Meeting of the Quality Council

Meeting Date	Meeting Time	Location
August 19, 2021	4:00 pm – 6:00 pm	Webinar/Zoom

Participant Name and Attendance

Quality Council		
Susannah Bernheim	Danyal Ibrahim (representing Syed Hussain)	Andy Selinger (Chair)
Rohit Bhalla	Michael Jefferson	Daniel Tobin
Stephanie De Abreu	Nikolas Karloustos	Orlando Velazco
Tiffany Donelson	Doug Nichols	Jeannette Weiss
Lisa Freeman	Joe Quaranta	Steve Wolfson
Amy Gagliardi	Laura Quigley	Rob Zavoski
Karin Haberlin	Brad Richards	
Others Present		
Michael Bailit, Bailit Health	Kelly Sinko, OHS	Olga Armah, OHS
Deepti Kanneganti, Bailit Health	Jeannina Thompson, OHS	Donna Balaski, DSS
Hanna Nagy, OHS	Krista Moore, OHS	
Members Absent:		
Elizabeth Courtney	Paul Kidwell	Marlene St. Juste
Sandra Czunas	Jeffrey Langsam	Alison Vail

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 4:02pm.	
2.	**Public Comment**	**Andy Selinger**
	Andy Selinger welcomed public comment. None was provided.	
3.	**Approval of July 15, 2021 Meeting Minutes**	**Andy Selinger**
	Steve Wolfson motioned to approve minutes of the Quality Council's July 15th meeting. Amy Gagliardi seconded the motion. No one objected or abstained from approving the meeting minutes. The motion passed.	
4.	**Conclude Discussion of Quality Benchmarks**	**Michael Bailit, Bailit Health**
	Michael Bailit shared the three topics the Quality Council members were slated to discuss during the meeting – which measures the Council recommended including in the Quality Benchmarks, the levels at which performance should be evaluated, and the performance goal for each measure for 2025. Michael Bailit reminded the Council of its adopted guiding principles to inform Quality Benchmark selection. He noted that the Council tentatively recommended ten measures focused on behavioral health, obesity, oral health and health equity. The Council also considered access to care, patient experience, patient safety and readmission measures, but did not recommend any measures for adoption due to either lack of available measures or performance data. Michael relayed that following the last meeting, Lisa Freeman expressed continued interest in hospital infection measures, including sepsis, for the Quality Benchmarks because there is still sufficient opportunity within the state, notably at the hospital level. Michael shared four types of hospital infection measures for the Council to consider, including: (1) six measures that assess the prevalence of healthcare-associated infections (HAI), (2) a measure that assesses the percentage of hospitals with a rate above/below a specified target for one or more HAI measures, (3) five measures that assess appropriate care for sepsis infections, and (4) a measure that assesses the percentage of hospitals with a rate above/below a specified target for one or more sepsis measures. He invited comment from the Council. • Joe Quaranta asked why sepsis treatment was considered for patient safety measure. Michael noted that Lisa identified sepsis as a patient safety issue, and he presented the measures with publicly available data related to sepsis. • Rohit Bhalla noted that hospitals are already evaluated on the types of measures that had been presented and performance data are published annually. He added that there is limited incremental value for adopting these measures for the Quality Benchmarks because these measures are already included in various value-based programs. Rohit asked how hospitals would be attributed to advanced networks.	

- Michael shared that the Quality Benchmarks will first be applied at the state level. He added that the Council could recommend assessing performance at additional levels, such as by hospital.
- Danyal Ibrahim agreed that sepsis treatment was not a candidate for a patient safety measure. He shared that a measure that considers secondary sepsis, or sepsis acquired in a hospital, would be a patient safety measure.
- There was no interest voiced by Council members in adopting any hospital infection or sepsis measures.
- **Recommendation**: Do not recommend any hospital infection or sepsis measures for the Quality Benchmarks.

