Meeting of the Quality Council

Meeting Date	Meeting Time	Location
February 17, 2022	4:00 pm – 6:00 pm	Webinar/Zoom

Participant Name and Attendance

Quality Council		
Susannah Bernheim	Amy Gagliardi	Joe Quaranta
Amy Bethge	Karin Haberlin	Brad Richards
Ellen Carter	Danyal Ibrahim (representing Syed Hussain)	Andy Selinger (Chair)
Elizabeth Courtney	Michael Jefferson	Daniel Tobin
Sandra Czunas	Nikolas Karloutsos	Alison Vail
Stephanie De Abreu	Paul Kidwell	Steve Wolfson
Lisa Freeman	Doug Nichols	
Others Present		
Kelly Sinko Steuber, OHS	Hanna Nagy, OHS	Michael Bailit, Bailit Health
Jeannina Thompson, OHS	Krista Moore, OHS	Deepti Kanneganti, Bailit Health
Members Absent:		
Rohit Bhalla	Marlene St. Juste	Orlando Velazco
Kaisha Velazquez		

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, Chair**
	Andy Selinger called the meeting to order at 4:02pm. Andy Selinger welcomed Amy Bethge from Emblem Health and Ellen Carter from the Connecticut Health Foundation as new Quality Council members. Amy Bethge introduced herself and her role at Emblem Health, the parent company of ConnectiCare.	
2.	**Public Comment**	**Andy Selinger, Chair**
	Andy Selinger welcomed public comment. None was offered.	
3.	**Approval of January 20, 2022 Meeting Minutes**	**Andy Selinger, Chair**
	Steve Wolfson motioned to approve the meeting minutes. Michael Jefferson seconded the motion. No one objected to or abstained from approving the meeting minutes. The motion passed.	
4.	**Continue Discussion of Strategies to Improve Quality Benchmark Performance**	**Michael Bailit, Bailit Health**
	Michael Bailit said the meeting would focus on two topics: a continued discussion of strategies to improve quality benchmark performance and a discussion of the Core Measure Set. Michael reminded the Quality Council that during the prior meeting, members brainstormed strategies that payers, providers, and agencies could implement to generate action to improve performance on the Quality Benchmarks. Michael said that the strategies focused on the three Phase 1 measures: *Asthma Medication Ratio, Controlling High Blood Pressure* and *Hemoglobin A1c Control for Patients with Diabetes: Poor Control*. Michael said that Bailit Health and OHS generated additional strategies following the meeting and added them to the list. Michael asked the Quality Council to consider, as it reviewed the strategies, which the OHS should prioritize, being mindful that the OHS had limited funding to support improvement work. Michael said the first strategy focused on public reporting of provider and payer performance on the Quality Benchmarks annually with Cost Growth Benchmark, and on Healthscore CT. Michael said the first strategy might motivate these entities to improve performance, so they did not appear to be poor performers. Michael said the second strategy focused on public recognition of providers and payers that perform well relative to an absolute benchmark or demonstrating improvement on the Quality Benchmarks. • Lisa Freeman asked if it was possible to reframe the first strategy's theory of change to say, "to encourage providers to be the best performers" rather than "so they do not appear to be poor performers." Michael agreed that could be done. Michael asked Lisa if she preferred either strategy. Lisa said transparency was appropriate and suggested that the OHS tailor reporting toward the public in addition to the payers and providers, perhaps through two separate reports. • Danyal Ibrahim said he liked both strategies and suggested a composite score, like the CMS Star Rating as the benchmarks grow to be seven. Michael agreed that this could be a good idea.	

- Andy Selinger asked whether public reporting could mean publishing performance on TV or in the printed news.

Michael shared the third strategy which focused on creating a true set of "core measures" in the Core Measure Set and making the Phase 1 Quality Benchmarks the only the newly defined Core Measures. Michael said the current Core Measure Set is actually a *menu set* of measures because OHS encouraged insurers to select any measures from the full measure set. Michael said a "true" core set, as practiced in other states, would specify that the three Phase 1 Quality Benchmark measures would be the Core Measures that the Quality Council would recommend that insurers and Advanced Networks (AN) include in all value-based payment (VBP) contracts. Michael said OHS categorized this strategy as "medium" level difficultly because it might be challenging to engage insurers to commit to including the Phase 1 measures in all of their contracts. Michael said the theory of change for the third strategy is that if all payer/AN VBP contracts included Phase 1 Quality Benchmarks, there would be more attention to the measures and therefore payers and providers would be more likely to improve performance.

