Quality Council
February 18, 2021

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Agenda

Time	Topic
4:00 p.m.	Call to Order
4:05 p.m.	Public Comment
4:15 p.m.	Approval of January 21, 2021 Meeting Minutes
4:20 p.m.	Continue Annual Review of Core Measure Set
4:55 p.m.	Break
5:00 p.m.	Continue Annual Review of Core Measure Set
5:50 p.m.	Wrap-up & Next Steps
6:00 p.m.	Adjourn

Call to Order

Public Comment

Approval of January 21, 2021 Meeting Minutes

Continue Annual Review of the Core Measure Set

Recap of the January 21, 2021 Meeting

- The Council voted to **approve the measure selection criteria**, which were distributed with the meeting materials and included in the appendix of this PowerPoint.
- The Council also expressed interest in **reviewing whether measures in the Core Measure Set have identified inequities** in performance during the annual review process.
  - Bailit Health has since conducted an equity review, the results of which will be summarized today as we review each individual measure.
  - The Council will consider how to measure health inequity after it completes its initial review of the current measure set.

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Recap of the January 21, 2021 Meeting (Cont'd)

- Finally, the Council **began its review** of the Core Measure Set in earnest, making the following decisions:
  - **Retain**: Plan All-Cause Readmission, Breast Cancer Screening
  - **Remove**: Annual Monitoring for Patients on Persistent Medications
  - **Revisit**: PCMH CAHPS

CAHPS: Consumer Assessment of Healthcare Providers and Systems (a patient survey instrument)
PCMH: Patient-Centered Medical Home

Equity Review

- Bailit Health conducted an equity review to identify inequities in performance related to race/ethnicity, language, disability status, and other social determinants of health using the following sources:
  - Connecticut Health Foundation's "Health Disparities in CT" 2020 Report
  - Connecticut Department of Public Health's "Healthy CT 2025: State Health Assessment"
  - A literature review conducted by the MA Department of Public Health
  - Performance data provided by MA health systems and ACOs
  - State disparities research (focusing on data from CA, MI, and MN)
  - Buying Value's "disparities-sensitive" measure status, based on NQF's 2017 Disparities Project Final Report
  - AHRQ's National Healthcare Quality and Disparities Report (2018)
  - A literature review conducted by Bailit Health to supplement the above data sources

Note: Not all results are displayed on each slide. All information can be found in the Crosswalk distributed with the meeting materials.

ACO: Accountable Care Organization
AHRQ: Agency for Healthcare Quality and Research
NQF: National Quality Forum

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Reminders!

- **Alignment with national measure sets of interest (max score: 7)**
  - CMS Electronic Clinical Quality Measures (eCQMs)
  - CMS Medicaid Child Core Set
  - CMS Medicaid Adult Core Set
  - CMS Merit-based Incentive Payment System (MIPS)
  - CMS Medicare Shared Savings Program ACO and Next Generation ACO
  - Core Quality Measures Collaborative Core Sets
  - NCQA HEDIS
- **Use by Connecticut payers (max score: 5)**
  - Dept. of Social Services (DSS) Patient-Centered Medical Home Plus (PCMH+)
  - Responses from four of six surveyed commercial insurance carriers

Reminders! (Cont'd)

- **CT state Health Priorities/Needs**

1. chronic conditions
   - hypertension: 30%
   - asthma: 15%
   - diabetes: 10%
2. access to substance use disorder (SUD) treatment
   - 29.9 drug deaths per 100,000 (*CT ranks 42nd*) and 30.7 drug poisoning deaths (*CT ranks 41st*) in 2018
3. childhood obesity
   - 17% of children are obese and 15% are overweight
4. behavioral health treatment
   - suicide is the leading cause of intention injury and death in the state.
5. lead screening/prevention
   - 26.6% of housing stock has a lead risk (*CT ranks 46th*)
6. low birthweight racial gap
   - increased 19% from 5.4 to 6.4 (2017-18)
7. emergency room (ER) use
   - 22% of individuals received care in an ER one to two times in the last year

Sources include: 2020 America's Health Rankings, 2020 Commonwealth Fund's Scorecard, 2019 CT State Health Assessment, Healthy CT 2025 and DataHaven.

Reminders! (Cont'd)

- **Opportunity for Improvement**
  - Commercial: weighted average plan performance from Quality Compass 2020
  - Medicaid: PCMH+ performance from DSS (PCMH+) for 2019 and statewide performance from CMS (CMS) for FFY 2019

Key:				
<25th	Between 25th and 50th	Between 50th and 75th	Between 75th and 90th	≥90th

- **Alignment with the Quality Council's Measure Selection Criteria**
  - The criteria are meant to aid the Council in recommending measures for inclusion in the Core Measure Set.
  - Measures do not need to satisfy all the criteria to be recommended.
  - See the first two slides of the Appendix or the Word document distributed with the meeting materials for the list of criteria.

