Quality Council
March 17, 2022

Call to Order

Roll Call

Agenda

Time	Topic
4:00 p.m.	Call to Order
4:05 p.m.	Public Comment
4:15 p.m.	Approval of February 17, 2022 Meeting Minutes—Vote
4:20 p.m.	Discuss Adoption of a "True" Core Measure Set
4:45 p.m.	Consider Candidate Measures to Fill Identified Gaps
5:25 p.m.	Wrap-up & Next Steps
5:30 p.m.	Adjourn

Public Comment

Approval of February 17, 2022 Meeting Minutes—Vote

Follow-up Actions from February Meeting

- **Quality Benchmark Strategies**
  - During the last meeting, the Quality Council discussed how to prioritize strategies that payers, providers, and/or agencies could implement to achieve the Quality Benchmarks.
  - **Next Step**: OHS and Bailit Health are working on a draft strategy implementation plan. We will bring the plan back to the Quality Council for discussion during a future meeting.

- **2022 Quality Council Insurer Survey**
  - OHS is still working on collecting quality measure data from all insurers.
  - **Next Step**: OHS will share the full results of the 2022 Quality Council Insurer Survey this spring following additional efforts to receive complete responses from all insurers.

Discuss Adoption of a “True” Core Measure Set

Reminder: Quality Council Responsibilities

Core Measure Set

- A ***menu*** of measures from which OHS requests insurers select measures for use in **value-based contracts with Advanced Networks**
- For 2022, it consists of 26 measures across six domains: acute and chronic care, behavioral health, care coordination, consumer engagement, health equity and prevention

Quality Benchmarks

- **Annual measures and target values** that all public and private **payers, providers and the State** must work to achieve to improve healthcare quality in Connecticut
- The Quality Benchmarks are comprised of three measures for 2022-2023 and seven measures for 2024-2025

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Adopting a "True" Core Measure Set (Cont'd)

- One strategy for increasing alignment is to create a "true" Core Measure Set.
- Adopting a "true" Core Measure Set would mean:
  - OHS would ask insurers to use the Core Measures in value-based contracts with Advanced Networks.
  - The existing Core Measure Set measures not selected as Core Measures would be renamed "Menu Measures" and would be optional for use in value-based contracts. Insurers would be asked to limit their contracts to only Core and Menu measures.
  - The Quality Council would annually review the Core Measure Set and decide whether measures should be (a) added to the Core Set, (b) moved from Menu to Core or from Core to Menu status, or (c) removed from the Measure Set entirely.
  - OHS would continue to annually survey insurers for measures in use in value-based contracts with Advanced Networks to monitor fidelity to the Core Measure Set.

Adopting a "True" Core Measure Set (Cont'd)

- Examples from other states:
  - In **Rhode Island**, the Office of the Health Insurance Commissioner has required that commercial insurers use Core Measures in value-based contracts since 2017. Medicaid has always aligned voluntarily.
  - In **Massachusetts**, Medicaid and commercial insurers have voluntarily adopted an aligned measure set since 2019.

	Rhode Island ACO Measure Set	**Massachusetts ACO Measure Set**
# Core Measures	8	4
# Menu Measures	13	22
Core Measure Domains	Chronic Disease, Hospital, Prevention	Behavioral Health, Consumer Experience, Chronic Disease

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Adopting a “True” Core Measure Set (Cont’d)

- Should the Quality Council recommend adopting a “true” Core Measure Set, we recommend using the Phase 1 Quality Benchmark measures as the “true” Core Measures in MY 2023.

  1. *Asthma Medication Ratio*
  2. *Controlling High Blood Pressure*
  3. *HbA1c Control for Patients with Diabetes: HbA1c Poor Control*

- **Does the Quality Council support the adoption of a “true” Core Measure Set?**
  - **If so, does the Quality Council agree with OHS’ recommendation to use the Phase 1 Quality Benchmark measures as the measures for the “true” Core Measure Set in MY 2023?**

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Measures to Fill Identified Gaps in the Core Measure Set