- Lisa Freeman asked what would happen if insurers pushed back on the measures. Michael said OHS could only ask insurers to use the core measures because it would benefit the common good, but there would be no consequences if insurers used other measures they deemed to be more important.
- Andy Selinger said he was in favor of the third strategy because it would hold payers accountable. Michael noted that it would also hold ANs accountable. Michael Jefferson said he agreed with Andy Selinger.
- Ellen Carter said that she agreed with prior comments and said it made sense to push insurers towards using the measures.
- Stephanie de Abreu said UnitedHealthcare supported quality measurement, especially use of HEDIS or standardized measures. She spoke against requiring core measures that would interfere with selecting measures that some providers needed to work on more than others. Stephanie also said the Council should ensure the third strategy did not create additional reporting burdens.
- Doug Nichols said Cigna supported measure alignment and agreed with Stephanie de Abreu's comment about requiring use of measures that insurers did not already include in value-based contracts.

Michael shared the fourth strategy, which focused on partnering with other agencies on a public relations and education campaign in order to increase awareness of the goals of the Quality Benchmarks and what strategies payers and providers could implement to improve performance. Michael said this strategy could involve OHS working with Department of Social Services, the Department of Public Health and the Office of State Comptroller to generate meaningful improvement on the Quality Benchmarks. Michael shared the fifth strategy which focused on creating at toolkit to give to provider organizations. Michael noted that the fifth strategy would not require creating a toolkit from scratch because many existing resources are available.

- Susannah Bernheim said, regarding the fifth strategy, that there was already a fair amount of work done to develop resources like this so the task would just involve aggregating and disseminating existing strategies.
- Michael asked Danyal Ibrahim if a toolkit would be helpful. Danyal said that a toolkit would be extremely helpful because it would provide actionable items to push improvement projects forward. Danyal also suggested including a section explaining the measures so providers could better understand how performance is calculated and what data points impact measure performance.
- Andy said he thought provider organizations would be very grateful to have a toolkit to deploy without needing to reinvent the wheel to meet the Quality Benchmarks.
- Joe Quaranta said Community Medical Group uses toolkits quite a bit. Joe said toolkits were most helpful when embedded into the provider's direct workflow, which may make it difficult to create one toolkit multiple providers could use.

Michael shared strategy six, which focused on increasing insurer and employer use of community health workers (CHWs), patient navigators and/or health coaches focused on Phase 1 Quality Benchmark topics and targeted in communities of greatest need. Michael noted that although there was tremendous enthusiasm for this strategy at the last Quality Council meeting, OHS categorized this strategy as "very hard" because it requires payers to add investment or redirect investment to support use of these provider types.

- Andy Selinger asked whether the state government could use increased primary care funds from Executive Order No. 5 to support this strategy. Michael said practices could use increased payments to expand their teams to include CHWs. Michael said he would still categorize strategy six as "very hard" because there are no consequences, other than public reporting, if payers do not meet the Primary Care Spend Target. Michael said if Connecticut was going to hit the Primary Care Spend Target and allow practices to invest in their primary care teams to include CHWs, it would happen because of the voluntary commitment from Connecticut payers. Andy clarified with Michael that the Primary Care Spend Target was aspirational and the Executive Order did not call for higher government spending.

- Danyal Ibrahim commented that the three Quality Benchmark measures focused on chronic conditions, which are more prevalent among vulnerable populations and require more patient engagement. Danyal said a toolkit could suggest investing in a patient navigator or coach to increase patient engagement.
- Lisa Freeman said there were other successful programs that involved CHWs and navigators to which OHS could refer. Michael agreed with Lisa and said OHS would need to find funds for such a program. Lisa said finding successful models may motivate insurance companies to consider implementing them because they would save money. Andy mentioned return-on-investment calculators, with inputs for population, units of expense and categories of expense to calculate likely return on investment.

Michael shared strategy seven, which focused on expanding existing evidence-based programs associated with the Quality Benchmarks. Michael noted that OHS categorized strategy seven as "medium/hard." Michael shared the eighth strategy which focused on leveraging gynecologists to help postpartum women receive support post-delivery and follow-up to ensure they receive care to control their blood pressure.