Follow-up from the January 21, 2021 Meeting

- The Quality Council considered three patient experience surveys at the last meeting:
  - Clinician and Group **(CG) CAHPS**, a widely used survey;
  - **PCMH CAHPS**, a supplemental item set that can be added to CG CAHPS; &
  - Person-Centered Primary Care Measure (**PCPCM**) developed by Ertz et al., suggested by Brad Richards for consideration
- The Council wished to compare the three surveys before deciding which to use in the Core Measure Set.

Survey Comparisons

	CG CAHPS	PCMH CAHPS	PCPCM
Number of Questions	Adult: 31 Child: 39	Adult: 6 Child: 10	11
Domains	Accessibility of Care, Communication with Providers, Care Coordination, Interactions with Staff	Access, Communication, Coordination of Care, Comprehensiveness, Information, Self-Management Support, Shared-Decision Making	Accessibility, Advocacy, Community Context, Comprehensiveness, Continuity, Coordination, Family Context, Goal-Oriented Care, Health Promotion, Integration, Relationship
Validated/ Psychometrically Tested?	Yes	Yes	Yes

Survey Comparisons (Cont'd)

	CG CAHPS	PCMH CAHPS	PCPCM
Advantages	• Most commonly used survey among providers • Scientifically designed and trusted to reliably assess patient experience • Provided by many survey vendors	• Easy to add onto CG CAHPS without requiring additional validation • Provides more tailored questions related to access, care coordination, etc.	• Developed with parsimony in mind, i.e., may be less burdensome to the patient • Effectively captures primary care-focused experience
Disadvantages	• Focused on consumer experience of care delivery rather than primary care • Survey length (31-39 questions)	• Survey length (37-49 questions when combined with CG-CAHPS)	• Not as widely used as the CAHPS survey • May be harder to encourage adoption among ANs

CAHPS PCMH Survey

Summary of Major Specification Changes	None	
Alignment with National Measure Sets of Interest	**0**	
Use by Connecticut Payers	**4** (DSS PCMH+ [Scoring], 3 of 4 commercial insurers)	
Addresses State Health Priorities/Needs?	No	
Opportunity for Improvement	**Commercial performance:** N/A	**Medicaid performance (2019):** N/A

CG CAHPS

Race/Ethnicity	Language	Disability Status
• A MA health system found that **all racial/ethnic minorities performed lower than Whites** on: Care Coordination, Provider Communication, and Provider Rating. Asians had lower patient experience on all ambulatory composite [MA Health System, 2018-2019].	• A MA health system found that **non-English-speaking patients are more likely to recommend their provider**. **Non-English-speaking patients have lower patient experience scores** in the areas of Care Coordination, Provider Communication, and Provider Rating [MA Health System, 2018-2019].	• Dual eligible beneficiaries with a **disability were more likely to report being unable to get needed health care** compared to beneficiaries without a disability (14% versus 10%) [CMS 2019].
Other		
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).		

Cervical Cancer Screening

Summary of Major Specification Changes	MY 2019: Updated screening methods to include primary high-risk HPV testing to count for numerator compliance.	
Alignment with National Measure Sets of Interest	**5** *(CMS eCQM, CMS Medicaid Adult Core Set, CMS MIPS, CMS Core Quality Measures Collaborative, NCQA HEDIS)*	
Use by Connecticut Payers	**3** (DSS PCMH+ [Reporting Only], 2 of 4 commercial insurers)	
Addresses State Health Priorities/Needs?	No	
Opportunity for Improvement	**Commercial performance (2019):** 81.8%	**Medicaid performance (2019 - CMS):** 66.4%

Cervical Cancer Screening

Race/Ethnicity	Disability Status	Income
• Rates of screening in CT were **highest for Whites** (86%), followed by Blacks (85%), then Hispanics (82%) [2025 CT State Health Assessment] • The Medicaid managed care cervical cancer screening rate was 8.2 percentage points **higher for Blacks than for Whites** in California, and 4.5 percentage points higher for Blacks than for Whites in Michigan (state disparities research).	• Women aged 18+ with disabilities were **less likely to have had a Pap Test in the past 3 years** than women without disabilities. About 83% of women without disabilities had the test, compared with 71% of women with basic actions difficulty and only 65% of women with complex activity limitation (CDC, 2001-2005 Report).	• Rates of screening in CT were **highest for households making $75k+** (91%), followed by $35k-$74.9k (84%), then <$35k (78%) • In 2015, **low-income women and middle-income women** were less likely to receive a Pap Test in the last 3 years compared to high-income women (AHRQ, 2018).
Other		
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).		

