health Network (ECHN) to conduct a pilot and send out the survey to a random selection of patients as a provider group. Steve Wolfson and Alan Coker supported Andy's proposal. Andy said he would pursue the idea with ECHN and get back to the Council. Deepti welcomed any additional payers or providers interested in participating in the pilot to reach out to Hanna. The Quality Council continued its review of the Core Measure Set: • Comprehensive Diabetes Care: HbA1c Testing o Deepti reminded the Council that it previously recommended retaining the HbA1c Poor Control measure, which is inclusive of HbA1c testing. She noted that both measures (Poor Control and HbA1c Testing) are typically not both included in a measure set because they are redundant. o Marlene St. Juste asked what NCQA's proposed change to the measure would be. Deepti explained that NCQA is proposing removing the HbA1c Testing component from the suite of Comprehensive Diabetes Care measures and retaining all the other components. o Michael Bailit recommended dropping the testing measure because Connecticut already has the control measure in the Core Measure Set. o Rohit Bhalla said diabetes control is more important than diabetes testing and that this measure is not always accurately captured. o **Recommendation**: Remove	

- Comprehensive Diabetes Care: Eye Exam
  - Deepti said other states have found it hard to get data for this measure because the eye exam is often performed by a provider outside of the patient's primary care practice. Deepti shared that Yale Northeast Medical Group suggested not including the measure because of difficulty capturing data due to coding and billing and not including abnormal eye results on the claims.
  - Steve Wolfson asked how eye exams are done with telehealth. Laura Quigley and Deepti confirmed that telehealth is for identifying patients for inclusion in the denominator, and not for the eye exams (the measure numerator).
  - Andy Selinger said Connecticut needed to retain this measure because it is indicative of disparities. Steve Wolfson agreed with Andy.
  - Andy Selinger asked why Medicaid performance was characterized as "N/A" and Deepti explained that data were not available from DSS or from CMS about Connecticut's Medicaid performance.
  - Brad Richards spoke in favor of retaining the measure, despite challenges with getting data.
  - Marlene St. Juste expressed her preference for retaining the measure. She asked if the ophthalmologist has any responsibility for sharing data with primary care providers. Michael Bailit reminded the Council that these measures are for use with Advanced Networks, which may include ophthalmologists. He said ideally the Advanced Network would develop data collection protocols with the ophthalmologists with whom their patients are going to be most active. Elizabeth Courtney noted it is advantageous to include this measure in a contract because it incentivizes care systems to develop such protocols.
  - Rob Zavoski shared that there are health centers that are using retinal cameras at the primary care site and sending the scans to the ophthalmologist for review
  - **Recommendation**: Retain
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
  - Deepti Kanneganti said Bailit Health did not recommend retaining this measure because it is not being maintained and NCQA will not update specifications. She asked if the Council would like to instead adopt the new HEDIS replacement measure – Kidney Health Evaluation for Patients with Diabetes.
  - Steve Wolfson recommended replacing Medical Attention for Nephropathy with Kidney Health Evaluation for Patients with Diabetes. Marlene St. Juste, Rob Zavoski, and Brad Richards agreed with Steve.
  - **Recommendation**: Replace with Kidney Health Evaluation for Patients with Diabetes
- Controlling High Blood Pressure
  - Steve Wolfson asked if all insurers cover home blood pressure devices, noting that his was not covered by Medicare. Andy Selinger said in cases of documented hypertension, most commercial insurers cover a digital home blood pressure cuff, although there may be a deductible.
  - Andy Selinger confirmed that this measure is Connecticut's only hypertension measure. Deepti Kanneganti added that it is also one of Connecticut's few outcome measures. Andy Selinger spoke in favor of retaining the measure and Steve Wolfson agreed.
  - Rohit Bhalla said it is one of the most important measures Connecticut has in terms of morbidity and mortality reduction.
  - **Recommendation**: Retain
- Use of Imaging Studies for Low Back Pain
  - Deepti Kanneganti reported that Yale Northeast Medical Group recommended not including this measure because it is difficult to match a claim to when a patient first began experiencing pain.
  - Andy Selinger said he was unsure if he supported this measure because he was not sure if the Quality Council should make a judgement on what is low-value care versus high-value care. He recommended omitting the measure and substituting some of the gap-filling measures instead.
  - Sandra Czunas said this measure might encourage folks to receive unnecessary care and that follow-up care post-imaging is also a concern with this measure.
  - Rohit Bhalla asked how the Council should interpret Commercial Performance (76%) and if desirable performance was at 100%. Deepti Kanneganti explained that "76%" meant that 76% of patients with low back pain did not have an imaging study within 28 days of diagnosis. Michael said that like many other measures, there will never be 100% performance because there will always be small numbers of patients whose circumstances don't match the measure specifications. Rohit Bhalla agreed, stating that there will always be patients for whom it is appropriate to image.
  - Alan Coker shared that he received imaging for low-back pain and noted that he is an individual who fits into this group Rohit described as a patient. He agreed with Andy Selinger's previous comment, highlighting that provision of low-back pain care is set up in a way that patients often receive what is needed right away.
  - Amy Gagliardi asked if certain groups are more likely to receive imaging services than others. Deepti Kanneganti clarified that Bailit Health could not find disparity in imaging, only in back pain by race/ethnicity.

