Quality Council
April 15, 2021

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Agenda

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

Call to Order

Public Comment

Approval of March 18, 2021 Meeting Minutes

Continue Annual Review of the Core Measure Set

Reminders!

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

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Reminders! (Cont'd)

- **CT Health Priorities/Needs**

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

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

Reminders! (Cont'd)

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

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

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

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Reminders! (Cont'd)

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

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

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

Recap of the March 18, 2021 Meeting

- The Council **continued its review** of the Core Measure Set, making the following decisions:
  - **Retain (5)**: PCMH CAHPS, Behavioral Health Screening (Medicaid-only), Follow-up Care for Children Prescribed ADHD Medication, Metabolic Monitoring for Children and Adolescents on Antipsychotics (Medicaid-only)*, Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
  - **Remove (4)**: Screening for Clinical Depression and Follow-up Plan, Depression Remission at Twelve Months, Depression Response – Progress Towards Remission, Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
  - **Replace (1)**: Medication Management for People with Asthma with Asthma Medication Ratio

- The Council agreed to pursue a pilot of the PCPCM.
  - Are there any payer or provider organizations that are interested in volunteering to participate in the pilot at this time?

*This measure has historically been designated by the Quality Council as a Medicaid-only measure.

PCMH: Patient-Centered Medical Home PCPCM: Patient-Centered Primary Care Measure

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Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing

Summary of Major Specification Changes	Proposed Change for MY 2022: NCQA is proposing to retire this measure because it does not assess the test result or the quality of care to assess blood sugar control and performance has been consistently high. MY 2020: Removed the restriction that only one of two eligible visits can be via telehealth. MY 2018: Added telehealth.		
Alignment with National Measure Sets of Interest	**2** *(CMS Core Quality Measures Collaborative, NCQA HEDIS)*		
Use by Connecticut Payers	**6** (DSS PCMH+ [Scoring], OSC, 4 of 6 commercial insurers)		
Addresses State Health Priorities/Needs?	Yes - 10 percent of CT residents in 2018 had diabetes according to Data Haven.		
Opportunity for Improvement	**Commercial performance (2019):** 92.2%	**Medicaid performance (2019):**	
		PCMH+: 89.2%	**CMS:** 87.0%

Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing

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

Comprehensive Diabetes Care: Eye Exam

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

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Comprehensive Diabetes Care: Eye Exam

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

Comprehensive Diabetes Care: Medical Attention for Nephropathy

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

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Comprehensive Diabetes Care: Medical Attention for Nephropathy

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

Controlling High Blood Pressure

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

Controlling High Blood Pressure

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

Use of Imaging Studies for Low Back Pain

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

Use of Imaging Studies for Low Back Pain

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

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

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

Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis

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

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

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

Appropriate Treatment for Upper Respiratory Infection

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

Review Measure Proposals

Identified Measure Gaps

- OHS solicited feedback from the Quality Council following the last meeting on gaps in the Core Measure Set. The Council, in addition to Bailit Health, identified many gaps over the last few months:
  - Access
  - Behavioral health
    - Depression screening
    - Mental health, more broadly
    - Substance use treatment (inclusive of tobacco)
  - Care coordination
  - Equity
    - Infant mortality & low birthweight racial gap
    - Lead screening
    - SDOH needs & referrals
  - Hospital/inpatient care (inclusive of maternity care)
  - Obesity
  - Oral health
  - Outcome measures (in general)
  - Patient-reported outcomes
  - Patient safety

SDOH: Social determinants of health

Process to Fill Measure Gaps

- Bailit Health researched measures to fill the identified gaps using the following sources:
  - **Buying Value Measure Selection Tool**, which includes over 800 measures and measures in use by 13 federal and national and 6 state measure sets;
  - **Buying Value Benchmark Repository**, which includes nearly 50 non-HEDIS and homegrown measures in use by states;
  - **NQF's Quality Positioning System**, which includes over 1,100 measures that are or were previously endorsed by NQF;
  - **CMS' Measures Inventory Tool**, which includes nearly 700 measures in use by various CMS programs; and
  - **Guideline Central**, which is a database of measures that were previously included in the National Quality Measures Clearinghouse, a discontinued Agency for Healthcare Research and Quality (AHRQ) database.

Process to Fill Measure Gaps (Cont'd)

- We are narrowed the list of candidate measures for the Council to consider by:
  - only including candidate measures that are still being **maintained by the measure stewards**, and
  - bringing forth candidate measures for gaps with many available measures (e.g., Behavioral Health) that were **most aligned in CT's national measure sets of interest** (max #: 7) and in the national and state **measure sets included in the Buying Value Tool (BVT)** (max #: 19).

Of note, we are also identifying which measures are in use by **DSS' PCMH+** program and **RI's and MA's aligned measure sets for ACOs** as well.