Chlamydia Screening

Summary of Major Specification Changes	None		
Alignment with National Measure Sets of Interest	**6** *(CMS eCQM, CMS Medicaid Adult Core Set, CMS Medicaid Child Core Set, CMS MIPS, CMS Core Quality Measures Collaborative, NCQA HEDIS)*		
Use by Connecticut Payers	**4** (DSS PCMH+ [Reporting Only], 3 of 4 commercial insurers)		
Addresses State Health Priorities/Needs?	No		
Opportunity for Improvement	**Commercial performance (2019):** 66.2%	**Medicaid performance (2019 - CMS):**	
		Ages 16-20: 62.2%	**Ages 21-24:** 73.3%

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Chlamydia Screening

Race/Ethnicity	Disability Status
• The Medicaid managed care **chlamydia screening rates for Whites were above those for Blacks** by 17.2 percentage points in Michigan and 17 percentage points in Minnesota (state disparities research).	• Young people with mild/moderate intellectual disabilities are **more likely to have unsafe sex than their peers** (Baines et al., 2018).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Colorectal Cancer Screening

Summary of Major Specification Changes	None	
Alignment with National Measure Sets of Interest	**5** *(CMS eCQM, CMS MSSP/Next Gen ACO, CMS MIPS, CMS Core Quality Measures Collaborative, NCQA HEDIS)*	
Use by Connecticut Payers	**3** (3 of 4 commercial insurers)	
Addresses State Health Priorities/Needs?	No	
Opportunity for Improvement	**Commercial performance (2019):** 72.8%	**Medicaid performance (2019):** N/A

Colorectal Cancer Screening

Race/Ethnicity	Disability Status	Income
• Rates of screening in CT were **highest for Whites** (77%), followed by Blacks (76%), then Hispanics (64%) [2025 CT State Health Assessment] • During 2012-16, incidence and mortality **rates in Blacks were 20% and 40%, respectively, higher than those in Asian/Pacific Islanders** [American Cancer Society]. • MA Health System performance showed a **higher screening rate for White** (72%) than other/multi-racial patients (58%) [MA Health System, 2020].	• Individuals with intellectual disability, spinal cord injury and blindness reported **lower odds of adherence to screening recommendations** (34%, 44% and 48%, respectively) compared to the general population (48%) (Deroche et al., 2017).	• Rates of screening in CT were **highest for households making $75K+** (78.7%), followed by $35k-$74.9K (77.2%), then <$35K (68.7%) [2025 CT State Health Assessment]
Other		
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).		

Immunizations for Adolescents

Summary of Major Specification Changes	MY 2017: Added a two-dose HPV vaccination series (Combo 2).		
Alignment with National Measure Sets of Interest	**4** *(CMS Medicaid Child Core Set, CMS MIPS, CMS Core Quality Measures Collaborative, NCQA HEDIS)*		
Use by Connecticut Payers	**2** (2 of 4 commercial insurers)		
Addresses State Health Priorities/Needs?	No		
Opportunity for Improvement	**Commercial performance (2019):**		**Medicaid performance (2019 - CMS):** **Combo 1 (no HPV):** 87.8%
	Combo 1: 83.9%	**Combo 2:** 20.9%	

Immunizations for Adolescents

Race/Ethnicity	Disability Status
• The Medicaid managed care performance was **4.7% lower for Whites than for Blacks** in California and **1.8% higher for Whites than for Blacks** in Michigan (state disparity research).	• A literature review showed that people with disabilities have **lower rates of immunization uptake** across a range of different vaccines then their typically developing peers (O'Neill et al., 2019).

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents

Summary of Major Specification Changes	MY 2020: Removed the exclusion of member-reported biometric values. MY 2018: Change in ICD-10 coding no longer allowed BMI to be billed for people of normal weight (only impacts administrative-reporting method).	
Alignment with National Measure Sets of Interest	**5** *(CMS eCQM, CMS Medicaid Child Core Set, CMS MIPS, CMS Core Quality Measures Collaborative, NCQA HEDIS)*	
Use by Connecticut Payers	**1** (1 of 4 commercial insurers)	
Addresses State Health Priorities/Needs?	Yes - the 2019 CT State Health Assessment and Healthy CT 2025 Framework includes percentage of children who are obese as a key impact measure. 17% of children 5-17 years are obese and 15% are overweight.	
Opportunity for Improvement	**Commercial performance (2019):** 78.0%	**Medicaid performance (2019 - CMS):** 81.6%

