Meeting of the Quality Council

Meeting Date	Meeting Time	Location
January 21, 2021	4:00 pm – 6:00 pm	Webinar/Zoom

Participant Name and Attendance

Quality Council		
Rohit Bhalla	Amy Gagliardi	Brad Richards / Kate McEvoy
Alan Coker (Co-Chair)	Karin Haberlin	Andrew Selinger (Co-Chair)
Nettie Rose Cooley	Michael Jefferson	Marlene St. Juste
Elizabeth Courtney	Nikolas Karloutsos	Carolyn (Cary) Trantalis
Sandra Czunas	Paul Kidwell	Steve Wolfson
Stephanie DeAbreu	Joseph Quaranta	
Arielle Levin Becker, on behalf of Tiffany Donelson	Laura Quigley	
Others Present		
Michael Bailit, Bailit Health	Hanna Nagy, OHS	Jeannina Thompson, OHS
Deepti Kanneganti, Bailit Health	Kelly Sinko, OHS	Susannah Bernheim
Members Absent:		
Steven Choi	Syed Hussain	Orlando Velazco
Mark DeFrancesco	Robert Nardino	
Lisa Freeman	Christine (Chrissy) Tibbits	

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 4:03 pm.	
2.	**Public Comment**	**Andy Selinger**
	Andy Selinger welcomed public comment. None was voiced.	
3.	**Approval of December 17, 2020 Meeting Minutes**	**Andy Selinger**
	Rohit Bhalla motioned to approve minutes of the Quality Council's December 17th meeting. Carolyn Trantalis seconded the motion. No one opposed or abstained from approving the meeting minutes. The motion passed.	
4.	**Review Subcommittee's Measure Selection Criteria Recommendations**	**Michael Bailit**
	Michael Bailit reminded the Council that during the December meeting, it reviewed measure selection criteria from Connecticut, Massachusetts and Rhode Island and then completed a survey to identify which criteria Council members individually prioritized for adoption. OHS convened a subcommittee of the Quality Council to identify which measure selection criteria to recommend to the Council for final adoption today. He reminded the Council that the measure selection criteria are intended to aid the Council in determining whether measures should be included in the Core Measure Set. The Quality Council reviewed the subcommittee's recommended measure selection criteria to apply to individual measures. Michael explained that a measure would not need to meet all of the criteria for inclusion in the Core Measure Set. • #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. o Rohit Bhalla asked how this criterion would apply if a measure had good overall data, but weak demographic data. Michael said the Council would discuss this issue later in the meeting. • #2: Represents an opportunity for improvement in quality of care, inclusive of outcomes and of population health. o No one expressed concern with this criterion. • #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 and varied over time. o Andy asked what is meant by "more varied" over time. Michael noted that this language was unclear and proposed revising the phrase to end the criterion at "more refined over time." Andy agreed with Michael's proposed revision. o Joseph Quaranta said he understood the measure to mean that over time, the measure would leverage additional data sources as applicable. o Nettie Rose Cooley spoke on behalf of payers, noting that it is important that the measure should be operationalizable.	

- **Next Step**: Revise criterion to end in "…as technology evolves and becomes more refined over time."
- #4: Evidence demonstrates that the structure, process, or outcome being measured correlates with improved patient health.
  - No one expressed concern with this criterion.
- #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.
  - No one expressed concern about this criterion.
- #6: Measures and methods are valid and reliable at the data element and performance score level.
  - Brad Richards noted that there will be a tension between what measures are currently valid and reliable, and what measures are important, but may not currently be as valid and reliable (e.g., health equity measures). Michael agreed with Brad, reminding the group that measures would not need to meet all of the criteria. He added that the Council will need to identify which health equity measures are currently most valid and reliable when considering their inclusion in the Set.
- #7: Useable, relevant and has a sufficient denominator size.
  - Marlene St. Juste asked if a measure would be excluded from the Core Measure Set if it had a small denominator size. Michael noted that Bailit Health would flag small denominator size as an issue when the Council reviews individual measures, but the Council could still decide to include the measure in the Set.

The Quality Council reviewed the measure selection criteria to apply to the measure set as a whole. Michael explained that the Council would utilize these criteria to evaluate all measures after it completed its initial review of each individual Core Measure Set measure.