Michael Bailit shared three sets of oral health measures that DSS assesses annually for the pediatric and the adult population – receipt of any dental service, receipt of preventive dental service and dental treatment services. Michael shared that the pediatric measures had low absolute rates, despite performance being higher than the national average. The adult measures had associated performance below the national average. He reminded the Council of three other oral health measures it previously tentatively recommended: *Percentage of Eligibles that Received Preventive Dental Services*, *Percentage of Adults who Visited the Dentist or Dental Clinic within the Past Year* and *Dental Equity Measure - Percentage of Adults who Visited the Dentist or Dental Clinic within the Past Year, Stratified by Race/Ethnicity*.

- Donna Balaski, the Dental Director at DSS, noted that the newly presented measures assess performance for DSS members who have been continuously enrolled in Medicaid for 90 days. She noted that performance for older adults has opportunity for improvement.
- Rob Zavoski said it is important to assess dental care, but noted that there may be data collection issues given that many individuals do not have dental insurance.
- Steve Wolfson asked if it is possible to assess performance for a non-Medicaid population because dental care correlates with employability. Michael noted the only non-Medicaid measure is from the BRFSS survey, but performance data are only published every other year.
- Susannah Bernheim confirmed that the pediatric preventive dental services measure from DSS is the same as *Percentage of Eligibles that Received Preventive Dental Services*.
- There was no interest expressed by Council members in adding additional dental care measures.
- **Recommendation**: Do not recommend any additional dental measures for the Quality Benchmarks.

Michael reminded the Council of the purpose of the Quality Benchmarks, as stated in Executive Order No. 5 and based on previous recommendations made by the Council. He shared that since the last meeting Bailit Health scored the tentatively recommended measures against the Council's Guiding Principles. The health status measures could receive a maximum score of 10 (because there are no health status measures in the Core Measure Set) whereas healthcare measures could receive a maximum score of 12. Michael shared that the two lowest-scoring health status measures (*High School Students Who Seriously Considered Attempting Suicide* and *Weight Classification by BMI*) received a score of seven. He shared the three lowest-scoring healthcare measures (*Percentage of Eligibles that Received Preventive Dental Services*, *Percentage of Adults who Visited the Dentist or Dental Clinic within the Past Year* and *Dental Equity Measure - Percentage of Adults who Visited the Dentist or Dental Clinic within the Past Year, Stratified by Race/Ethnicity*) received scores of four and five. Finally, Michael noted that the OHS cannot operationalize a previously recommended measure (*Adults Who Had an Appointment for Routine Health Care in the Last Six Months Who Sometimes or Never Got Appointments for Routine Care As Soon As Wanted (Medicaid)*) because DSS is no longer administering the CAHPS 5.0 survey. In addition, he reported that DSS does not administer any SDOH measures for its total population.

Michael asked the Council to review the list of tentatively recommended measures and consider (1) the mix of measure topics, (2) the population captured by the measure and (3) what is the right number of measures to serve as Quality Benchmarks. He invited comment from the Council on whether any tentatively recommended measures should be removed from consideration.

- Andy Selinger asked how many measures other states adopted for their Quality Benchmarks. Michael noted that Delaware is the only other state with Quality Benchmarks. It adopted both health status measures and healthcare measures.
- Rohit Bhalla asked if there are any implications for not having a preventive care-focused and chronic care-focused measure in the Quality Benchmarks. Michael observed that there was an oral health prevention measure. He said the big question was what becomes of the measures after they are adopted and what actions stakeholders will take to improve performance. Michael indicated that the goal is for the Benchmarks to highlight areas on which Connecticut stakeholders should focus improvement activity. He noted that the State may already address prevention and chronic health issues through existing programs.
- Steve Wolfson shared that access to healthy foods and other social needs is a major contributor to obesity. He asked if there is a way to include a social determinant of health-focused measures in the Quality Benchmarks. Michael agreed that there are multiple contributors to obesity, including access to healthy foods. He noted that improving access to healthy food is one of many actions Connecticut could take to improve performance on the obesity-focused metrics.