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents

Overall Obesity Rates Among Youth (5-17) in CT (2025 CT State Health Assessment)		
• By **race**: Hispanic (30%), Black (23%), Other (17%), White (12%) • By **income**: <$25K (31%), $25K+ (16%) • By **age**: 5-11 (27%), 12-17 (9%)		
Race/Ethnicity	**Disability Status**	**Income**
• Among youth aged 2-19 in 2015-16, the prevalence of obesity is **higher among Blacks and Hispanics compared to Whites and Asians** CDC NCHS Data Brief). • BMI has been found to **underestimate body fatness in South Asian** children and to **overestimate body fat composition in African American** children (Byrd et al., 2018).	• Obesity among children with **developmental disabilities/ autism** (30%) appears **significantly higher** compared with the general population (Fox et al., 2014).	• An **inverse association exists between family income and obesity prevalence among White females (all ages) and White males (ages 2-19)**, but it's weak or positive among other groups (CDC, 2011).

BMI Screening and Follow-Up

Summary of Major Specification Changes	MY 2018: Revised numerator to specify that a patient with BMI documented in the previous 12 months (used to be six months) meets the criteria. Measure lost NQF endorsement in January 2020 because CMS and Mathematica decided to not pursue NQF re-endorsement of this measure.	
Alignment with National Measure Sets of Interest	**3** *(CMS eCQM, CMS MIPS, CMS Core Quality Measures Collaborative)*	
Use by Connecticut Payers	**1** (1 of 4 commercial insurers)	
Addresses State Health Priorities/Needs?	No	
Opportunity for Improvement	**Commercial performance (2019):** N/A	**Medicaid performance (2019):** N/A

BMI Screening and Follow-Up

Overall Obesity Rates Among Adults (18+) in CT (2025 CT State Health Assessment)		
• By **race**: Black (37%), Hispanic (31%), White (26%), Other (18%) • By **income**: <$25K (31%), $25K+ (28%) • By **age**: 35-54 (33%), 55+ (29%), 18-34 (20%) • By **education**: high school or less (31%), more than high school (25%)		
Race/Ethnicity	**Disability Status**	**Income**
• Data from 2002-16 show that the **disparity between Hispanics and non-Hispanic Whites was narrowing**; Hispanic performance improved (39% to 52%) and **White performance declined** (50% to 46%) [AHRQ, 2018]. • Data for 2015-17 found that **Black adults had the highest prevalence of obesity** (38.4%), **followed by Hispanics** (32.6%), **then Whites** (28.6%) (CDC: Petersen et al., 2019).	• **Individuals with physical disabilities and cognitive disabilities experienced more obesity** than those without. Age-adjusted prevalence rates of obesity (per 1,000) without disabilities: 24%; cognitive limitations: 33.3%; physical disabilities: 39.9% (Reichard et al., 2010).	• An **inverse association exists between family income and obesity prevalence among White females (all ages)**, but the association is weak or positive (Black men aged >= 20 years) among other groups (CDC, 2011).

Developmental Screening in the First Three Years of Life

Summary of Major Specification Changes	MY 2021: Updated the list of recommended tools to align with the Bright Futures Recommendations for Preventive Care, which reference an updated January 2020 American Academy of Pediatrics (AAP) statement. Measure lost NQF endorsement in May 2017 because measure steward did not have sufficient funding to submit the required documentation.		
Alignment with National Measure Sets of Interest	**2** *(CMS Medicaid Child Core Set, CMS Core Quality Measures Collaborative)*		
Use by Connecticut Payers	**1** (DSS PCMH+ [Scoring])		
Addresses State Health Priorities/Needs?	No		
Opportunity for Improvement	**Commercial performance (2019):** N/A	**Medicaid performance (2019):**	
		PCMH+: 68.0%	**CMS:** 61.3%

Developmental Screening in the First Three Years of Life

Race/Ethnicity	Language	Disability Status
• **White children are more likely to be referred to early intervention before developmental screening** and non-White children are more likely to be referred at the time of a positive screen, suggesting that screening decreases disparities in accessing services by race/ethnicity (Wallis et al., 2021).	• Children from **non-English and non-Spanish speaking families have lower odds of receiving developmental surveillance** at 100% of well-child visits and of being **screened with a standardized developmental screening tool** (Rodrigues et al., 2016).	• Children with severe disabilities are at a **greater risk for receiving less than optimal health care** than children with less debilitating conditions (Sannicandro et al., 2017). • -Children with **developmental disabilities have the most profound inequality** in their health care experiences (Prokup et al., 2017).