Prioritized Measure Gaps for 2021

- In total, Bailit Health found over 50 candidate measures for the Council to review to address the identified gaps.
- Given the Council's limited time, we are **prioritizing two gaps for this year** because they were identified to be of high importance for the Council and the State:
  - Behavioral Health
  - Equity
- OHS is **deferring consideration of the remaining gaps for discussion next year** as there will be more available time then.

Behavioral Health Measures

- As a reminder, the Quality Council already reviewed and made recommendations to **retain** the following four behavioral health measures:
  - Behavioral Health Screening (*Medicaid-only*)
  - Developmental Screening in the First Three Years of Life
  - Follow-Up Care for Children Prescribed ADHD Medication,
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics (*Medicaid-only*)
- There are only two measures as of now that are intended for use with commercially insured populations, and none for adults.

Behavioral Health Measures (Cont'd)

- As a reminder, the Quality Council already reviewed and made recommendations to **remove** the following behavioral health measures:
  - Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
  - Depression Remission at Twelve Months
  - Depression Response at Twelve Months – Progress Towards Remission
  - Screening for Clinical Depression and Follow-Up Plan
  - Tobacco Use: Screening and Cessation Intervention

Behavioral Health: Depression Screening

- There are many depression screening measures that are not NQF-endorsed and that are not maintained by their measure stewards.
- SAMHSA only recommends Screening for Clinical Depression and Follow-up Plan. The Council recommended it for removal in March, but given the limited availability of alternate measures and the measure's wide use in other states, we raise it for reconsideration.

NQF # / Status	Measure Name	Steward	Measure Type	Alignment – CT	Alignment – BVT	Measure Set Use
0418 (No Longer Endorsed)	Screening for Clinical Depression and Follow-up Plan	CMS	Process	6	10	MA Core
0712 (Endorsed)	Depression Utilization of the PHQ-9 Tool	MNCM	Process	0	0	

SAMHSA: Substance Abuse and Mental Health Services Administration MNCM: Minnesota Community Measurement

Behavioral Health: Mental Health

NQF # / Status	Measure Name	Steward	Measure Type	Alignment – CT	Alignment – BVT	Measure Set Use
0576 (Endorsed)	Follow-Up After Hospitalization for Mental Illness	NCQA	Process	5	8	DSS PCMH+, MA Menu (7-Day), RI Core (7-Day)
3489 (Endorsed)	Follow-Up After Emergency Department Visit for Mental Illness	NCQA	Process	2	4	DSS PCMH+, MA Menu (7-Day and 30-Day), RI Menu
0105 (Endorsed)	Antidepressant Medication Management	NCQA	Process	4	5	DSS PCMH+

Behavioral Health: Substance Use

NQF # / Status	Measure Name	Steward	Measure Type	Alignment – CT	Alignment – BVT	Measure Set Use
0004 (Endorsed)	Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment	NCQA	Process	4	7	MA Menu (Initiation and Engagement), RI Menu
3488 (Endorsed)	Follow-Up After Emergency Department Visit for Alcohol and Other Drug (AOD) Abuse or Dependence	NCQA	Process	2	4	RI Menu
NA	Alcohol and Drug Misuse: Screening, Brief Intervention and Referral for Treatment (SBIRT)	Oregon Health Authority	Process	0	1	

Behavioral Health: Substance Use (Cont'd)

NQF # / Status	Measure Name	Steward	Measure Type	Alignment – CT	Alignment – BVT	Measure Set Use
NA	Substance Use Assessment in Primary Care	Inland Empire Health Plan	Process	0	0	
3389 (Endorsed)	Concurrent Use of Opioids and Benzodiazepines	Pharmacy Quality Alliance	Process	2	5	RI Developmental
3400 (Endorsed)	Use of Pharmacotherapy for Opioid Use Disorder	CMS	Process	1	2	
3175 (Endorsed)	Continuity of Pharmacotherapy for Opioid Use Disorder	University of Southern California	Process	1	1	MA Menu

Behavioral Health: Substance Use – Tobacco (Cont'd)

NQF # / Status	Measure Name	Steward	Measure Type	Alignment – CT	Alignment – BVT	Measure Set Use
2803 (No Longer Endorsed)	Tobacco Use and Help with Quitting Among Adolescents*	NCQA	Process	1	1	MA Developmental

*This measure is maintained by NCQA for the MIPS program, but is not a HEDIS measure.

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Health Equity Measures

- The Quality Council has placed a high priority on selecting measures that will advance health equity. Use of quality measures for this purpose is still emerging, but there are a few approaches so far:
  1. measures applied at the total population-level for which there are known disparities (e.g., maternal health, lead screening)
  2. measures that assess removal of barriers to equity (e.g., access to translator services)
  3. measures that assess collection of race, ethnicity, language, and disability status (RELD)
  4. measures that assess disparities by stratifying performance by race, ethnicity, language, disability status, gender, geography, etc.

