Quality Council
May 20, 2021

OHS
CONNECTICUT
Office *of* Health Strategy

Agenda

Time	Topic
4:00 p.m.	Call to Order
4:05 p.m.	Public Comment
4:15 p.m.	Approval of April 15, 2021 Meeting Minutes
4:20 p.m.	Continue Review of Measure Proposals
4:55 p.m.	Break
5:00 p.m.	Continue Review Measure Proposals
5:30 p.m.	Begin Discussion of Quality Benchmarks
5:55 p.m.	Wrap-up & Next Steps
6:00 p.m.	Adjourn

Call to Order

Public Comment

Approval of April 15, 2021 Meeting Minutes

Continue Review of Measure Proposals

Recap of the April 15, 2021 Meeting

- The Council **continued its review of the Core Measure Set**, making the following recommendations:
  - **Retain (2)**: Comprehensive Diabetes Care: Eye Exam, Controlling High Blood Pressure
  - **Remove (4)**: Comprehensive Diabetes Care: HbA1c Testing, Use of Imaging Studies for Low Back Pain, Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis, Appropriate Treatment for Upper Respiratory Infection
  - **Replace (1)**: Comprehensive Diabetes Care: Medical Attention for Nephropathy with Kidney Health Evaluation for Patients with Diabetes
- The Council identified overuse as a measure gap, specifically measures that focus upon:
  - low-back pain treatment using alternate therapies (e.g., physical therapy) and location of where treatment is received (e.g., ED), and
  - primary care and readmissions.

Recap of the April 15, 2021 Meeting (Cont'd)

- The Council **began its review of measure proposals** to fill two gaps – behavioral health and health equity – making the following recommendations:
  - **Retain (1):** Screening for Depression and Follow-up Plan
  - **Add (2)**: Follow-up After Hospitalization for Mental Illness (7-Day), Follow-up After Emergency Department Visit for Mental Illness (7-Day)
  - **Do Not Add (2)**: Depression Utilization of the PHQ-9 Tool, Antidepressant Medication Management*
- The Council will discuss the other identified measure gaps during the 2022 annual review process.

*The Council recommended revisiting this measure during the 2022 annual review process.

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Behavioral Health: Substance Use

BVT = Buying Value Tool

NQF # / Status	Measure Name	Steward	Measure Type	Alignment – CT	Alignment – BVT	Measure Set Use in MA and RI
0004 (Endorsed)	Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment	NCQA	Process	4	7	MA Menu, 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 in MA and RI
NA	Substance Use Assessment in Primary Care	Inland Empire Health Plan	Process	0	0	Proposed MA Menu addition in for 2022
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 in MA and RI
2803 (No Longer Endorsed)	Tobacco Use and Help with Quitting Among Adolescents*	NCQA	Process	1	1	MA Developmental (proposed for removal for 2022)

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

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) data
  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

- America's Health Rankings rated CT as 46th on the Housing with Lead Risk measure (26.6% of housing stock have lead risk in CT compared to the national average of 17.6%).
  - According to Healthy CT 2025, the Black (3.9%) and Hispanic (2.7%) children are more likely than non-Hispanic White (1.7%) children to have lead poisoning before turning six.

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

Health Equity:
Total Population Measures with Known Disparities (Cont'd)

- 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.

Health Equity:
Measures that Assess Removal of Barriers to Equity

NQF # / Status	Measure Name	Steward	Measure Type	Alignment – CT	Alignment – BVT	Measure Set Use in MA and RI
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 likely evolution of SDOH measures is as follows:

SDOH Screening → **Referral to Services** → **Improved Outcomes following Referral**

- There is little standardization of SDOH measures today. All measure options are homegrown and focus on screening.

NQF # / Status	Measure Name	Steward	Measure Type	Alignment – CT	Alignment – BVT	Measure Set Use in MA and RI
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 RELD Data

- Other states are pursuing new measures to improve RELD data capture and measure stratification.
- One way to do this is to encourage provider organizations to collect complete RELD data for its patients.

Measure concept from RI Medicaid: percentage of attributed patients with a primary care visit for whom their attributed primary care provider possesses their race, ethnicity and language data

https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/Attachment_K_PY4_Incentive_Program_Requirements.pdf

Health Equity:
Measures Involving Stratifying Performance by RELD

- Providers with complete RELD data can stratify performance for select measures 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	

Health Equity:
Measures Involving Stratifying Performance by RELD (Cont'd)

- Covered California has been requiring plans to collect self-reported race / ethnicity data for its enrollees since 2018.
- Beginning in 2020, it has required plans to demonstrate a reduction in disparities in performance for select measures.
  - For 2022, it is proposing to assess the disparities gap for Comprehensive Diabetes Care: HbA1c Control and Controlling High Blood Pressure.
  - Specifically, it assesses whether the gap between the race/ethnicity category with the lowest performance and the plan average decreases by a certain percentage each year.