- Steve Wolfson asked if there were any data on prescribing physical therapy for lower back pain. Deepti Kanneganti said that Bailit Health did not readily have access to those data.
- Steve Wolfson said if the measure did not factor in patients who were not being treated, it lowered the measure's value. He spoke in favor of imaging only after a patient seeks alternative treatment for pain. Rob Zavoski said this alternate treatment is difficult to pick up from claims and imaging is also more likely to be done in the Emergency Department. Michael Jefferson echoed that it is a low-value measure.
- Deepti Kanneganti summarized that the Council preferred looking at alternate low-back pain measures, including whether an individual has received physical therapy or alternate treatment and in which location(s) patients receive imaging services.
- **Recommendation**: Remove, but look for alternate low-back pain treatment measures that include other therapies for low-back pain and address where back pain treatment is received.

- Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis
  - Deepti Kanneganti shared that Massachusetts excluded this measure from its aligned measure set because it thought providers could "game" the measure by not coding for bronchitis. She reported that Yale Northeast Medical Group recommended not using the measure for a similar reason.
  - Andy Selinger said there was a study that looked at the incidence of delivering low-value care at community health centers that found community health centers did a better job at delivering high-value care than low-value care compared to private practices. He reiterated that he was unsure if the Council should make a judgement call on low-value versus high-value care.
  - Rohit Bhalla confirmed that this is one of the only measures the Council has for overuse or inappropriate use. He said not having any measure that looks at inappropriate utilization may not be desirable.
  - Rob Zavoski said he was struggling with this measure for two reasons. First, it combines bronchitis and bronchiolitis, which are two radically different diagnoses, in one measure. Second, NCQA has had the Avoidance of Antibiotic Treatment for Acute Bronchitis measure for years and performance has not really changed that much.
  - Elizabeth Courtney asked if this measure is effective at curbing the overuse of antibiotics, and if not, was there any measure encouraging more appropriate use. Michael Bailit noted that Connecticut's performance is among the worst in the country on this measure per NCQA. Rob Zavoski asked if the Council could receive data on how Connecticut has performed on this measure over the past five years. Steve Wolfson said patients are often the source of pressure to use antibiotics and physicians vary in their skill of dealing with that pressure.
  - Rohit Bhalla said it would be great if the Council could come out with a measure set that includes some check on overutilization. Michael Bailit reminded the Council that OHS has implemented a cost growth benchmark. Rohit Bhalla said it would behoove the Council to have a measure with the goal of minimizing overuse to complement the benchmark.
  - **Recommendation**: Remove measure, flag overuse as a measure set gap and try to find better measures that are primary care-focused or readmission-focused.
- Appropriate Treatment for Upper Respiratory Infection
  - Deepti Kanneganti shared that Yale Northeast Medical Group recommended not including this measure because of small denominators due to the COVID-19 pandemic. Rob Zavoski shared that he was unsure if Yale's concern was actually happening.
  - Elizabeth Courtney asked if there was more information on what is defined as "appropriate treatment." Deepti said the measure defines appropriate treatment as treatment of the condition without antibiotics.
  - Rob Zavoski said this measure was introduced at the same time NCQA introduced the Acute Bronchitis measure. He explained that the American Academy of Pediatrics pushed pediatricians not to prescribe antibiotics for illness and as a result antibiotic use for children plummeted. Rob said this did trend was not repeated for the adult metric.
  - Rohit Bhalla said the contrast between the two measures is acute bronchitis can have a bacterial connotation whereas upper respiratory can have a viral connotation. Rohit and Andy Selinger shared that they preferred this measure over the acute bronchitis measure.
  - Rob Zavoski confirmed that there was more room for improvement on the upper respiratory measure compared to the acute bronchitis measure. Andy Selinger said it all comes down to correct coding by the clinical provider and the upper respiratory measure lends itself to greater accuracy.
  - Deepti Kanneganti asked Rob Zavoski what he thought. Rob Zavoski said the upper respiratory measure has done quite well in Connecticut, but on the acute bronchitis measure Connecticut "has not moved the ball." Rob Zavoski said he could not comment on bacterial overlay because he was not an adult provider, but he added that the measure stewards must not think it is not an issue. Rob added he did not see where Connecticut was going to see improvement on the upper respiratory measure and he recommended not including it. He added that while there is room for improvement on the bronchitis measure, he did not like the measure due to the changes he previously described. Rob said he could easily remove both measures.