- #1: Includes topics and measures for which there are opportunities to promote health equity by race, ethnicity, language and/or disability status.
  - No one expressed concern with this criterion.
- #2: Broadly address population health.
  - No one expressed concern with this criterion.
- #3: Prioritizes health outcomes, including measures sourced from clinical and patient-reported data.
  - Andy favored the inclusion of patient-reported data, adding that the Council will need to evaluate the reliability of these 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.
  - No one expressed concern with this criterion.
- #5: Balances comprehensiveness and breadth with the need for parsimony to enable effective quality improvement.
  - No one expressed concern with this criterion.
- #6: Representative of the array of services provided, and the diversity of patients served, by the program.
  - No one expressed concern with this criterion.

Andy asked for a motion to adopt the measure selection criteria. Steve Wolfson motioned to accept the Quality Council Subcommittee's recommended measure selection criteria, as amended by the Quality Council. Amy Gagliardi seconded the motion. The Council conducted a vote by roll call, with the following members voting to approve the motion: Alan Coker, Nettie Rose Cooley, Elizabeth Courtney, Sandra Czunas, Stephanie DeAbreu, Amy Gagliardi, Karin Haberlin, Michael Jefferson, Nikolas Karloutsos, Paul Kidwell, Laura Quigley, Brad Richards, Andy Selinger, Marlene St. Juste, Cary Trantalis, Steve Wolfson. The motion passed.

Decision: The Quality Council approved the measure selection criteria.
Next Steps: OHS will distribute a document with the final measure selection criteria for the Quality Council to utilize when evaluating the Core Measure Set.

The Quality Council then discussed how to address health equity as it relates to the Core Measure Set. Michael shared two options with the Council: 1) prioritize inclusion of measures targeting conditions or services with large inequities based on research and any available CT-specific data, and/or 2) adopt measures that specifically measure health inequity (e.g., adopt a measure focused on reducing the gap associated with disparities in colorectal cancer screening between Black and White men) and/or promote actions to reduce health inequity (e.g., Oregon adopted a measure that assesses accessibility to translator services). Paul Kidwell noted, referring to the Oregon example, that the Council should consider what state laws may require when selecting measures.

Michael shared that the National Committee for Quality Assurance (NCQA) is planning on releasing health equity measures for public comment in the near future. Andy added that CMS' payment guidelines now reimburse for physicians coding for areas of need related to social determinants of health. Michael described several challenges associated with measuring health inequities.

First, commercial payers generally do not collect information on race, ethnicity and language (REL), and rarely, if ever, collect disability status information. Without these data, commercial payers are unable to stratify measure performance. Michael added that state Medicaid agencies typically collect this information as part of the enrollment process. He explained that provider organizations are much better at collecting these data, but may not always capture these data in a consistent format. Michael shared that over time, OHS is interested in using the health information exchange (HIE) to collect these data, but that is not feasible today. NCQA is allowing plans to impute REL when stratifying quality measures. Imputation is most commonly performed using U.S. Census Bureau data.

Susannah Bernheim agreed with Michael. She noted that while some organizations express discomfort with imputing REL data using Census data, it is a pragmatic way to understand progress related to health equity. Susannah recommended focusing on upstream measures (i.e., access and prevalence measures), noting that events that occur outside of a visit have a major impact on health. Michael said the Core Measure Set is intended to be utilized in payer contracts with Advanced Networks (ANs). He added that it is reasonable to hold ANs accountable for access, but not prevalence. Marlene shared that she understood Susannah's perspective, adding that providers in federally qualified health centers (FQHCs) may be more incentivized to improve care for select conditions because their populations have a higher prevalence of these conditions. Andy highlighted that zip codes are an important predictor of health status.

Michael asked the Council how it wished to apply health equity to the Core Measure Set. Paul, Marlene and Amy Gagliardi advocated for pursuing both approaches. Andy noted that the first option (i.e., prioritize inclusion of measures targeting conditions or services with large inequities) is more operationalizable at this time, and recommended implementing the second option (i.e., adopt measures that specifically measure health inequity and/or promote actions to reduce health inequity) after.

Next Step: Starting at the next meeting, Bailit Health will identify where there are inequities in performance as it introduces each measure. After the Council completes its initial review of the Core Measure Set, it will consider how to include measures that specifically measure health inequities.