Health Equity: Total Population Measures with Known Disparities

- The CT state health assessment identified infant mortality and low birthweight as two areas with known disparities in performance.
  - These measures, however, are typically hospital-focused measures.
  - The Council has not yet decided whether to include hospital-focused measures in the Core Measure Set. Therefore, we are deferring consideration of these measures until next year.

NQF # / Status	Measure Name	Steward	Measure Type	Alignment – CT	Alignment – BVT	Measure Set Use
NA	Lead Screening in Children	NCQA	Process	1	1	RI Menu

Health Equity: Measures that Assess Removal of Barriers to Equity

NQF # / Status	Measure Name	Steward	Measure Type	Alignment – CT	Alignment – BVT	Measure Set Use
NA	Meaningful Access to Health Care Services for Persons with Limited English Proficiency	Oregon Health Authority	Process	0	1	

Health Equity: Measures that Assess Removal of Barriers to Equity (Cont'd)

- SDOH measures, in the long-term, also assess removal of barriers to equity. The evolution of SDOH structural measures is as follows:

- There is little standardization of SDOH measures today, and most options are homegrown.

NQF # / Status	Measure Name	Steward	Measure Type	Alignment – CT	Alignment – BVT	Measure Set Use
NA	Health-related Social Needs Screening	MA EOHHS	Process	0	0	
NA	SDOH Screening	RI EOHHS	Process	0	1	RI Developmental

SDOH: Social determinants of health

Health Equity: Measures Involving Race, Ethnicity, Language and Disability (RELD) Data and Stratifying Performance

- Other states are pursuing new measures to improve RELD data capture and measure stratification.
  1. percentage of attributed patients for which a provider organization has complete R/E, L and/or D data
  2. performance on selected measures stratified by R/E, L and/or D
     - This is a first step to measuring disparity and (in the future) linking incentives to disparity reduction
     - NCQA is requiring payers to stratify the following measures by race/ ethnicity in 2022: Controlling High Blood Pressure, Comprehensive Diabetes Care (HbA1c Control and Eye Exam), Prenatal and Postpartum Care, Well-Child Visits in the First 30 Months of Life, Child and Adolescent Well-Care Visits

NQF # / Status	Measure Name	Steward	Measure Type	Alignment – CT	Alignment – BVT	Measure Set Use
NA	ED Utilization among Members with Mental Illness	Oregon Health Authority	Process	0	1	

Additional Questions to Consider

- Now that the Council has addressed the identified gaps, it must now consider the following questions:
  - Is there the right **balance of process and outcome** measures?
  - Is there the right **distribution of measures across conditions**?
  - Should the Council recommend **adoption of a true core set**, i.e., measures that are recommended for use in *all* contracts, to better balance comprehensiveness and breadth with the need for parsimony.
- Of note, the Council expressed interest in discussing the limitations of pursuing outcome measures in the absence of a health information exchange.
  - The Council will return to this topic after discussing the Quality Benchmarks this summer.

Wrap-up & Next Steps

Meeting Wrap-Up & Next Steps

- Begin the final review of the Core Measure Set to identify whether any changes should be made
- Finalize recommended changes to the Core Measure Set

- Begin discussion of Quality Benchmarks

- Continue discussion of Quality Benchmarks

Appendix

Criteria to Apply to Individual Measures

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

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Criteria to Apply to Individual Measures (Cont'd)

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

Criteria to Apply to the Measure Set as a Whole

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

Data Sources for the Five Considerations

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

Data Sources for the Five Considerations (Cont'd)

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

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

CT State Health Priorities: Needs and Opportunities

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

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

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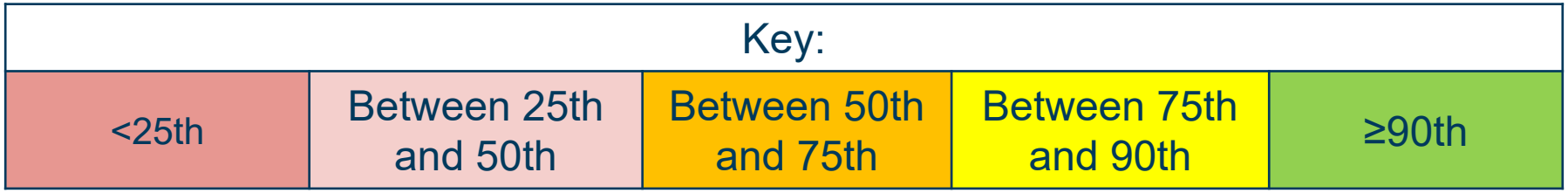
Data Sources for the Five Considerations (Cont'd)

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



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