Meeting of the Quality Council

Meeting Date	Meeting Time	Location
May 20, 2021	4:00 pm – 6:00 pm	Webinar/Zoom

Participant Name and Attendance

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

Meeting Information is located at: https://portal.ct.gov/OHS/SIM-Work-Groups/Quality-Council/Meeting-Materials

	Agenda	Responsible Person(s)
1.	**Welcome and Introductions**	**Andy Selinger**
	Andy Selinger called the meeting to order at 4:04 pm.	
2.	**Public Comment**	**Andy Selinger**
	Andy Selinger welcomed public comment. None was voiced.	
3.	**Approval of April 15, 2021 Meeting Minutes**	**Andy Selinger**
	Michael Jefferson motioned to approve minutes of the Quality Council's April 15th meeting. Rohit Bhalla seconded the motion. No one objected or abstained from approving the meeting minutes. The motion passed.	
4.	**Continue Review of Measure Proposals**	**Michael Bailit/Deepti Kanneganti**
	Michael Bailit reminded the Council that it previously recommended pursuing a pilot of the Patient-Centered Primary Care Measure (PCPCM) to increase awareness and use of the survey tool before including it in the Core Measure Set. Michael summarized some national and state efforts supporting adoption of the PCPCM that Andy Selinger found when speaking with the measure developer, including National Quality Forum (NQF) and CMS endorsement expected in 2021, among others. He asked if any plan or provider organizations in the Quality Council was willing to participate in the pilot given the national and state movement towards using the measure. Brad Richards said the Department of Social Services (DSS) is interested in being part of the pilot but cannot commit to joining a pilot at this time. Rohit Bhalla shared that when there is a survey for an advanced practice network, there is usually a contracted vendor that administers the survey. He noted that it is important to ensure that vendors can administer the survey in order for there to be long-term adoption of the measure. Michael noted that there were not any payer or provider organizations volunteering to participate in the pilot. He recommended revisiting the pilot recommendation in the future to see if there are any new organizations that are interested and able to participate. Michael summarized the recommendations from the April meeting, which included retaining two measures, removing four measures and replacing one measure in the Core Measure Set. The Council also began its review of measure proposals to fill two gaps (i.e., behavioral health and health equity), and recommended retaining one measure and adding two measures. The Quality Council continued its review of behavioral health measure proposals to fill gaps in the Core Measure Set. Michael introduced seven substance use measures for the Council's consideration: • Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET) ○ Michael shared that the MA Measure Alignment Taskforce (a body similar to the Quality Council), as well as its specially convened subgroup of substance use experts, expressed a strong dislike for this measure because of concerns about the measure's validity. This is, however, a widely used HEDIS measure. • Follow-Up After Emergency Department Visit for Alcohol and Other Drug (AOD) Abuse or Dependence • Alcohol and Drug Misuse: Screening, Brief Intervention and Referral for Treatment (SBIRT)	

- Michael shared that Oregon developed this measure based on federal SBIRT requirements. Beginning in 2021, it is being implemented as an EHR-based measure (it previously relied on medical record review).

- Substance Use Assessment in Primary Care
  - Michael shared that the MA Taskforce will adopt this measure as a pay-for-reporting (P4R) measure in 2023 and a pay-for-performance (P4P) measure in 2024. He noted that it is a claims-based measure, which requires practices to code for the assessment being performed. Michael added that the Taskforce preferred to adopt an assessment and follow-up measure, but such a measure currently does not exist. Finally, Michael shared that this measure is currently focused on adults, but the Taskforce hopes that it will include adolescents in the future.
- Concurrent Use of Opioids and Benzodiazepines
  - Michael explained that this is a "Developmental" measure in RI, which means the RI Work Group hopes to adopt the measure in its "Core" and "Menu" sets the future.[1]
- Use of Pharmacotherapy for Opioid Use Disorder
- Continuity of Pharmacotherapy for Opioid Use Disorder
  - Michael noted that the MA Taskforce substance use experts liked this measure a lot and recommended that it remain in the state's "Menu" set.

Michael asked the Council for its opinion on the substance use measures.