5.	**Begin Annual Review of the Core Measure Set**	**Michael Bailit/Deepti Kanneganti**

Michael explained that the Quality Council's review of the Core Measure Set will begin with an individual review of each measure, followed by an assessment of and an effort to fill any gaps in the Set. He shared that the Council previously requested a review of Connecticut's health needs and opportunities. He reported that DataHaven found that high blood pressure/ hypertension, asthma and diabetes are three prevalent chronic conditions in the State. He added that four additional sources (i.e., Healthy Connecticut 2025, 2019 Connecticut State Health Assessment, 2020 America's Health Rankings, and 2020 Commonwealth Fund's Scorecard) found the following health issues to be additional statewide priorities: access to substance use disorder (SUD) treatment, childhood obesity, behavioral health treatment, lead screening/prevention, low birthweight racial gap, and emergency room (ER) use.

Deepti Kanneganti explained that for each measure, Bailit Health identified (1) whether there were any major changes to the measure's specifications/endorsement status since it was first adopted by the Council in 2016, (2) whether there were any changes to the measure's status in the national measure sets of interest to the Council, (3) if the measure is currently in use by Connecticut payers, (4) if the measure addresses any of the state health priorities Michael reviewed and (5) if there was an opportunity for performance improvement.

Sandy Czunas noted that the state employee program is rolling out a new incentive program that includes new clinical and outcome measures, and added that she could share these measures with OHS after the meeting. Kate McEvoy introduced Brad Richards, Medicaid's new Chief Medical Officer, and asked that the assessment of opportunity for performance improvement utilizes measure data from the CMS Medicaid scorecard.

The Quality Council began its review of the measures in the Core Measure Set.

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient-Centered Medical Home (PCMH) Survey
    - Rohit encouraged retention of a patient survey so that there is a focus on patient experience. Elizabeth agreed with Rohit.
    - Deepti explained that the PCMH Survey is a supplemental item that can be added to the Clinical and Group (CG) CAHPS survey. She said CT could use CG CAHPS as an alternative. She identified use of CG CAHPS in federal measure sets, including the Merit-based Incentive Payment System (MIPS) measure set.
    - Rohit advocated for use of CG CAHPS.
    - Kate said DSS had been using PCMH CAHPS, but would be open to considering CG CAHPS.
    - Brad noted that there was another survey, created by Rebecca Ertz, that may be worthwhile for the Council to consider (https://www.annfammed.org/content/17/3/221/tab-article-info).
    - Michael suggested bringing a comparison of the three surveys to the next meeting.

- **Next Step**: Bailit Health will provide a comparison of the PCMH CAHPS, CG CAHPS and Rebecca Ertz's survey to the February Council meeting.

- Plan All-Cause Readmission
  - Marlene expressed concern about the measure specifications for post-partum women with preeclampsia and felt the measure should be adjusted.
  - Deepti said changing the measure would make it a homegrown measure.
  - Michael suggested addressing maternity measure separately to address Marlene's concern. Marlene agreed.
  - Rohit noted that unlike other measures, this one focused on something with direct financial implication. He added that all hospitals are measured for this. He said this measure was strengthened by including observation days.
  - **Decision**: Retain measure
- Annual Monitoring for Patients on Persistent Medications
  - Andy proposed retirement. Others agreed with Andy.
  - **Decision**: Drop the measure due to it (1) being retired by NCQA, (2) losing endorsement by the National Quality Forum (NQF), (3) having no commercial benchmark and (4) having a weak process-of-care focus.
- Breast Cancer Screening
  - Andy said the measure should be retained. Rohit and Marlene agreed with Andy.
  - Marlene expressed interest in starting the age range at age 40, and not age 50.
  - Michael noted that if the measure began at age 40, there would be no comparable benchmark rate.
  - Brad said the U.S. Preventive Services Taskforce (USPSTF) gave screening beginning at 50+ a B grade and 40+ a C grade. He suggested stratified measurement to address differences in opinion.
  - Rohit suggested focusing on the population with no dispute – 50+.
  - Deepti explained that NCQA allows the measure to be adjusted for use with providers to lower the age range to 40+. She suggested footnoting the measure to indicate this and also share the USPSTF grades.
  - **Decision**: Retain the measure, adopting Deepti's recommendation to footnote the ability to begin at 40+ and associated rationale.

Rohit asked if OHS/Bailit Health could provide numerator and denominator statements for each measure in advance of the next meeting. Michael committed to doing so.

Next Step: Provide measure specifications with the meeting materials.

6.	**Adjourn**	**Andy Selinger**
	Amy Gagliardi made a motion to adjourn the meeting. Marlene St. Juste seconded the motion. There were no objections. The meeting adjourned at 5:59 pm.	