https://hbex.coveredca.com/stakeholders/plan-management/library/2022-Attachment-14-Draft_Clean-1-14-21.pdf

Additional Questions to Consider

- Now that the Council has addressed the identified gaps, it must now consider the following questions *(note: tables reflect distribution of measures as of 4-15-2021)*:

1. Is there the right **balance of process and outcome** measures?

Process	Outcome	Patient Experience	Total
18 measures (82%)	3 measures (13.5%)	1 measure (4.5%)	**22 measures** (100%)

2. Is there the right **distribution of measures across conditions**?

Cancer	Cardio-vascular	Diabetes	Infectious Disease	Behavioral Health	Patient Safety	Pregnancy	Respiratory	Other*	Total
3 (14%)	1 (4.5%)	3 (14%)	2 (9%)	6 (27%)	1 (4.5%)	1 (4.5%)	1 (4.5%)	4 (18%)	22 (100%)

*Includes 3 well-visit/developmental screening measures and 1 patient experience measure.

Additional Questions to Consider (Cont'd)

3. Should the Council recommend **adoption of a true core set** within the larger 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, there are two questions the Council will return to after discussing Quality Benchmarks over the next few meetings:
  - How can CT pursue outcome measures in the absence of a health information exchange?
  - Should the Council promote use of modifiers to identify when depression screens are positive or negative (as CT and MA Medicaid are currently doing), and if so, how?

Final Review of Measures

- Before the next meeting, OHS and Bailit Health will score the measures recommended for inclusion in the Core Measure Set against the Council's measure selection criteria.

- It will present the results of this analysis in June, at which time the Council can finalize its recommendations for the MY 2022 Core Measure Set.

Quality Benchmarks

Overview of the Quality Council's Charge for the Quality Benchmarks

- As a reminder, Executive Order #5 charges the Quality Council with developing healthcare quality benchmarks to become effective on January 1, 2022. 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.
- The Council must solicit input from the following: Department of Social Services (DSS), Department of Public Health (DPH), Insurance Department (CID) and OHS' Technical Team.
- The Council may wish to coordinate its work with DSS, which is developing a public transparency strategy for Medicaid cost and quality reporting, as directed by Executive Order #6.

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Quality Benchmark Design Decisions

- As previously discussed, there are three key design decisions that the Council will need to consider in order to develop the Quality Benchmarks:
  1. What **criteria** should the Quality Council use to select measures?
  2. Which **measures** should the Quality Council select for the quality benchmarks?
  3. What **values** should the Quality Council adopt for the quality benchmarks?
- In order to answer these questions, the Council must first provide OHS with some guidance on what direction it wishes to pursue with regards to the Quality Benchmarks.

Preparation for June Quality Benchmark Discussion

1. What **criteria** should the Quality Council use to select measures?
   - Should the criteria be related to those used by the Council to select the Core Measure Set?
   - Please consider these questions and email Hanna with any recommendations you may have at Hanna.Nagy@ct.gov by Friday, May 28th.

Preparation for June Quality Benchmark Discussion (Cont'd)

2. Which **measures** should the Quality Council select for the quality benchmarks? Let's start by assessing measure types. Does the Council wish to focus on:
   - **health status measures**, which quantify certain population-level characteristics of CT residents?
     - e.g., statewide adult obesity rate, high school students who were physically active, opioid-related overdose deaths, statewide adult tobacco use
   - **healthcare measures**, which quantify performance on healthcare processes or outcomes and are assessed at the state, market, insurer and provider levels?
     - e.g., Emergency Department (ED) utilization, beta-blocker treatment after heart attack, statin therapy for cardiovascular disease, cancer screening rates, children who received preventive dental services
   - **both**?
   - **something else**?

Example of Quality Benchmarks from Delaware: https://dhss.delaware.gov/dhcc/files/benchmarkproposedqlty04092021.pdf

Preparation for June Quality Benchmark Discussion (Cont'd)

2. Which **measures** should the Quality Council select for the quality benchmarks?
   - Should the Benchmarks draw from the **Core Measure Set**?
   - What are the **specific topics of interest** the Council wishes to address via the Quality Benchmarks?
     - The Council identified the following priorities for the Core Measure Set: behavioral health, health equity, patient safety and care experience.
     - Executive Order #5 also highlighted over- and under-utilization and patient safety as possibilities.

Wrap-up & Next Steps

Meeting Wrap-Up & Next Steps

- Review results of scoring measures against selection criteria
- Finalize recommended changes to the Core Measure Set
- Begin discussion of Quality Benchmarks

- Continue discussion of Quality Benchmarks

- Continue discussion of Quality Benchmarks

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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.

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.