- Andy Selinger said the Council needs a substance use measure and expressed his preference for adopting two measures – one focused on screening and the other focused on continuity. He noted that the pharmacotherapy measures could serve as the continuity measure. Andy said that between the two pharmacotherapy-focused measures, he preferred Continuity of Pharmacotherapy for Opioid Use Disorder because it assesses performance for people with at least 180 days of treatment.
- Joe Quaranta shared that the proposed measures fall into three categories – (1) general population-based screening measures, (2) measures to identify people with opioid disorders and (3) measures that evaluate management of opioid use disorder. He explained that population-based screening measures will have larger denominators, whereas the other two categories may have insufficient denominator sizes at the provider organization level. He shared that Concurrent Use of Opioids and Benzodiazepines has reliable data, is producible and assesses a broad number of patients (including those who do not have opioid use order). Joe shared that he did not think there would be sufficient denominator size for either pharmacotherapy-focused measures, especially given that primary care providers typically do not manage opioid use disorder.
- Karin Haberlin shared her preference for including both a screening measure and an engagement/continuity measure. She noted that the IET measure is in wide use and said it would be important to consider if people are staying in treatment in 30 days, especially given the stigma associated with substance use treatment. She said the Concurrent Use of Opioids and Benzodiazepines measure is important because that combination can be quite deadly. She said if she had to pick, she would choose IET and the Use of Pharmacotherapy for Opioid Use Disorder (because the latter assesses an effective treatment and performance varies significantly by race, ethnicity and socioeconomic status).
- Brad Richards said CMS recently announced that physicians can prescribe buprenorphine without the "X-waiver" requirement, which increases its availability. He added that the Use of Pharmacotherapy for Opioid Use Disorder therapy measure will capture initiation of treatment, which is important. He agreed that it would be helpful to have a screening measure.
- Andy Selinger spoke in favor of Substance Use Assessment in Primary Care because it has the most "bang for the buck." Steve Wolfson agreed with Andy, noting that it is the least burdensome measure, which could increase adoption of the measure. Joe Quaranta confirmed that the measure would be easy to adopt because it assesses provision of a service that providers already are doing and code for.
- Susannah Bernheim asked why the MA Taskforce did not like IET. Michael explained that it was primarily because it viewed the measure as lacking validity (a higher rate could indicate worse performance).
- Rob Zavoski shared that he would endorse Use of Pharmacotherapy for Opioid Use Disorder. He also spoke in favor of Concurrent Use of Opioids and Benzodiazepines, noting that the percentage of people on both drugs in CT is staggering. He said most PCPs may not know if their patient is simultaneously using both drugs because another provider is writing the script. He said it would be easy to implement using claims data.
- Rohit Bhalla spoke in favor of Substance Use Assessment in Primary Care because it includes a broad population and can move the needle on an important topic. He also spoke in favor of Concurrent Use of Opioids and Benzodiazepines, noting that a lot of opioid use is because people are using both drugs.

[1] A "Core" set measure is a measure that is expected/required to be used in all contracts between a payer and a provider organization. A "Menu" set measure is a measure that can be used, but is not expected/required to be used in all contracts. In MA, payers and provider organizations are voluntarily aligning with the measure set. In RI, commercial payers are required to adhere to the measure set and Medicaid is voluntarily aligning.

- Michael proposed including all three measures for this this year because they are claims-based. He asked if DSS and a commercial payer could run the measures at the Advanced Network (AN) level in the next year to confirm if the denominator sizes are meaningful. Brad confirmed that DSS could do so. There were no commercial payer volunteers. OHS will follow up individually with the payers.

Recommendation: Add Substance Use Assessment in Primary Care, Concurrent Use of Opioids and Benzodiazepines and Use of Pharmacotherapy for Opioid Use Disorder.
Next Steps: OHS will reach out to commercial payers that can volunteer to run the claims-based substance use measures in the next year to confirm if there are sufficient denominator sizes at the Advanced Network level. It will follow up with DSS and any commercial payer volunteers to obtain the requested data.

Michael introduced one additional tobacco use measure for the Council's consideration.

- Tobacco Use and Help with Quitting Among Adolescents
  - Michael shared that the MA Taskforce did not include this measure because it excludes vaping, which is a common form in which adolescents use tobacco. He recommended revisiting tobacco-focused measures in the future, noting that measure stewards are likely update their measures to incorporate vaping.
  - Andy agreed with Michael, noting that that the Council's time is best spent on other priorities until there are better tobacco measures available.
  - **Recommendation**: Do not add.