- Rob Zavoski noted that obesity leads to many of the chronic health conditions that arise as adults.
- Dan Tobin asked how to interpret performance for *Substance Use Disorder in the Past Year*. He noted that if performance increases over time, that could be due to more diagnoses of substance use rather than an increased rate of substance use. Deepti Kanneganti clarified that this measure is assesses patient-reported substance use and may not reflect actual diagnoses.
- Susannah Bernheim considered the potential actions that could arise from selecting these ten measures. She asked how the Quality Benchmark slate would be monitored and potential modified over time. Michael noted that the Council will consider this question later in the process.
- Susannah added that she liked the process the Council took to get to these ten tentatively recommended measures, but not the final measures. Michael noted that unfortunately there are limited numbers of measures with publicly available data.
- Michael Bailit expressed concern about the number of measures included in this list, noting that it would be challenging to dedicate sufficient resources to improve performance on all ten measures. Danyal Ibrahim shared that several measures focus on similar topics, such as oral health and obesity.
- Danyal Ibrahim noted that with CMS programs, Medicaid typically sets the measure slate and then commercial payers followed suit. He shared that he thought a similar evolution could occur with the Quality Benchmarks.
- Susannah Bernheim added that Council could be creative when setting performance goals for each Quality Benchmark measure (e.g., adopting one goal for multiple measures focused on a single topic) to reduce the number of measures.
- Andy Selinger and Amy Gagliardi noted that it seemed redundant to have both Weight Classification by BMI and Obesity Equity Measure. Michael shared that the *Obesity Equity Measure* is focused on reducing disparities in obesity by race/ethnicity whereas the *Weight Classification by BMI* measure is focused on reducing obesity overall. Amy noted that the Council could create a composite measure that assesses performance for the whole population.
- Deepti highlighted that data for three measures are only available every other year – *High School Students Who Seriously Considered Attempting Suicide*, *Percentage of Adults who Visited the Dentist/Dental Clinic In the Past Year* and *Dental Equity Measure – Percentage of Adults who Visited the Dentist or Dental Clinic within the Past Year, Stratified by Race/Ethnicity*. Andy Selinger said that he did not think this diminished the value of these measures.
- Steve Wolfson asked whether the tentatively recommended measures added reporting burden for providers. Michael responded that they did not.
- **Recommendation**: Retain all ten tentatively recommended measures for the Quality Benchmarks.

5. Discuss Levels of Measurement — **Deepti Kanneganti, Bailit Health**

Deepti Kanneganti identified state, market, insurer and advanced network (AN) as four potential levels for measuring Quality Benchmark performance. Delaware collects data by insurer and advanced networks, with insurers providing the advanced network data. Deepti observed that for the health status measures, only state-level measurement is possible. For the *Follow-up After Hospitalization for Mental Illness* and *Follow-up After ED Visit for Mental Illness* healthcare measures, however, lower levels of measurement are possible. Deepti invited comment from the Quality Council.

- Steve Wolfson commented that the intended use of the measures should dictate the level of measurement.
- Rohit Bhalla questioned applying different levels of measurement for different measures. He worried that doing so would create some confusion for stakeholders. He recommended picking the same level of measurement for all measures.
- Deepti responded that Delaware uses commercial and Medicaid benchmark values for healthcare benchmarks. Connecticut could do the same and then report performance by market and by insurer.
- Andy Selinger advocated for measurement by AN wherever possible because accountability rests with providers. He supported market and insurer-level measurement too.
- Rob Zavoski recommended measurement at as many levels as possible, as additional information will provide additional insight.
- Susannah Bernheim noted that only two of 10 measures could be assessed at the AN level, and for this reason recommended measurement and reporting only at the state level.
- Brad Richards supported Susannah's recommendation.
- **Recommendation**: Perform Quality Benchmark measurement at the state level only at the outset.

6. Begin Discussion of Quality Benchmark Values — **Deepti Kanneganti, Bailit Health**

Deepti Kanneganti introduced the Quality Benchmarks values discussion by stating that initially the focus would be to set performance goals for 2025. She said values for 2022-2024 would be discussed during the next meeting. She also observed that because the benchmark values were being established so late in 2021, it was unlikely to expect any change in performance in 2022.