Reminder: 2022 Core Measure Set

1. PCMH CAHPS Survey
2. Plan All-cause Readmission
3. Breast Cancer Screening
4. Cervical Cancer Screening
5. Chlamydia Screening in Women
6. Colorectal Cancer Screening
7. Immunizations for Adolescents (Combo 2)
8. Developmental Screening in the First Three Years of Life
9. Well-child Visits in the First 30 Months of Life
10. Child and Adolescent Well-care Visits
11. Prenatal and Postpartum Care
12. Screening for Depression and Follow-up Plan
13. Behavioral Health Screening*
14. Asthma Medication Ratio
15. Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Poor Control (>9%)
16. Eye Exam for Patients with Diabetes
17. Kidney Health Evaluation for Patients with Kidney Disease
18. Controlling High Blood Pressure
19. Follow-up Care for Children Prescribed ADHD Medication
20. Metabolic Monitoring for Children and Adolescents on Antipsychotics*
21. Follow-up After Hospitalization for Mental Illness (7-Day)
22. Follow-up After ED Visit for Mental Illness (7-Day)
23. Substance Use Assessment in Primary Care
24. Concurrent Use of Opioids and Benzodiazepines
25. Use of Pharmacotherapy for Opioid Use Disorder
26. Health Equity Measure

*Medicaid-only measure.

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Gap Analysis

- As a reminder, previously identified priority gaps in the Measure Set:
  - Care coordination
  - Maternity care
  - Opioid overdose deaths
  - Oral health
  - Outcomes for persons with multiple chronic conditions
  - Outcomes for persons with disabilities
  - SDOH screening
  - REL data completeness
- Today we will begin presenting candidate measures to fill these gaps.
  - When considering which measures to select, please keep in mind the measure selection criteria, included in Appendix of this presentation.

REL: race, ethnicity and language

SDOH: social determinants of health

Process to Fill Measure Gaps

- Bailit Health researched measures to fill the identified gaps using the following sources:
  - Buying Value Measure Selection Tool, which includes over 800 measures and measures in use by 13 federal and national and 6 state measure sets;
  - Buying Value Benchmark Repository, which includes nearly 50 non-HEDIS and homegrown measures in use by states;
  - NQF's Quality Positioning System, which includes over 1,100 measures that are or were previously endorsed by NQF, and
  - CMS' Measures Inventory Tool, which includes nearly 700 measures in use by various CMS programs.

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Care Coordination

- During past meetings, the Quality Council expressed interest in the following types of care coordination measures:
  1. Avoidable hospitalizations
  2. Follow-up after hospital admissions
  3. Timely referrals and treatment
  4. Transmission of information across providers
- The care coordination measures presented on the following slides are organized based on those categories, although some measures may fit in multiple categories and for some categories we could not find appropriate measures.

Care Coordination – Avoidable Hospitalizations

- We could not identify any appropriate measures related to avoidable hospitalizations, so we expanded our search to avoidable ED visits.

NQF # / Status	Measure Name	Steward	Measure Type	Description
NA	Potentially Avoidable Use of the Emergency Room	Washington Health Alliance	Outcome	Percentage of total ER visits considered potentially avoidable based on an agreed-upon list of ICD codes. This is considered a conservative measure of potentially avoidable ER use.
NA	Avoidable ED Visits (per 1,000 Members)	NYU Center for Health and Public Service Research	Outcome	The NYU Center for Health and Public Service Research has developed an algorithm to help classify ED utilization. Data abstracted from these records included the initial complaint, presenting symptoms, vital signs, medical history, age, gender, diagnoses, procedures performed, and resources used in the ED.

Note: *Plan All-cause Readmission* is already included in the Core Measure Set

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Care Coordination – Follow-up After Hospital Admissions

- Unfortunately, we could not identify any measures related to follow-up after hospital admissions.
  - If we identify any measures in the future, we will bring them to the Quality Council for consideration.

- As a reminder, *Follow-up After Hospitalization for Mental Illness (7-Day)* is already included in the Core Measure Set.

Care Coordination – Timely Referrals and Treatment

NQF # / Status	Measure Name	Steward	Measure Type	Description
NA	Care Coordination Quality Measures for Primary Care	AHRQ	Patient Experience	Survey of adult patients' experiences with care coordination in primary care settings (66 question survey with one question on timely referrals).

Care Coordination – Transmission of Information Across Providers

NQF # / Status	Measure Name	Steward	Measure Type	Description
NA	Closing the Referral Loop: Receipt of Specialist Report	CMS	Process	Percentage of patients with referrals, regardless of age, for which the referring provider received a report from the provider to whom the patient was referred

Maternity Care

- Bailit Health is currently working with an OB on the MA Quality Measure Alignment Taskforce to identify potential new maternity measures for that body.
  - Once this work is complete, we will bring new measures to the CT Quality Council for consideration.

Opioid Overdose Deaths

- The Quality Council expressed an interest in finding measures related to opioid overdose deaths.
  - Unfortunately, we did not identify any opioid overdose death-focused measures appropriate for use in value-based contracts.