Michael reminded the Council that health equity was of greatest importance to the Council. He described one framework that the Council could use to classify health equity measures – measures applied at the total population-level for which there are known disparities, measures that assess removal of barriers to equity, measures that assess collection of race, ethnicity, language and disability status (RELD) data and measures that assess disparities by stratifying performance by RELD, gender, geography, etc. He introduced several health equity measures:

- Lead Screening in Children
  - Michael said this is a measure applied for the full population for which there are known disparities. He explained that 26 percent of housing stock in CT has lead risk and Black and Hispanic children are more likely to have lead poisoning before turning six compared to non-Hispanic White children.
- Meaningful Access to Health Care Services for Persons with Limited English Proficiency
  - Michael noted that this is a new measure developed by the Oregon Health Authority for 2021.
- Health-related Social Needs Screening (MA steward) / Social Determinants of Health (SDOH) Screening (RI steward)
  - Michael shared that these two measures were developed with the assumption that if a person screens positive, they will be referred to services. Only screening measures exist today, but in the future it is likely that there will be measures focused on referral to and receipt of services. There are no national measures today, but there are two homegrown measures developed by MA and RI for their Medicaid programs. The RI is also included in the State's multi-payer measure set. Michael explained that NC also developed a measure for use with health plans, not providers, and OR is in the process of developing a measure.
  - Michael shared that the MA measure is for the whole attributed population whereas RI is for all patients with a visit. Deepti described the different required domains for each measure.
- Measure concept: Collecting RELD data
  - Michael shared that Covered California has been requiring plans to collect self-reported race and ethnicity data for its enrollees since 2018.
- Measure concept: Stratifying performance for select measures by RELD
  - Michael shared that NCQA is starting to require plans to stratify measures for a few select NCQA measures by race and ethnicity. He added that Covered California is now planning to require plans to demonstrate a reduction in the gap between the race/ethnicity category with the lowest performance and the plan average.
  - Michael shared that the MA Taskforce recently endorsed adding a pay-for-reporting measure that requires ACOs to report stratified performance for four measures by race, ethnicity and language: Comprehensive Diabetes Care: HbA1c Poor Control, Controlling High Blood Pressure, Screening for Clinical Depression and Follow-up Plan and Well Child Visits in the First 30 Months of Life. Deepti added that Rhode Island Medicaid is developing a similar measure.
- ED Utilization among Members with Mental Illness
  - Michael shared that OR found that disparities were greatest for members with mental illness, and therefore developed a measure looking at ED use specifically for individuals with mental illness.

Michael asked the Council for its opinion on the health equity measures.

- Rohit Bhalla expressed interest in measures that involve stratification because they build on existing measures that providers have worked so hard on and builds on federal efforts to require EHRs and patient-centered medical homes (PCMHs) to collect race/ethnicity data.
- Andy Selinger spoke in favor of adopting a SDOH measure, noting that there are domains for which providers are not collecting data. He said there are simple screens, some as few as 10 questions, that could move the needle. He said it was important that this is recognized and quantified for members of health plans.
- Tiffany Donelson agreed with Andy. She added that stratification is critically important, noting that "we can't improve what we're not measuring." She said that the quality measures should reflect the statewide effort to capture race/ethnicity data and reduce disparities.
- Steve Wolfson also spoke in favor of stratifying measures, acknowledging that this is a change in the health care system which previously tried to be agnostic to a patient's race/ethnicity. Steve added that there should also be a focus on translator services because they are frequently not available.
- Lisa Freeman supported measures focused on SDOH and stratification. She added that stratification is especially important for HbA1c- and blood pressure-focused measures that have clear disparities in performance. Lisa shared that patients who actively engage with their portal have better health outcomes than those who don't, sometimes because of developmental disabilities. She noted that this could be another health equity-focused measure to consider that is different than the traditional measures focused on race/ethnicity.
    - Michael said there is not a measure that currently exists that assesses portal use. He explained that CT could theoretically develop such a measure, but that would require significant effort and resources.
- Susannah Bernheim said that there will need to be a stepwise approach to addressing health equity. She spoke in favor of a two-phase approach that starts with collecting RELD data and stratifying existing measures before moving towards paying for closing gaps in performance.
- Steve Wolfson highlighted that the Council had not yet discussed data privacy when it comes to collecting RELD data, especially for undocumented populations. Michael noted that some patients will decline to share RELD data, which the health care system will need to accept. Steve agreed with Michael.
- Karin Haberlin spoke in favor of SDOH and stratification. She noted that there are more health equity variables beyond race/ethnicity, such as access to information and transportation. She noted that there could be additional reasons for why patients may not use a portal, including lack of interest and/or access to digital technology/ infrastructure.
- Joe Quaranta summarized that the Council appeared to be interested in adopting two types of measures – screening patients for SDOH and stratifying outcome-based measures by RELD. Michael agreed with Joe and outlined three outstanding questions – which SDOH measure should the Council adopt, 2) which measures should the Council stratify and by what factors (e.g., race, ethnicity, language and/or disability status) and 3) what does the path towards gap reduction look like? He recommended that Bailit Health develop a proposal for the Council to consider it at the next meeting.