Well-Child Visits in the First 15 Months of Life

Summary of Major Specification Changes	MY 2020: Replaced this measure with "Well-Child Visits in the First 30 Months of Life."		
Alignment with National Measure Sets of Interest	**1** *(CMS Medicaid Child Core Set – adopted the new measure)*		
Use by Connecticut Payers	**2** (2 of 4 commercial insurers)		
Addresses State Health Priorities/Needs?	No		
Opportunity for Improvement	**Commercial performance (2019):** 86.5%	**Medicaid performance (2019):**	
		PCMH+: 78.6%	**CMS:** 87.2%

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Well-Child Visits in the First 15 Months of Life

Race/Ethnicity	Language	Disability Status
• A MA ACO performance for well-child visits in the first 15 months showed **highest performance for Blacks** (75%) and **lowest performance for Other Race** (68%) and **lower rates for Hispanics** (66%) than non-Hispanics (MA ACO research, 2021). • A MA Health System performance for well-child visits in the first 15 months showed **higher performance in Whites** (85%) than in Hispanics (73%) [MA Health System, 2020].	• A MA ACO performance was **similar for English and non-English** language preference individuals, but **lower rates for Portuguese speakers** (MA ACO research, 2021).	• Children with severe disabilities are at a **greater risk for receiving less than optimal health care** than children with less debilitating conditions (Sannicandro et al., 2017). • Children with **developmental disabilities have the most profound inequality** in their health care experiences (Prokup et al., 2017).

Adolescent Well-Care Visits

Summary of Major Specification Changes	MY 2020: Combined this measure with "Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life" to make "Child and Adolescent Well-Care Visits."		
Alignment with National Measure Sets of Interest	**1** *(CMS Medicaid Child Core Set – adopted the new measure)*		
Use by Connecticut Payers	**3** (DSS PCMH+ [Scoring], 2 of 4 commercial insurers)		
Addresses State Health Priorities/Needs?	No		
Opportunity for Improvement	**Commercial performance (2019):** 71.1%	**Medicaid performance (2019):**	
		PCMH+: 73.4	**CMS**: 69.5%

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Adolescent Well-Care Visits

Race/Ethnicity
• MA Health System performance showed **higher performance for Whites than for Blacks** for ages 12-21: 67% White; 55% Black or African American (MA Health System, 2020). *If expanded to ages 3-21:* • A MA ACO's well-child 3-6 performance: 84% Asian compared to 79% Other Race; 83% Hispanic or Latino compared to 77% not Hispanic or Latino. AWC: 79% Asian compared to 68% multiple races; 73% Hispanic or Latino compared to 70% non-Hispanic or Latino (MA ACO research, 2021). • A MA health system's performance showed **higher performance for Whites than for** Blacks (this was not true of the MA ACO data) across all age ranges (MA Health System, 2020).

Tobacco Use: Screening and Cessation Intervention

Summary of Major Specification Changes	MY 2018: Revised measure to include three rates: 1. Patients screened for tobacco use within 24 months 2. Patients identified as a tobacco user who received cessation intervention 3. Patients screened for tobacco use within 24 months AND who received tobacco cessation intervention if identified as a tobacco user	
Alignment with National Measure Sets of Interest	**4** *(CMS eCQM, CMS MSSP/Next Gen ACO, CMS MIPS, CMS Core Quality Measures Collaborative)*	
Use by Connecticut Payers	**0**	
Addresses State Health Priorities/Needs?	No	
Opportunity for Improvement	**Commercial performance (2019):** N/A	**Medicaid performance (2019):** N/A

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Tobacco Use: Screening and Cessation Intervention

Overall Tobacco Use in Adults (18+) CT (2025 CT State Health Assessment)		
• By **race**: Hispanic (22%), Black (19%), White (17%), Other (14%) • By **income**: <$25K (26%), $25-$34.9K (22%), $35-$49.9K (20%), $50-$74.9K (17%), +$75K (13%) • By **age**: 25-34 (26%), 18-24 (22%), 35-44 (20%), 45-54 (17%), 55-64 (16%), 65+ (9%) • By **education**: <high school (28%), high school/GED (23%), some college (21%), college graduate (8%)		
Race/Ethnicity	**Disability Status**	**Socioeconomic Status**
• Blacks have **lower tobacco use but are more likely to** die from tobacco-related diseases than Whites and **be exposed to secondhand smoke**. • American Indians/Alaskan Natives have the **highest prevalence of tobacco-use and risk of tobacco-related disease**. • Asian Americans and Hispanics/ Latinos have lower tobacco use (CDC, Tobacco-related Disparities).	• Current cigarette smoking is **significantly higher among adults with a disability** (27.8%) compared to adults without a disability (13.4%) (CDC).	• Adults with **lower educational attainment, who are unemployed and who live in poverty have higher rates of tobacco use**. They have **similar rates of quit attempts** but are **less successful** (CDC, Tobacco-related Disparities).

