Quality Council Subcommittee on Measure Selection Criteria

Meeting Date	Meeting Time	Location
January 3, 2021	12:00 pm – 1:00 pm	Webinar/Zoom

Participant Name and Attendance

Subcommittee					
Alan Coker		Marlene St. Juste			
Lisa Freeman		Steve Wolfson			
Andy Selinger					
Others Present					
Michael Bailit, Bailit Health		Hanna Nagy, OHS			
Deepti Kanneganti, Bailit Health		Kelly Sinko, OHS			

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**	**Hanna Nagy**
	Hanna called the meeting to order at 12:02pm.	
2.	**Measure Selection Criteria**	**Michael Bailit**

Michael reminded the group that at the last Quality Council meeting on December 17th, the Council looked at criteria that were utilized by the Council a few years ago, and also at those employed by RI and MA with their standing bodies that do measure alignment work. During that meeting OHS surveyed the Council to solicit their recommendations on measure criteria to apply to individual measures, and for the measure set at the whole. He explained that these criteria will serve as aids to help make decisions about individual measures.

Michael explained that for each measure, the Subcommittee should answer two questions: (1) should we include this criterion and (2) what language to use.

Marlene asked how many criteria should be adopted. Michael said there is no objective rule, but suggested that roughly a half dozen is manageable.

Criteria for Individual Measures

- Promotes health equity
  - Andy wondered if this was at odds with the evidence-based criterion. Michael said not all measures will need to meet each criterion.
  - Steve said the MA detailed language was a little dense. Michael explained that the bulleted language was to provide guidance on state staff on how to perform an equity review of a measure.
  - Andy said he understood health equity to focus on factors like transportation and housing.
  - Marlene preferred the CT criterion. She said the research into literature/data would be helpful to see if the measure promotes health equity.
  - Michael said the CT criterion doesn't help make a decision on whether to include the measure. He said perhaps a hybrid of MA and CT could include the language regarding performing an assessment.
  - The Subcommittee agreed to recommend this criterion, using Michael's suggested approach for wording.
- Opportunity for improvement
  - Michael noted that the CT language was specific to prioritizing outcome measures with opportunity for improvement. MA and RI language was broader.
  - Andy asked if the Quality Council was provider organization-focused or population health-focused. Michael said the Core Measure Set is specific to provider organizations, although they could be held accountable for population health.
  - Michael clarified that these criteria are for the Core Measure Set, and not for the Quality Benchmarks.
  - Andy asked if the data sources are specific to only claims and EHR databases. Michael said they need not be, but they need to be measured at the Advanced Network level. Andy asked if providers have access to social risk factor data. Michael said in RI, Medicaid ACOs are required to screen for social risk factors.
  - The Subcommittee agreed to recommend this criterion, including the language "...opportunity for improvement in quality of care, inclusive of outcomes and of population health."
- Feasible to collect/not burdensome
  - Steve said the CT wording sounded good. The overall intent is for the physician to focus on the patient, and not on charts.
  - Marlene and Andy agreed with Steve. Marlene added that FQHC providers are overwhelmed to get all the required data, especially because EMRs are trying to adapt to what the State requires. She noted that there are other clinical staff that can gather the required data for measurement.

- The Subcommittee agreed to recommend this criterion using the CT language.

