Meeting of the Quality Council

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

Participant Name and Attendance

Quality Council		
Susannah Bernheim	Lisa Freeman	Andrew Selinger (Co-Chair)
Rohit Bhalla	Karin Haberlin	Marlene St. Juste
Alan Coker (Co-Chair)	Danyal Ibrahim, on behalf of Syed Hussain	Cary Trantalis
Elizabeth Courtney	Michael Jefferson	Orlando Velazco
Sandra Czunas	Paul Kidwell	Jeannette Weiss
Stephanie DeAbreu	Joseph Quaranta	Steve Wolfson
Tiffany Donelson	Brad Richards	Robert Zavoski
Others Present		
Michael Bailit, Bailit Health	Hanna Nagy, OHS	
Jeannina Thompson, OHS	Kelly Sinko, OHS	
Members Absent:		
Steven Choi	Nikolas Karloustsos	Laura Quigley
Amy Gagliardi	Robert Nardino	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 04:03 pm.	
2.	**Public Comment**	**Andy Selinger**
	Andy Selinger welcomed public comment. None was voiced.	
3.	**Approval of February 18, 2021 Meeting Minutes**	**Andy Selinger**
	Paul Kidwell motioned to approve minutes of the Quality Council's February 18th meeting. Michael Jefferson 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**	**Michael Bailit**
	Michael Bailit 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. Michael provided a recap of the February 18th meeting, including the Council's preliminary decision to retain eight measures, remove three measures and revisit two measures – patient experience surveys and Screening for Clinical Depression and Follow-up Plan. Michael summarized the Council's previous discussion on three patient experience surveys: Clinician and Group (CG) CAHPS, a widely used survey; PCMH CAHPS, a supplemental item set that can be added to CG CAHPS; and Person-Centered Primary Care Measure (PCPCM). He reminded the Council that at the last meeting it agreed to review the questions in the PCPCM before deciding on which survey to recommend for inclusion. He shared that the Council liked the PCPCM but acknowledged that the CAHPS surveys were more widely used. Andy asked what the percentage completion rate was for the CG CAHPS survey across various race/ethnicity populations. Michael said completion rates tend to be low (~30%) and are typically higher for commercial populations vs. Medicaid populations. Andy asked whether completion rates would be higher with a shorter survey like the PCPCM. Michael speculated that this could happen but noted that he did not have expertise in survey administration to confirm this. Rohit Bhalla said it is favorable to have a shorter survey. He said longitudinally it would be helpful to be able to benchmark against other entities and states, which is currently easier to do with the CAHPS surveys. Michael noted that there is not a process to develop national benchmarks for CG CAHPS, despite how widely the survey is used. Rohit confirmed that entities other than a PCMH can use the PCMH CAHPS. Lisa Freeman noted that there is a balance between survey length and obtaining meaningful information from the questions. Michael explained that the biggest challenge with selecting the PCPCM is to work towards universal adoption of the survey. Currently, DSS and half of the commercial insurers are using the PCMH CAHPS survey, so it would take time to move payers	

and contracting partners to the PCPCM. Brad Richards suggested signaling that the Council is interested in adopting the PCPCM next year and retaining PCMH CAHPS. This would provide payers with additional time to prepare for implementing the survey. Joe Quaranta asked if it was possible to provide an option to select either the PCMH CAHPS or PCPCM if they are not using either survey now. He added that this would allow some payers and providers to begin using the PCPCM now, if they are ready, and can provide some data on the feasibility of adopting the survey. Michael shared that another option is to retain PCMH CAHPS and request a payer and provider to pilot the PCPCM. Karin Haberlin supported Michael's suggestion, highlighting issues related to survey fatigue. She spoke in favor of retaining the CAHPS survey.

Rob Zavoski noted that he selected the CAHPS survey in the past for Medicaid because there weren't other options available. He spoke in favor of the PCPCM and the pilot idea. Lisa Freeman asked for clarification on what would need to be done during the pilot. Michael explained the pilot would generate data for provider and payer organizations on how to operationalize the measure and whether the measure provides actionable data to improve care. It would ideally consist of one or two payers and a few provider organizations that are not already using a CAHPS survey. This would ideally be done in 2021 so that the Quality Council can review results when it meets in 2022.