Prenatal & Postpartum Care

Summary of Major Specification Changes	Added telehealth to the Prenatal rate and visits before enrollment. Revised the timing of the event/ diagnosis criteria and Postpartum numerator. Measure lost NQF endorsement in October 2016 because of concerns around timing of the measure (which has been updated), validity issues and potential for unintended consequences.		
Alignment with National Measure Sets of Interest	**3** *(CMS Medicaid Adult Core Set (Postpartum), CMS Medicaid Child Core Set (Prenatal), NCQA HEDIS)*		
Use by Connecticut Payers	**2** (DSS PCMH+ [Challenge], 1 of 4 commercial insurers)		
Addresses State Health Priorities/Needs?	Yes - America's Health Rankings ranks CT 25 out of 50 states on low-birthweight racial gap.		
Opportunity for Improvement	**Commercial performance (2019):** **Postpartum Care:** 85.7% **Timeliness of Prenatal Care:** 89.0%	**Medicaid performance (2019):**	
		PCMH+	**CMS**
		Postpartum: 58.1%	**Postpartum:** 68.2%
		Prenatal: 75.0%	**Prenatal:** 86.8%

Prenatal & Postpartum Care – Timeliness of Prenatal Care

Race/Ethnicity	Disability Status
• California Medicaid managed care **performance for Whites was higher than for Blacks** by 6.3% (state disparities research). • A 2016 National Vital Statistics Report showed that only **51.9% of Native Hawaiian or Other Pacific Islander women begin care in the first trimester** compared to 82.3% of non-Hispanic White women (Osterman et al., 2018). • In Connecticut during 2016-2018 (average), **White (88.1%) mothers had the highest rates of early prenatal care**, followed by Asian/Pacific Islanders (83.6%), American Indian/Alaska Natives (81.3%), Hispanics (79.2%) and blacks (77.4%) (March of Dimes).	• Compared with women without disabilities, women with intellectual and developmental disabilities are **less likely to initiate prenatal care in the first trimester** (Mitra, Monika, 2017).
Other	
• NQF identified this to be a "disparities-sensitive measure" (NQF, 2017).	

Prenatal & Postpartum Care – Postpartum Care

Race/Ethnicity	Disability Status
• The Medicaid managed care performance was **higher for Whites than it was for Blacks** by 11.1% in California and by 9.2% in Michigan (state disparities research).	• There are **high rates of postpartum hospital admissions and emergency department visits** among women with intellectual and developmental disabilities and a **significantly elevated risk of hospital utilizations for psychiatric reasons** compared with medical reasons (Mitra, Monika, 2017).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Screening for Clinical Depression and Follow-Up Plan

Summary of Major Specification Changes	MY 2020: Revised the numerator to also include patients screening for depression up to 14 days prior to the date of the encounter (used to only include screens performed on the date of the encounter). Measure lost NQF endorsement in September 2020 because CMS did not seek re-endorsement due to resource priorities.	
Alignment with National Measure Sets of Interest	**6** *(CMS eCQM, CMS Medicaid Adult Core Set, CMS Medicaid Child Core Set, CMS MSSP/Next Gen ACO, CMS MIPS, CMS Core Quality Measures Collaborative)*	
Use by Connecticut Payers	**1** (1 of 4 commercial insurers)	
Addresses State Health Priorities/Needs?	Yes - the 2019 CT State Health Assessment and Healthy CT 2025 Framework includes suicide rate as a surveillance measure.	
Opportunity for Improvement	**Commercial performance (2019):** N/A	**Medicaid performance (2019):** N/A

Screening for Clinical Depression and Follow-Up Plan

Race/Ethnicity	Disability Status
• Medicaid-covered Latinx, Asian/Pacific Islander, and Black youth were **less likely to have a depression diagnosis** than white counterparts. After a new diagnosis, Native American and Latinx youth were **less likely than white youth to have received an antidepressant or a mental health specialty visit** (Richardson et al., 2003). • Black and Asian adults were **less likely to be screened for depression** than white adults. Latinx adults were **more likely to be screened** for depression. Post-screening, Black adults, Latino males, and Asian adults were less likely to receive mental health care than their white counterparts (Hahm et al., 2015).	• The estimated **prevalence of depression in adults with disability (24.9-41%) is higher than that of adults without disability** (22.8-27.5%). Individuals with physical disability reported more pain, depression, and anxiety and a lower quality of life (Shen et al., 2017).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Behavioral health screening (pediatric, Medicaid-only, custom measure)

Summary of Major Specification Changes	None	
Alignment with National Measure Sets of Interest	**0**	
Use by Connecticut Payers	**1** (DSS PCMH+ [Challenge])	
Addresses State Health Priorities/Needs?	Yes - the 2019 CT State Health Assessment and Healthy CT 2025 Framework includes suicide rate and drug overdose deaths as two surveillance measures.	
Opportunity for Improvement	**Commercial performance (2019):** N/A	**Medicaid performance (2017 – PCMH+):** 45.9% (no benchmark, as measure is homegrown)