Recommendation: Adopt two measures – one focused on SDOH screening and one on stratifying measures by RELD.
Next Steps: Bailit Health will develop a proposal for the Council to consider in the June meeting, which will consist of a recommended SDOH screening measures, recommended measures to stratify by RELD and a framework for moving towards adopting measures focused on reducing gaps in measure performance.

The Council then considered the Core Measure Set in full after recommendations made during today's meeting. Deepti described the current composition of the Core Measure Set and asked if there was the right balance of process and outcome measures.

- **Post-meeting note**: As of May 20, 2021, there were 22 process measures (81%), three outcome measures (11%), one patient experience measure (4%) and one to-be-determined (TBD) measure (4%). The TBD measure will be updated based on which measures the Council recommends for stratification by RELD.
- Andy Selinger confirmed that the three outcome measures were Plan All-Cause Readmission, Comprehensive Diabetes Care: HbA1c Poor Control and Controlling High Blood Pressure.
- Elizabeth Courtney said she wasn't sure if this was the right question to ask given that the Council comprehensively considered which measures to recommend during the annual review. She said she was comfortable with the current distribution because each measure has been so thoroughly examined.
- Deepti agreed with Elizabeth that that Council considered each measure thoughtfully before making a final recommendation about its inclusion. She noted that the Council could strive to adopt more outcome measures moving forward. Steve Wolfson agreed with Deepti, and added that there were not good outcome measures available during the annual review.
- Susannah Bernheim said one of the limitations of adopting outcomes measures is due to the care setting. She explained that CMS has a fair number of outcome measures, but they're focused on what happens after a hospital visit. She noted

that there are more outcome-focused measures the Council could consider when it discusses hospital measures, including readmission measures, patient safety measures, and patient-reported outcome measures.
    - Deepti noted that patient safety and patient-reported outcomes were identified measure gaps that the Council will consider next year.
- Lisa Freeman shared that many measures do not capture the patient's perspective. She noted that while CAHPS measures are good, they are limited. She said she did not want to delay this year's annual review, but wanted to commit to considering more patient-reported outcomes and patient safety measures next year.
- Rob Zavoski highlighted that over time, several process measures can be used to predict outcomes. For example, breast cancer screening and positive mammograms can predict patient outcomes.
- Susannah Bernheim noted that one of the Council's priorities was to focus on outcome measures. She said that while some process measures are good predictors of outcomes, CT will not move far on equity if it is focused on closing gaps in processes of care. She asked what the Council would do if it decided that the balance of process and outcome measures is not okay.
    - Deepti explained that this is a topic the Council will need to defer to next year given that it hopes to finalize its recommendations in the June meeting. She added that some outcome measures can have a greater impact on health status than process measures, which should be recognized. For example, if the Council recommended stratifying performance for outcome measures by RELD, that can have a significant impact on patient outcomes.
    - Michael added that this year was the first annual review of the Core Measure set in quite some time. He explained that in next year, the Council will spend less time reviewing existing measures and will have more time to step back to answer the question "could we add more outcome measures and rebalance the measure set?"
- **Next Steps**: Revisit the balance of process and outcome measures during the annual review for the 2023 Core Measure Set.

Deepti described the current distribution of measures across conditions and asked the Council to consider if it recommended any changes given this information. The Council did not recommend any changes.

- **Post-meeting note**: As of May 20, 2021, there were nine behavioral health-focused measures (33%), three cancer-focused and diabetes-focused measures (11% each), two infectious disease-focused and health equity-focused measures (7% each), one cardiovascular-focused, patient safety-focused, pregnancy-focused and respiratory-focused measures (4% each) and four other measures (15%), which includes three well-visit measures and the CAHPS survey.

Deepti described the idea of a true core set, i.e., a set of measures that recommended for use in all payer/accountable network contracts. She explained that the Council will discuss whether to adopt a true core set during the June meeting when it finalizes its recommended changes to the Core Measure Set. In the June meeting, the Council will also review OHS' scoring of the measures recommended for the Core Measure Set against the Council's measure selection criteria. Deepti noted that the scoring exercise is meant to serve as a decision aid for the Council, as low-scoring measures may still be worthy for inclusion in the final Core Measure Set.

Deepti shared two questions the Council will consider after it discusses the Quality Benchmarks: 1) how can CT pursue outcome measures in the absence of a health information exchange and 2) should the Council promote use of modifiers to identify when depression screens are positive, and if so, how?