- Amy Gagliardi supported this strategy because uncontrolled blood pressure is one of the main causes of postpartum death. Amy said the Connecticut Hospital Association is already working on this issue. Michael asked if OHS should invest in this strategy given the Connecticut Hospital Association's work. Amy said OHS' involvement would decrease the level of difficulty of the strategy.
- Steve Wolfson suggested rephrasing the theory of change to read "this may improve performance if postpartum women have uncontrolled high blood pressure."
- Joe Quaranta said he did not think the eighth strategy would improve outcomes on the measure because a fairly low percentage of women who develop hypertension during pregnancy would qualify for the measure inclusion criteria. Joe said the easiest way to improve performance on the measure was to improve documentation because *Controlling High Blood Pressure* was notoriously difficult to document.

Michael shared a summary of all eight strategies and added Joseph Quaranta's proposed ninth strategy "optimization of correct reporting of quality measures." Michael asked the Quality Council to weigh in on which strategies would have the greatest potential impact on the three Phase 1 Quality Benchmark measures.

- Susannah Bernheim asked whether strategy seven included learning collaboratives. Michael said that instead of creating new collaborative, strategy seven would leverage existing improvement programs, which might include collaboratives. Susannah asked how the state would implement strategy seven. Michael said that this strategy was labeled hard as this might require identifying which programs exist and offering increased investment to bring programs to scale. Susannah said she preferred strategies one, five and seven. She said she was torn over strategy three.
- Steve Wolfson said strategy six bothered him because he was it was aimed at the wrong level. Steve said providers should employ CHWs, patient navigators, and health coaches, rather than insurers or employers who are more distant from the patient. Michael agreed that the strategy was not well phrased. Steve said he would prefer that strategy six be rephrased.
- Joe Quaranta said financial incentives would drive focus on the measures. Michael said he thought financial incentives fell within strategy three because having true core set would mean every value-based contract between insures and ANs would use all core measures. Steve Wolfson added that strategy six would include financial incentives. Michael agreed.
- Danyal Ibrahim said his top choices were strategies one, two, three and six.
- Lisa Freeman said preferred strategies one, five, and six.
- Andy Selinger said strategies four, six, and seven excited him the most.
- Michael Jefferson said he supported strategies two, three, six, and seven. Michael added that strategy six should be supported on multiple levels.
- Ellen Carter said she supported strategies one, two, six and seven.
- Steve Wolfson said that if OHS selected strategies one or two, it should ensure that ANs or insurers do not avoid sick patients.
- Amy Gagliardi said she supported strategies one, two, five, six, and eight.

Next Steps: Bailit Health and OHS will revise the strategies to generate action to improve Quality Benchmark performance to incorporate Quality Council feedback.
Next Steps: Bailit Health and OHS will develop a timeline and plan to operationalize the strategies that received greatest support from the Quality Council.

5.	**Revisit the Core Measure Set**	**Deepti Kanneganti, Bailit Health**

Deepti Kanneganti explained the process for reviewing the Core Measure Set. Deepti advised the Quality Council that the measure set should stay relatively consistent year over year, in order to allow ANs and insurers to make investments and see improvements.

Deepti said the Core Measure Set did not include hospital inpatient-focused measures and a preliminary review of the 2022 Quality Council Insurer Survey found that no insurance carriers were using hospital inpatient-focused measures in contracts with ANs. Deepti asked whether the Quality Council recommended including such measures in the Core Measure Set. Deepti noted that the Core Measure Set focused on holding ANs, not hospitals, accountable for the quality measures.

- Steve Wolfson said hospitals are very risk-averse and are already diligent about the necessary quality issues. Andy Selinger asked Steve if he thought hospitals were paying attention to adverse events in hospitals. Steve said he thought hospitals were paying attention to this topic. Deepti said there were CMS quality programs focused on hospitals, including patient safety.
- Lisa Freeman said medical errors were still occurring frequently in hospitals and suggested focusing on the sepsis bundle and readmissions. Deepti noted that *Plan All-Cause Readmission* was in the Core Measure Set.
- Joe Quaranta said he agreed with Lisa but said ANs were not the correct group to hold accountable for medical errors in hospitals because they are mostly made up of outpatient providers. Deepti proposed that OHS and Bailit Health research measures related to hospital follow-up and care coordination after admission, which would be more relevant to ANs.
- Lisa Freeman suggested measuring timely referrals or timely treatment, because poor care coordination may result in delayed diagnoses or inappropriate treatment.
- Danyal Ibrahim suggested measuring avoidable hospitalizations.
- Steve Wolfson suggested monitoring information sharing across a hospital system because information transfer from one set of physicians to another can create problems.