Behavioral health screening

Race/Ethnicity	Disability Status	Income
• From 2015 to 2017, nearly all racial/ethnic groups and age groups experienced significant increases in opioid-involved overdose death rates, **particularly Blacks aged 45–54 years (from 19.3 to 41.9 per 100,000) and 55–64 years (from 21.8 to 42.7)** in large central metro areas (AHRQ, 2018).	• Adults with disabilities were **significantly more likely than adults without disabilities to experience past year prescription opioid use** (52.3% with disabilities vs. 32.8% without), misuse (4.4% vs. 3.4%), and use disorders (1.5% vs. 0.5%) [Lauer et al., 2019]. • Substance abuse **among persons with disabilities is more prevalent than among other persons for most substances** (Glazier and Kling, 2013).	• In 2005, the rate of ED visits involving opioid-related diagnoses was 104.9 per 100,000 for poor people, and in 2016, the rate increased to 314.3. **Data from 2005 to 2016 show disparities widening between high-income and low-income people** (AHRQ, 2018).
Other		
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).		

Slides 38, 43 and 73 contain equity-related assessments for the “Tobacco Use: Screening and Cessation Intervention,” “Screening for Clinical Depression and Follow-up Plan” and “Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment” measures that may be relevant for “Behavioral Health Screening.”

Medication Management for People with Asthma

Summary of Major Specification Changes	MY 2020: Retired the measure because there are new recommendations for controller combination therapy and recent evidence suggests the measure is not coordinated with improved outcomes. Measure lost NQF endorsement in August 2016 due to concerns around the 50% and 75% thresholds and the ability of the measure to track outcomes.	
Alignment with National Measure Sets of Interest	**1** *(CMS MIPS)*	
Use by Connecticut Payers	**1** (DSS PCMH+ [Scoring])	
Addresses State Health Priorities/Needs?	Yes - America's Health Rankings ranks CT as 41 out of 50 states on this indicator as 10.5% of adults have asthma. According to DataHaven, 15% of individuals had asthma in 2018.	
Opportunity for Improvement	**Commercial performance (2019):** 58.5%	**Medicaid performance (2019 - PCMH+):** 43.7%

Medication Management for People with Asthma

Race/Ethnicity
• In CT, **Black and Hispanic children are 5.5x and 4.5x, respectively, more likely to go to the ED** because of asthma than White children (CT Health Foundation, 2020). • In CT, **Black and Hispanic children are 4.5x and 3x, respectively, more likely to be hospitalized** because of asthma than White children (CT Health Foundation, 2020). • In 2016, 1 in 12 children ages 0-17 had asthma. Among them, asthma **disproportionately affected males, non-Hispanic Black children, and children from low-income households** (AHRQ, 2018). • CA Medicaid managed care performance was 9.1 percentage points **higher for Whites than it was for Blacks** (state disparities research).

Medication Management for People with Asthma (Cont'd)

Disability Status	Housing	Income
• **Individuals with physical disabilities and cognitive disabilities experienced more asthma than those without.** Age-adjusted prevalence rates of asthma (per 1,000) without disabilities: 7.6%; cognitive limitations: 17%; physical disabilities: 71% (Reichard et al., 2010).	• **Substandard housing conditions** have been associated with poor health outcomes related to asthma (MA DPH Literature Review; Taylor, Lauren 2018).	• Even after controlling for other traditional measures of socioeconomic status, children are **more likely to have asthma the closer their family is to the federal poverty line** (MA DPH Literature Review; Taylor, Lauren 2018).

Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)

Summary of Major Specification Changes	MY 2020: Removed the restriction that only one of two eligible visits can be via telehealth. MY 2018: Added telehealth.	
Alignment with National Measure Sets of Interest	**6** *(CMS eCQM, CMS Medicaid Adult Core Set, CMS MSSP/Next Gen ACO, CMS MIPS, CMS Core Quality Measures Collaborative, NCQA HEDIS)*	
Use by Connecticut Payers	**1** (1 of 4 commercial insurers)	
Addresses State Health Priorities/Needs?	Yes - 10 percent of CT residents in 2018 had diabetes according to DataHaven.	
Opportunity for Improvement	**Commercial performance (2019):** 27.0%	**Medicaid performance (2019 - CMS):** 36.9%

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Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)