Deepti introduced information for each of the 10 benchmark measures to aid establishment of benchmark values for 2025.

- *Substance Use Disorder in the Past Year*
  - Deepti asked for input on whether to select a 12+ years or 18+ years measure, and what value to select.
  - Dan Tobin questioned the selection of a measure where CT performance is above the national average. Deepti explained that the Council recommended the measure because absolute performance (6.6-7.0%) was too high. Dan Tobin suggested the national 75th percentile as a potential goal for 2025, as the national 90th percentile seemed high.
  - Joe Quaranta described an alternative approach to setting benchmark values for 2025, one that focused on "where we are at and where we want to become." Joe then recommended a 10% improvement in the absolute rate. He acknowledged uncertainty about the impact of random variation, however, and whether 10% improvement could be reliably measured. Susannah agreed, and she recommended asking SAMHSA.
  - Rohit Bhalla endorsed the 12+ measure due to the problem of teen substance use. He also recommended using the 75th percentile for ease of communication.
  - Danyal Ibrahim agreed with Rohit, supporting clarity of public communication by using percentiles.
  - Deepti said that 6.25% would be the 75th percentile value for 12+ years. The group supported this benchmark value.
  - **Recommendation**: Adopt the 12+ years version of the measure and set the 2025 benchmark value at the national 75th percentile, i.e., 6.25%.
- *Drug Overdose Deaths Involving Any Opioids per 100,000 Residents*
  - Steve Wolfson, Andy Selinger and Rob Zavoski advocated for adopting the 75th percentile value (15.10%).
  - Lisa Freeman asked why comparisons were being made to national benchmarks and not to CT past performance. Deepti explained that using national benchmarks is customary for benchmarking practice to identify what is achievable, but acknowledged that looking at historical CT performance was possible.
  - Rohit Bhalla questioned whether the 75th percentile was achievable, and suggested the 50th percentile value (23.35%) instead given that movement would be hard-earned. Karen Haberlin expressed agreement.
  - Steve Wolfson recommended setting a percentage value and not a percentile. Deepti responded by explaining that the value would be a percentage value, but based on the percentile
  - Susannah Bernheim questioned the risk of being overly ambitious. Deepti responded by explaining that overly ambitious targets can lead to reduced improvement efforts.
  - Dan Tobin asked for regional rates and Deepti provided the values, ranging from approximately 15% (NY) to 30% (NH). Dan felt this information supported CT's ability to achieve the 75th percentile value.
  - Lisa advocated for the 75th percentile value.
  - Steve Wolfson asked for historical CT values. Deepti said she would bring that information to the next meeting. Dan Tobin added that CT's rate is the highest it has ever been.
  - Karin Haberlin said that DPH has a public dashboard with drug overdose information on its website. She said that many deaths occur in non-urban, western parts of the state.
  - **Next Steps**: Bailit Health will research CT's historical performance on this measure for the next meeting.
- *High School Students Who Seriously Considered Suicide*
  - Deepti stated that only the national average is available as a benchmark.
  - Steve Wolfson recommended setting the benchmark value based on historical CT experience. Others agreed.
  - **Next Steps**: Bailit Health will research CT's historical performance on all remaining measures for the next meeting.

7.	**Health Equity Measure Follow-Up**	**Deepti Kanneganti, Bailit Health**

Deepti reported that since the last Quality Council meeting the *REL Measure* was renamed the *Health Equity Measure* to improve clarity for external audiences. She said that the measure specifications were drafted and distributed prior to the meeting, and explained their construction. Deepti requested feedback on the draft specifications be shared with Hanna Nagy by **September 3rd**.

In response to a question from Susannah Bernheim, Deepti explained that the goal of the measure was to support race, ethnicity and language (REL) data collection and measure reporting. Disparity reduction would be a future focus for a future measure.

8.	**Adjourn**	**Andy Selinger**

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