Rohit Bhalla confirmed that the PCPCM does not include questions specific to respondent demographic information and requested that these questions be included for the pilot. He noted that these surveys are often rare opportunities to obtain information on patient perceptions of health. He advocated for the CAHPS survey because it includes these questions, and because benchmark data may be available nationally. Orlando Velazco asked if it was possible to do a study as part of the pilot using the CAHPS as a control group and the PCPCM as an intervention group. Steve Wolfson noted that the CAHPS survey is too long and he did not see providers using the survey.

Recommendation: Retain PCMH CAHPS.
Next Steps: The Quality Council will pursue a pilot of the PCPCM and research how to collect demographic information with the survey. Provider and payer organizations of the Quality Council will consider if they are interested in volunteering to be part of the pilot.

Michael Bailit summarized the Council's previous discussion on Screening for Clinical Depression and Follow-up Plan, explaining that the Council was revisiting the measure because it ran out of time during the February meeting before making a final decision on the measure's status. Michael explained that this measure did not define what was a positive screen and only provided broad guidelines for what constitutes a follow-up plan. Andy Selinger confirmed that there was no standard way to code for a positive screen. Michael added that some elements of a follow-up plan can be picked up through a claim, but others need to be obtained through a clinical record.

Joe Quaranta spoke in favor of a depression-focused measure. He expressed concern with a screening and follow-up measure because of the burden associated with collecting clinical data. He advocated for a depression screening measure without follow-up, noting that rates of screening are low and sometimes in the single digit range. Joe added that the current behavioral health resources are limited and should be focused on screening for depression, which can then be used to advocate for more resources to implement interventions. Steve Wolfson, Lisa Freeman and Rob Zavoski agreed with Joe. Marlene St. Juste said that she understood that the follow-up is component is challenge but expressed concern with screening patients without having adequate resources to provide them with treatment. Orlando Velazco noted that a measure that focuses on the use of the PHQ-2 could be helpful screener, but deferred to provider representatives to judge the viability of the idea.

Andy Selinger shared two CPT codes for brief behavioral health screenings that could help capture information for this measure. Rob Zavoski noted that some payers (including CT and MA Medicaid) have added a modifier that identifies whether screens are positive or negative, which could help provide information on screening results. Michael Bailit asked payer representatives on the Council to research whether they use modifiers as Rob described. Andy recommended reaching out to SAMHSA for guidance on behavioral health screens.

Recommendation: Remove measure.
Next Steps: Research a depression screening-only measure.

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

- Depression Remission at Twelve Months
    - Michael explained that other states de-prioritized remission and response measures to focus on getting follow-up visits after a positive depression screen. He recommended not retaining this measure given that the Council recommended dropping Screening for Clinical Depression and Follow-up Plan. Several Council members agreed with Michael.
    - **Recommendation**: Remove measure.
- Depression Response at Twelve Months - Progress Towards Remission

- **Recommendation**: Remove measure.

- Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
  - Michael Bailit explained that this measure tends to have a small denominator.
  - Elizabeth Courtney said that in light of the COVID-19 pandemic and associated mental health impact on students, depression is well documented. She added that there is pressure for PCPs to be more proactive about suicide risk. Michael clarified that this measure is not specific to primary care.
  - Joe Quaranta said it is standard to perform a suicide risk assessment if there is a diagnosis of depression. He expressed concern about capturing data for this measure because of its reliance on clinical data. He was unsure if there was a specific code for suicide risk assessment.
    - Andy Selinger agreed with Joe Quaranta, noting that this measure would require chart review.
    - Joe Quaranta suggested looking into G8932 as an option for coding suicide risk assessment.
  - Michael Bailit highlighted that there is a larger quality measurement infrastructure issue, specifically how to migrate towards measures that are derived from EHR data. This is where measurement is moving nationally, and is a topic for the Council to discuss after it completes its annual review.
  - **Recommendation**: Remove measure.
- Behavioral health screening (pediatric, Medicaid-only, custom measure)
  - Michael Bailit asked the Council if it wished to include a Medicaid-only measure and a measure that is not specified in the Core Measure Set.
  - Rob Zavoski explained the origins of this measure from when he was at Medicaid. He noted that Medicaid is requiring screening children annually (developmental screening in children and behavioral health screening in adolescents) and including a modifier for those who pass or fail their screens so that there is follow-up in one year. If there are two positive screens in a row, children and adolescents are to be referred to services. He agreed that the measure was specific to Medicaid and not appropriate for the Core Measure Set.
  - Alan Coker highlighted that if we exclude a Medicaid-specific measure, we may not capture data on low-income and minority populations.
  - Michael Bailit recommended retaining the measure as a Medicaid-only measure. Joe Quaranta noted that the Council would be revising the topic of a depression screening-only measure at the next meeting.
  - **Recommendation**: Retain measure as Medicaid-only.
- Follow-Up Care for Children Prescribed ADHD Medication
  - Elizabeth Courtney asked why rates were low for this measure. Marlene St. Juste said she thought it was an issue with reporting. Patients have to come back for a follow-up visit in order to receive medications.
  - Rob Zavoski agreed with Marlene, noting that children are prescribed in one location but follow-up often occurs in another location. He added that many stimulant medications are associated with loss of appetite, so providers should pay special attention to a child's weight as well.
  - Michael Bailit noted that performance on this measure was low in absolute terms and also relative to other states. Rob Zavoski added that that this could be because the Northeast has the highest rate of behavioral health providers, so children may be returning to other sites of care for their follow-up.
  - Joe Quaranta said the measure specifications stated that follow-up had to be with the prescribing clinician and occur within 30 days. He spoke in favor of the measure, noting that there are several actionable ways to improve performance.
  - Michael Bailit shared that RI removed this measure because intermittent use of ADHD medication is clinically inappropriate. MA removed the measure because of concerns that physicians might prescribe medications for longer than needed to meet the measure (i.e., gaming the measure). Joe Quaranta did not think either of these concerns were appropriate based on how the measure specifications are written.
  - Lisa Freeman, Andy Selinger, Steve Wolfson and Alan Coker spoke in favor of retaining the measure.
  - Rob Zavoski shared he would favor the measure more if it reflected actual practice better, specifically if follow-up did not need to occur with the prescribing provider. Michael Bailit said this is a limitation of the measure, but the measure overall may do more good than harm.
  - Joe Quaranta added that there is power in this measure because it can accurately capture follow-up for a behavioral health condition. This measure could serve as a gateway for other behavioral health measures. Lisa Freeman and Andy Selinger agreed with Joe.
  - **Recommendation**: Retain measure.
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
  - Michael Bailit noted that this measure would likely also have small denominators because not many children are on antipsychotics.
  - Andy Selinger explained in response to a question that metabolic monitoring included blood sugar and cholesterol. Lisa Freeman asked how metabolic monitoring impacts children on antipsychotics. Michael Bailit said the monitoring was to look for medical side effects of being on antipsychotic medications.

- Andy Selinger spoke against the measure, stating that there were better measures available. Karin Haberlin agreed with Andy and asked whether there was a parallel measure for adults, noting that adults with behavioral health diagnoses tend to die 20-25 years earlier than the general population and metabolic disorders are a part of that. Michael Bailit shared that such a measure would be more appropriate for DSS rather than for commercial and Medicaid populations combined.
- Rob Zavoski said the side effects of antipsychotic medications are potentially lifelong and dire, adding that children rapidly gain weight and can become morbidly obese. Andy Selinger confirmed that these prescribing activities are done by psychiatrists, but the metabolic monitoring can occur elsewhere. Rob noted that providers often assume a different provider is monitoring, and in the end no one is monitoring.
- Joe Quaranta said this measure addressed a high-risk, underserved group. He spoke in favor of this measure because it could draw attention to an important population.
- Michael Bailit reminded the Council that the purpose of the Core Measure Set was to create alignment in measures in use in contracts by insurers and providers. He asked Joe Quaranta if he would use this measure in such context. Joe said he would not because of denominator issues, but he would use it for monitoring at a statewide level.
- Susannah Bernheim highlighted that many measures are narrow in scope, but touch upon behavioral health access for children, which is important. She asked if it was possible to highlight this as an issue in the gaps analysis and research if there is another measure that has a larger denominator.
- Michael Bailit observed that there is a broader issue, which is that there are defined subpopulations that have significant burden of illness and lots of health risks, but for which denominators tend to be quite small when applied at the provider organization level. As a result, these populations are often left out of measure sets. Susannah added that this measure could be added to the measure set, but DSS would be the only payer one who ends up using the measure.
- Rob Zavoski noted that the measure is asking PCPs and psychiatry to communicate about key health issues. There is a narrow opportunity to meaningfully improve health outcomes. He shared that this was "low-hanging fruit." Brad Richards agreed with Rob, noting that there were not better measures currently available.
- **Recommendation**: Retain measure.