- Please note, the following opioid-related measures are already included in the Core Measure Set:
  - *Substance Use Assessment in Primary Care*
  - *Concurrent Use of Opioids and Benzodiazepines*
  - *Use of Pharmacotherapy for Opioid Use Disorder*

Oral Health

NQF # / Status	Measure Name	Steward	Measure Type	Description
2528 (Endorsed)	Topical Fluoride for Children	NCQA	Process	Percentage of members 1-20 years of age who received at least two topical fluoride applications during the MY.
2517 (Endorsed)	Oral Evaluation, Dental Services*	NCQA	Process	Percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the MY.

Note: These measures were originally stewarded by DQA but are now proposed as new HEDIS measures for MY 2023 by NCQA. CMS previously added the DQA measures to the CMS Medicaid/CHIP Child and Adult Core Health Care Measure Sets.

*Medicaid-only measure

Outcomes for Persons with Multiple Chronic Conditions

- Unfortunately, we could not identify any outcome measures for persons with multiple chronic conditions, but we did identify the following process measure.

NQF # / Status	Measure Name	Steward	Measure Type	Description
NA	Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions	NCQA	Process	Percentage of emergency department (ED) visits for members 18 years and older who have high-risk multiple chronic conditions who had a follow-up service within 7 days of the ED visit.

Note: *Plan All-cause Readmission* is already included in the Core Measure Set

Outcomes for Persons with Disabilities

- The CAHPS survey includes an optional item set focused on people with mobility impairments (PWMI), which can be added either to the CAHPS Health Plan Survey or the CAHPS Clinician & Group Survey.
  - The PWMI item set for both surveys contains questions that cover many topics relating to physical disabilities, including difficulty moving around the restroom, pain, fatigue, being weighed at the doctor's office, and being examined on the examination table.
  - Also, the PWMI set includes questions about getting physical/occupational/ speech therapy and mobility equipment.

SDOH Measure

NQF # / Status	Measure Name	Steward	Measure Type	Description
NA	Social Needs Screening and Intervention	NCQA*	Process	Percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive. Six rates are reported: 1. Food screening 2. Food intervention 3. Housing screening 4. Housing intervention 5. Transportation screening 6. Transportation intervention

* Proposed as a new HEDIS measure for MY 2023 by NCQA. See next slides for additional specification details.

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SDOH Measure (Cont’d)

- NCQA is considering phasing in the different components and modifying the follow-up time frame (currently 30 days)
- NCQA has a list of approved screening tools for each component, which it is considering expanding based on public comment
  - NCQA also has a definition for what is considered a “positive need” based on each survey/question
- The SDOH measure aligns with HL7 FHIR and can only be reported electronically

SDOH Measure (Cont'd)

- The following are homegrown SDOH screening measures from Massachusetts and Rhode Island that do not require electronic reporting.

NQF # / Status	Measure Name	Steward	Measure Type	Description
NA	Health-Related Social Needs Screening	MA EOHHS	Process	The Health-Related Social Needs Screening is conducted to identify members who would benefit from receiving community services to address health-related social needs that include, but are not limited to: housing stabilization services; housing search and placement; utility assistance; transportation and food insecurity.
NA	Social Determinants of Health Screening	RI EOHHS	Process	Percentage of attributed patients who were screened for Social Determinants of Health using an EOHHS-approved screening tool, where the Accountable Entity (AE) has documented the screening and results.

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REL Data Completeness Measures

- There are no national measures focused on capture of race, ethnicity and language (REL) data.
- Public Act 21-35 requires OHS to complete an implementation plan for healthcare providers to report REL data in the state Health Information Exchange.
- The Governor's proposed budget allocates $1.2 Million over the next two years to initiate the systems change needed to collect these data.

Wrap-up & Next Steps

Meeting Wrap-Up & Next Steps

- Continue considering measures to fill identified gaps in the Core Measure Set
- Review measure specification changes and opportunities for improvement for measures in the Core Measure Set
- Discuss follow-up items from the 2021 annual review of the Core Measure Set

- Discuss a proposed implementation plan for strategies to improve performance on quality benchmarks
- Finalize 2023 Core Measure Set

Appendix

Measure Selection Criteria

- The Quality Council revised its measure selection criteria during the 2021 annual review of the Core Measure Set.
- As a reminder, these criteria are meant to help the Council ensure that each measure has sufficient merit for inclusion in the Core Measure Set. A measure does not need to satisfy all criteria.
- There are two sets of measure selection criteria:
  - a set of criteria that apply to individual measures and
  - a set of criteria to apply to the measure set as a whole.

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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.