Deepti reviewed the measure selection criteria that applied to individual measures and the measure set as a whole. Deepti reminded the Quality Council that measures need not satisfy all of the measure selection criteria for inclusion in the measure set. Deepti shared the list of gaps the Quality Council and Bailit Health previously identified in the Core Measure Set.

- Deepti began the gap analysis discussion by sharing tables with the distribution of Core Measures by age, data source, domain and conditions. She asked the Quality Council if it thought there was a correct balance of measures by these variables. Ellen Carter asked about the availability of self-reported measures. Deepti said patient-reported outcome measures existed but were not in widespread use. Deepti said patient-reported measures were a gap the Council identified and said there was a slide later in the presentation that identified potential patient-reported outcome measures.
- Andy Selinger said he thought there was a good mix of measures by domain.
- Lisa Freeman asked about measures focused on individuals with disabilities. Deepti said she thought disabilities were usually addressed through stratification but said would research this topic.

Deepti asked if there were other gaps in the Core Measure Set that the Quality Council identified. There were no suggestions.

Deepti asked if there were any gaps in the Core Measure Set that the Council wanted to prioritize.

- Andy Selinger suggested prioritizing opioid overdose deaths. Daniel Tobin agreed with Andy. Lisa Freeman noted the relevance of lower back pain and overuse to opioid overdose deaths.
- Ellen Carter supported prioritizing maternity care.
- Steven Wolfson suggested prioritizing oral health.
- Deepti noted that for some topics there may not be available robust measures, citing obesity treatment and tobacco use as examples. Deepti also said some measures presented accountability challenges, such as oral health measures that require use of dental claims.
- Susannah Bernheim mentioned CMS' proposed social determinants of health measure for the MIPS program. Susannah noted that many prevention measures focus on specific chronic disease prevention measures and recommended potentially searching for broader measures.

Deepti shared that the Council previously identified outcome measures, including patient-reported outcomes, as a measure gap. She presented the types of outcome measures that were available. Deepti asked the Quality Council which outcome measure topics were of interest.

- Steve Wolfson asked for the definition of optimal vascular care. Deepti said it was a composite measure from Minnesota Community Measurement that included blood pressure levels, use of statins for high blood pressure, and aspirin following a heart attack. Michael Bailit said it was an "all-or-nothing" measure, meaning the measure only recognized providers that meet all of the multiple measure components.
- Daniel Tobin asked why ear infection rate was considered "Patient Safety." Deepti clarified that the measure focused on the receipt of appropriate treatment following an ear infection diagnosis within an appropriate timeline.

	• Andy Selinger asked whether weight loss, tobacco cessation and fall prevention were outcome measures. Deepti said tobacco cessation measures were not outcome measures because they do not focus on whether patients stopped using tobacco, only whether the physician provided counseling. Deepti said there are homegrown outcome measures focused on weight loss, but they have not been validated. • Danyal Ibrahim said the Quality Council could consider outcome measures focused on avoidable hospitalizations. • Susannah Bernheim suggested considering measures focused on outcomes for patients with multiple chronic conditions. Michael asked Susannah whether there would be enough patients that fall within this category in the commercial population. Susannah said she was not sure. **Next Steps**: Bailit Health will research additional measures that are appropriate for ANs focused on follow-up and care coordination after hospital admissions, timely referrals and treatment, avoidable hospitalizations and transmission of information across providers, outcomes for persons with disabilities, opioid overdose deaths, maternity care, oral health and outcomes for persons with multiple chronic conditions. Deepti said the Quality Council would review the results of the 2022 Quality Council Insurer Survey and continue considering measure to fill identified gaps in the Core Measure Set during the March 17th meeting.	
6.	**Adjourn**	**Andy Selinger, Chair**
	Steve Wolfson made a motion to adjourn the meeting. Sandra Czunas seconded the motion. There were no objections. The meeting adjourned at 5:56pm.	