5. Begin Discussion of Quality Benchmarks — **Deepti Kanneganti**

Deepti Kanneganti provided an overview of the Quality Council's charge for the Quality Benchmarks. Executive Order #5 states that the Council will develop benchmarks to become effective on January 1, 2022 that the benchmarks shall ensure the maintenance and improvement of healthcare quality, shall be applied across all public and private payers and *may* include clinical quality, over- and under-utilization and patient safety measures. She noted that the Council must solicit input from DSS, the Department of Public Health, the Insurance Department and OHS' Technical Team. Deepti added that the Council may wish to align its work with Medicaid's cost and quality reporting. Brad Richards will provide an overview of this scope of work, as directed in Executive Order #6, during the July meeting.

Andy Selinger asked about the difference between a quality measure and a quality benchmark. Deepti noted that the Core Measure Set only identifies a menu of measures that payers and providers can use in contracts but does not specify what the targets should be for each measure. The quality benchmarks, on the other hand, will identify both specific measures and statewide performance targets for each measure. Michael added the definition of quality for the benchmarks is broader than for the Core Measure Set because it can capture population health-focused metrics across the state's entire population.

Deepti explained the two types of quality benchmarks. Health status measures are measures that quantify certain population-level characteristics of CT residents (e.g., statewide adult obesity rates, opioid-related overdose deaths). This category of

measures is broader than healthcare measures, which quantify performance on healthcare processes or outcomes and are assessed at the state, market, insurer and provider levels (e.g., ED utilization, cancer screening rates, children who received preventive services). She asked the Council for its feedback on which types of measures it recommended.

- Andy Selinger said the quality benchmarks provided an opportunity to adopt health status measures and relate it back to RELD stratification.
- Elizabeth Courtney and Lisa Freeman agreed with Andy. Elizabeth said it was exciting to consider health status measures and consider the big picture of what impacts health. Lisa noted that health status measures capture real life decisions that can impact health outcomes. Lisa noted that the health status measures would provide another opportunity for the Council to add more outcome-focused measures.
- Andy Selinger and Steve Wolfson spoke in favor of adoption dental care measures. Steve said the Council should also consider adult-focused dental care measures, noting its impact on employment. Deepti shared that there are several adult-focused dental care measures from the Dental Quality Alliance that the Council could consider.
- Lisa Freeman agreed with Andy and Steve and highlighted the correlation between dental health and physical health. Lisa and Elizabeth Courtney noted that dental care measures could also be a proxy for measuring health equity.
- Rob Zavoski said health status measures are important because they are the state's aspirational goals. He said once the Council selects health status measures, it will likely use healthcare measures to impact statewide performance.
- Paul Kidwell asked how to measure performance on the quality benchmarks and whether it was important to select healthcare measures that are applicable across all providers. Deepti noted that Delaware aggregated performance across payers to obtain state- and market-level performance.
- Paul Kidwell asked how to capture dental care performance, specifically if it would be limited to Medicaid or medical dental claims. Deepti noted that it is challenging to incorporate dental measures in a medical health care contract because medical providers do not have access to dental claims data. She said most contracts focus on medical dental claims (e.g., preventive care services that can be performed by a health care provider). She added that the Council could look into whether it was feasible to acquire dental claim information.

Deepti shared that the Council previously identified an interest in behavioral health, health equity, patient safety, care experience and dental as topics of interest. She asked if the Council had any additional priorities.

- Elizabeth Courtney expressed a preference for selecting measures that align with the statewide health priorities. She added that childhood obesity is another area of interest, especially given the impact of COVID-19 on obesity.
- Steve Wolfson agreed with Courtney and recommended focusing on childhood and adult obesity simultaneously. He noted that obese adults don't look at obese children as a problem.
- Steve Wolfson added that education has a big impact on obesity. Elizabeth Courtney asked how broad could the quality benchmarks be? Deepti said that the measures need to have a reliable data source and be related to healthcare, but otherwise could be fairly broad.
- Andy Selinger noted that he was interested in pursuing both over- and under-utilization and patient safety measures, as highlighted in the Executive Order, because it can help identify high-value care processes on which to focus.
- Lisa Freeman said over- and under-utilization leads to medical harm and medical errors in many cases. She said she considered these as patient safety measures. Lisa added that over- and under-utilization has a big cost impact as well.

Deepti asked the Council to share its feedback on 1) which criteria the Quality Council should use to select measures, 2) whether the quality benchmarks should draw from the Core Measure Set and 3) any additional topics of interest. Council members can email Hanna Nagy (Hanna.Nagy@ct.gov) with their thoughts by Friday, May 28th.

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

Steve Wolfson made a motion to adjourn the meeting. Rob Zavoski seconded the motion. There were no objections. The meeting adjourned at 5:58 pm.