- Medication Management for People with Asthma
  - Michael Bailit explained that because the measure had been retired by NCQA, the Council could not continue to use it. He described an alternative, similar measure in use by NCQA – Asthma Medication Ratio.
  - Rob Zavoski expressed concern about Asthma Medication Ratio for children because children are dispensed controller medications for home, but obtain rescue medications for multiple locations (e.g., school, home). As a result, it appeared as if children were overusing rescue medications even if they were actually being well-prepared. He added that the measure was okay for adults. Joe Quaranta expressed agreement with Rob.
  - Rohit Bhalla shared that he did not like that the measure looked at dispensed medications.
  - Tiffany Donelson agreed that this may not be the perfect measure, but highlighted that uncontrolled asthma frequently happens in children in color. She asked if there was an alternative measure to consider. Michael noted that available asthma measures have been a persistent source of frustration for many measure selection bodies across the country. He said Asthma Medication Ratio has been adopted most often, despite misgivings. He asked if the limitations were so profound so as not to include the measure.
  - Joe Quaranta, reading from the specifications, noted that if multiple inhalers were prescribed on the same day, it only counted as one event. He said this might help address some of the concerns Rob Zavoski had raised. Joe spoke in favor of retaining the measure, despite its limitations given the importance of asthma. Marlene St. Juste said she agreed with Joe.
  - Rob Zavoski said that he had been swayed by Tiffany, with the caveat that performance rates for children may be worse than reality.
  - **Recommendation**: Drop Medication Management for People with Asthma.
  - **Recommendation**: Add Asthma Medication Ratio.
- Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
  - Michael shared this measure is in wide use nationally and in Connecticut, and diabetes is a state health priority. He recommended retaining the measure.
  - Joe asked if HbA1c Control (<8.0%) was in the measure set. Michael said states typically gravitate towards >9.0% because of concerns associated with excessive HbA1c control in some subpopulations.
  - **Recommendation**: Retain measure.

5.	**Gaps Analysis of the Core Measure Set**	**Michael Bailit**

Michael introduced the purpose of the gaps analysis, which is to consider whether the Core Measure Set is representative and balanced as it relates to domain, condition, measure type, data source, population and alignment with the Council's measure selection criteria. He summarized the gaps Bailit Health had identified in the Core Measure set, which included equity (inclusive of infant mortality and low birthweight racial gap, lead screening), oral health, hospital/inpatient care (inclusive of

	maternity care) and substance use treatment. He asked the Quality Council to identify any additional gaps. He explained that at a future meeting, Bailit Health will ask the Council to prioritize gaps and select measures to fill the gaps. At that time, the Council will also consider replacing some process measures with outcome measures, and potentially more evenly spreading measures across conditions. The Council will also consider adopting a true core set, or measures that are recommended for use by all payers in all contracts, which MA and RI has in place for their measure sets. Council members should share any measure gaps and/or measure recommendations to fill the gaps with Hanna Nagy (Hanna.Nagy@ct.gov) by March 31st (of note, the original deadline was March 26th, but OHS extended the deadline following the Quality Council meeting).	
6.	**Adjourn**	**Andy Selinger**
	Joe Quaranta made a motion to adjourn the meeting. Lisa Freeman seconded the motion. There were no objections. The meeting adjourned at 5:55 pm.	