- Steve Wolfson asked what the difference was between bronchitis and upper respiratory diagnoses. Michael Jefferson said it is a clinical diagnosis and there is tremendous overlap between the two. Andy Selinger said the abusiveness in prescribing comes from acute care centers and there is a laziness of coding.
- Andy Selinger spoke in favor of addressing overutilization and low-value care in a different way. Michael Jefferson recommended use of readmission-focused measures.
- **Recommendation**: Remove measure, flag overuse as a measure set gap and try to find better measures that are primary care-focused or readmission-focused.

5. Review Measure Proposals — **Michael Bailit**

Michael Bailit summarized that OHS solicited feedback from the Council following the last meeting on gaps in the Core Measure Set. The Council and Bailit Health identified many gaps over the last few months, including access, behavioral health, care coordination, equity, hospital/inpatient care, obesity, oral health, outcome measures, patient-reported outcomes, and patient safety. He described Bailit Health's process for identifying measures to fill the measure gaps, noting that it found over 50 candidate measures in total. Given the Council's limited time, OHS is prioritizing two gaps for this year because of a) time constraints, and b) the gaps were identified to be of high importance for the Council and the State. He identified the two measure sets gaps as behavioral health and health equity. He explained that OHS was deferring consideration of the remaining gaps for discussion of the 2023 Core Measure Set.

Michael Bailit reminded the Council of the behavioral health measures they had already reviewed and recommended for either retention or removal. Susannah Bernheim asked if OHS could share with the Council the 50 measures Bailit Health found. Susannah Bernheim asked if the focus on behavioral health and equity will limit the measures that can be selected for setting quality benchmarks. Michael said no, there were no strings attached concerning the quality benchmarks. Michael said the Governor's Executive Order is quite broad and while the Quality Council may want to select measures from this measure set there was no obligation to do so.

Next Step: OHS will share with the Quality Council the 50 candidate measures to fill the identified gaps, as identified by Bailit Health.

The Quality Council began its review of candidate measures to address behavioral health and equity gaps:

- Screening for Clinical Depression and Follow-up Plan
  - Michael Bailit reminded the Council that it recommended the measure be removed at its March 2020 meeting because it (1) does not define what is a positive screen, (2) there is a very prescribed definition of what constitutes a follow-up plan, and (3) data cannot be generated through claims, only through record review or through clinical data exchange. Michael said from a content perspective the measure is fine, but operationally it is hard to implement.
  - Sandra Czunas asked if OHS has surveyed ACOs/providers on what it will take for them to collect clinical data for this measure and other measures. Michael confirmed this had not been done. Sandra added that the Council has deferred discussion of how to advance measures that rely on clinical data.
  - Andy Selinger asked if there is an ICD-10 code that identifies screening for depression. Michael Bailit said the measure looks for an indication of a positive screen, which is not linked to a diagnosis code. Andy Selinger said a score of 10 on PHQ-9 is accepted as a positive screen clinically. He added that he assumed there would be representative sampling that statistically represents how the provider group is doing.
  - Michael Bailit reiterated that this measure addresses an important priority, but is hard to operationalize. Sandra Czunas, Andy Selinger and Elizabeth Courtney (via Zoom chat) agreed with Michael.
  - Rob Zavoski agreed with Sandra Czunas' earlier comment on clinical data collection and the Council's deferred discussion on the topic. Sandra Czunas said Connecticut should not keep waiting for "the Epics" because EHRs are not prioritizing primary care.
  - **Recommendation**: Retain
- Depression Utilization of the PHQ-9 Tool
  - Andy Selinger said Minnesota Community Measurement's specifications included the PHQ-9 and not PHQ-3.
  - Deepti Kanneganti clarified that this measure screens patients who already have a diagnosis of depression, and thus is quite different than the Screening for Clinical Depression and Follow-Up Plan measure.
  - **Recommendation**: Do not include
- Follow-Up After Hospitalization for Mental Illness/Follow-Up after Emergency Department for Mental Illness
  - Michael Bailit introduced two follow-up measures – Follow-Up after Hospitalization for Mental Illness and Follow-Up after Emergency Department Visit for Mental Illness.
  - Rob Zavoski noted that seven days for follow-up is a challenge for many organizations.
  - In response to a question, Deepti Kanneganti clarified that follow-up must occur with a mental health provider.