- Evidenced-based
  - Lisa said this is essential, as work that doesn't correlate with improved patient health is not worth doing.
  - Lisa, Steve, Alan and Marlene voiced preference for the MA language.
  - The Subcommittee agreed to recommend this criterion, using the MA language.
- Addresses state health priorities / needs and/or measure set goals
  - Michael said MA operationalizes its criterion by obtaining data from its public health department and from the Secretary of Health and Human Services on the state's priorities. The list is subject to change, and so the specific priorities are not "hard-coded" in the criterion.
  - Andy requested MA's Aligned Measure Set priorities.
  - Michael explained that Bailit Health is preparing data on CT's opportunities for improvement, for OHS and then Quality Council review.
  - Lisa asked who defines the MA state priorities, and how often is it reassessed. Michael said in MA it's refreshed every year by the state public health department and the Secretariat of Health and Human Services , which includes health and social service organizations. He explained that this isn't done in every state.
  - Lisa expressed concern because CT's criterion focuses on concepts. She worried about being too vague and focusing on financial concerns, not things like patient safety.
  - Michael recommended using CT's language, but not include the four bullets, so there is flexibility to adapt to shifting priorities over time.
  - Lisa disagreed, noting that health equity will take a lifetime of work, patient safety is far from achieving goals, and care experience can always be improved, although is least important of the four bullets. Regarding behavioral health, she thought we're just starting to connect this with body health.
  - Michael noted that detailing would restrict the group from adding something like obesity in the future because the criterion would be limited to the four current bulleted topics.
  - Steve suggested adding "beginning with" to replace "including".
  - The Subcommittee agreed to recommend this criterion, adopting Steve's recommended edit.
- Valid and reliable
  - Michael said this criterion gets at the essence of a measure's worth – does it measure what it's purporting to measure, and are there reliable results if you re-measure multiple times. Michael recommended including the criterion.
  - Andy asked what is meant by the term "fairness" in the CT criterion. Michael said he was unsure as he was not involved in the development of the criterion.
  - Lisa said validity and reliability are fundamental components of measures. NQF uses them too.
  - Michael agreed with Lisa, noting if a measure is NQF-endorsed it passes these criteria.
  - The Subcommittee agreed to recommend this criterion.
- Michael noted there was less support for the other criteria when the Quality Council was surveyed on December 17th. He asked the group whether they favored prioritization of any of them.
  - Andy asked if "can be operationalized" is similar to "opportunity for improvement." Michael said they were different in meaning. He explained there are some measures that rely on complex aggregation of data that are really challenging to operationalize. He cited small denominator size as another example of a challenge in operationalizing a measure, e.g., if the population is so narrowly defined, the measure may yield a very small denominator at the Advanced Network level and the result will not be statistically stable.
  - Andy asked about the language "broadly applicable", and noted that if we are dealing with different patient groups, then that means if you are in a high-income vs. low income group, then it doesn't matter what the measure is because it will focus on both. He asked if the group should focus on targeting areas of need. Michael said he interpreted this criterion to mean you wouldn't pick a measure of quality of long-term care because it's not applicable for a commercially insured population. He added that he thought the Quality Council could also include measures that focus on subpopulations.
  - The Subcommittee discussed "prioritizes nationally-endorsed measures." Michael observed that this is more of a preference statement rather than a requirement. Andy asked if there are measures that address health equity that are nationally endorsed. Michael said NCQA is developing some new health equity measures. Right now, there are few measures that do this.
  - Michael noted there are some good measures without benchmarks (e.g., social risk factors). Steve said the Quality Council addressed lack of benchmarks in the past by having some measures set up for data reporting vs. analysis. Michael added that some states create internal benchmarks (e.g., percentiles using state data).
  - Michael asked the group if it wanted to include any of the remaining criteria from (#'s 7-15).
  - Lisa said she wanted to include "can be operationalized." She said she saw parallels between "value" and what CMS is doing to promote high-value care. She said "transparency and credibility" are important to improve quality of care. She believed "broadly applicable" seemed aligned with "can be operationalized."

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- Steve wanted to include "sufficient denominator size." Andy agreed with Steve.
- Marlene said criterion #7 sounded important but wondered if different entities would be excluded from the measure if they don't have EMRs, for example. Michael said the Subcommittee discussion was about deciding whether a measure should be included in the measure set, and not whether a provider could be absolved from responsibility for a measure.
- Marlene asked how criterion #10 applied. Michael said it meant if the measure was put into a contract with an AN/ACO, that it would make sense in that context. Michael didn't think the criterion added much value. Steve said the Subcommittee could replace "ACO" with "AN."
- Marlene said she liked criteria #'s 7 and 9.
- Michael expressed concern with criterions #9. He said he didn't know how a measure could "promote credibility." Michael added that a measure cannot "promote transparency" – that's something a State or organization does. Steve agreed with Michael. Lisa asked if there was a way to include transparency somehow. Michael said that's something OHS does with actions like the Quality Scorecard. It is an action, not a measure feature.
- Andy asked for an explanation of how "benchmark" and "measure." Michael explained that a "benchmark" is a value associated with a measure, and is generated outside of an organization or state for the purpose of compare performance on a measure.
- The Subcommittee agreed to recommend adding the criterion #7 ("sufficient denominator size").

<u>Criteria for the Measure Set as a Whole</u>

- Promotes health equity
  - Michael said this criterion could be used at the measure set level to complement its use at the individual measure level.
  - The Subcommittee agreed to recommend this criterion.
- Focused on improving public health / population health
  - The Subcommittee agreed to recommend this criterion.
- Focused on outcomes
  - Michael said the CT language was perhaps overly verbose. Andy spoke in favor of MA's language. Others agreed with Andy.
  - The Subcommittee agreed to recommend this criterion.
- Advances care delivery
  - The Subcommittee agreed to recommend this criterion.
- Reasonable number of measures / balanced measure set
  - Michael recommended shortening the language by stopping after the word "prioritize." Steve and Andy agreed with Michael. Lisa spoke in favor of retaining the purpose statement.
  - The Subcommittee agreed to recommend this criterion.
- Not burdensome
  - Michael said the Subcommittee had addressed this at the individual measure criterion level and by addressing measure set size. He didn't think it was needed, therefore. Others agreed with Michael.
- Promotes value and supports the Triple Aim
  - Michael said this criterion seemed to overlap with #4. The group agreed with Michael.
- Universally applicable, holistic and/or representative
  - Steven liked the RI language, but didn't like "holistic." Andy and Alan agreed with Steve.
  - The Subcommittee agreed to recommend this criterion.
- Aligned
  - Michael explained that this criterion means to give preference to measures currently in use in contracts.
  - Marlene observed that some measures in contracts are working, but not all.
  - Michael said, if anything, this criterion should apply to individual measures, and not the measure set as a whole. He agreed that not all measures are good measures though.
  - Lisa noted this criterion could stifle innovation.

Michael and Hanna thanked the Subcommittee for its productive work. Michael added that staff will distribute the agreed-upon language to get the Subcommittee's approval before sharing it with the Quality Council for endorsement at its next meeting on January 21st.

3.	**Adjourn**	**Hanna Nagy**
	The meeting adjourned at 12:55pm.	