- Andy Selinger shared that a 30-day Emergency Department follow-up is more practical if follow-up cannot occur with a primary care provider. Michael Jefferson agreed with Andy, but said seven days is often what someone in crisis is going to need, particularly someone with opiates or a suicide attempt.
- Michael Jefferson said every hospital in Massachusetts has a system whereby the moment an individual hits the Emergency Room the system notifies the individual's health plan and primary care physician.
- Michael Bailit recommended the Council should choose what's right for the patient, not what is most easily attainable for the state right now. Rob Zavoski and Marlene St. Juste spoke in favor of follow-up within seven days.
- Karin Haberlin said (via Zoom chat) that seven days seemed too short and said 30 days was more reasonable. She explained that there are often structural barriers (e.g., access to timely data) to getting people into care within seven days.
- Susannah Bernheim (via Zoom chat), Karin Haberlin (via Zoom chat) and Rob Zavoski asked if the Council could modify the measure to look at follow-up within a different time frame (e.g., eight, 10 or 14 days). Michael Bailit said NCQA will not allow insurers to generate a HEDIS measure with modified specifications.
- Sandra Czunas shared that there has been an explosion of need in behavioral health during the COVID-19 pandemic and that there may be a significant wait time for follow-up. Rob Zavoski asked Sandra how often OSC covered lives received follow-up within seven days due to use of PatientPing. Sandra Czunas offered to look into this question. She noted that a short follow-up time comes at a per-member-per-month (PMPM) cost.
- Michael Jefferson said telehealth has been a game changer for provider availability.
- Brad Richards and Amy Gagliardi spoke in favor of follow-up within seven days. Amy added that Patient Ping is "miraculous."
- Amy Gagliardi asked if anyone had any data on compliance with behavioral health appointments, asked about the uptake on referrals, and agreed that telehealth has been a game changer. Michael Bailit said it is unclear if lack of follow-up is because of the patient or because of the lack of availability of mental health providers.
- **Recommendation**: Add Follow-Up After Hospitalization for Mental Illness (7-day) and Follow-Up after Emergency Department for Mental Illness (7-day)

- Antidepressant Medication Management
  - Andy Selinger said this measure struck him as being a bit "in the weeds" and it sounded like it could require chart review. Deepti Kanneganti clarified that the measure is claims-based and looks at prescription fills.
  - Michael Jefferson confirmed that performance rates for Connecticut were between the national 75th and 90th percentiles. Steve Wolfson said that performance is better than he would have expected.
  - Andy Selinger asked if the Council would be setting the benchmark for the measure (e.g., 80% adherence at six months). Michael Bailit said payers and Advanced Networks would need to decide how to incorporate measures from the Core Measure Set into contracts.
  - Andy Selinger recommended focusing on the two follow-up measures first and reconsidering this measure next year. Steve Wolfson agreed with Andy.
  - **Recommendation**: Do not include. Revisit during next year's review.

Michael Bailit explained that at the next meeting the Council would continue to discuss the candidate measures to fill the behavioral health and health equity measure set gaps. It will then finalize its recommended changes to the Core Measure Set before beginning discussion of quality benchmarks in June.

6.	**Adjourn**	**Alan Coker**
	Steve Wolfson made a motion to adjourn the meeting. Michael Jefferson seconded the motion. There were no objections. The meeting adjourned at 5:56 pm.	