Race/Ethnicity	Disability Status
• In CT, **Black and Hispanic residents are more than 2x more likely than Whites to have diabetes** and have severe complications from it. Blacks are **>2x more likely than Whites to die from diabetes** (CT Health Foundation, 2020). • Prevalence of diabetes is **77% higher among Blacks and 66% higher among Hispanic** adults compared to Whites (MA DPH Literature Review; Piccolo, Rebecca et al., 2016). • MA Health System performance showed **highest control for Asians** (75%) and **lowest for Blacks or African Americans** (65%) [MA Health System, 2020). • Rate of HbA1c poor control is **6 percentage points worse for Black patients compared to White patients** in CA's Medicaid program (state disparities research).	• **Individuals with physical disabilities and cognitive disabilities experienced more diabetes than those without**. Age-adjusted prevalence rates of diabetes (per 1,000) without disabilities: 3.7%; cognitive limitations: 18%; physical disabilities: 15% (Reichard et al., 2010).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing

Summary of Major Specification Changes	MY 2020: Removed the restriction that only one of two eligible visits can be via telehealth. MY 2018: Added telehealth.		
Alignment with National Measure Sets of Interest	**2** *(CMS Core Quality Measures Collaborative, NCQA HEDIS)*		
Use by Connecticut Payers	**3** (DSS PCMH+ [Scoring], 2 of 4 commercial insurers)		
Addresses State Health Priorities/Needs?	Yes - 10 percent of CT residents in 2018 had diabetes according to Data Haven.		
Opportunity for Improvement	**Commercial performance (2019):** 92.2%	**Medicaid performance (2019):**	
		PCMH+: 89.2%	**CMS:** 87.0%

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Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing

Race/Ethnicity	Disability Status
• In CT, **Black and Hispanic residents are more than 2x more likely than Whites to have diabetes** and have severe complications from it (e.g., death). (CT Health Foundation, 2020). • A MA health system's performance showed **higher performance for Hispanics (82%) than for Black or African Americans (78%)** [MA Health System, 2020]. • Michigan Medicaid managed care performance was 6% **higher for Whites than it was for Blacks** (state disparity research).	• Compared to adults without disability, **those with physical disabilities and those with cognitive limitations experienced more diabetes** (Reichard et al., 2010).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Comprehensive Diabetes Care: Eye Exam

Summary of Major Specification Changes	MY 2020: Removed the restriction that only one of two eligible visits can be via telehealth. MY 2018: Added telehealth.	
Alignment with National Measure Sets of Interest	**4** *(CMS eCQM, CMS MIPS, CMS Core Quality Measures Collaborative, NCQA HEDIS)*	
Use by Connecticut Payers	**4** (DSS PCMH+ [Reporting Only], 3 of 4 commercial insurers)	
Addresses State Health Priorities/Needs?	Yes - 10 percent of CT residents in 2018 had diabetes according to Data Haven.	
Opportunity for Improvement	**Commercial performance (2019):** 65.7%	**Medicaid performance (2019):** N/A

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Comprehensive Diabetes Care: Eye Exam

Race/Ethnicity	Disability Status
• In CT, **Black and Hispanic residents are more than 2x more likely than Whites to have diabetes** and have severe complications from it (e.g., death). (CT Health Foundation, 2020). • The Michigan Medicaid managed care performance on this measure was 6.4 percentage points **higher for Whites than for Blacks** (state disparity research). • A MA health system's performance showed eye exam rate of 39% for Black/African Americans and 32% for other race/multi-racial people (MA Health System, 2020).	• Compared to adults without disability, **those with physical disabilities and those with cognitive limitations experienced more diabetes** (Reichard et al., 2010).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Comprehensive Diabetes Care: Medical Attention for Nephropathy

Summary of Major Specification Changes	MY 2020: Replaced the measure with "Kidney Health Evaluation for Patients with Diabetes" because the measure is not precise enough to meet the needs of kidney health evaluation as an aspect of diabetes management.	
Alignment with National Measure Sets of Interest	**3** *(CMS eCQM, CMS MIPS, CMS Core Quality Measures Collaborative, NCQA HEDIS)* *Of note – NCQA includes the newer HEDIS measure*	
Use by Connecticut Payers	**2** (DSS PCMH+ [Reporting Only], 1 of 4 commercial insurers)	
Addresses State Health Priorities/Needs?	Yes - 10 percent of CT residents in 2018 had diabetes according to Data Haven.	
Opportunity for Improvement	**Commercial performance (2019):** 88.4%	**Medicaid performance (2019):** N/A

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Comprehensive Diabetes Care: Medical Attention for Nephropathy

Race/Ethnicity	Disability Status
• In CT, **Black and Hispanic residents are more than 2x more likely than Whites to have diabetes** and have severe complications from it (e.g., death). (CT Health Foundation, 2020). • The Michigan Medicaid managed care performance on this measure is **not significantly different between Whites and Blacks** (state disparity research). • The rate of **end-stage renal disease due to diabetes is higher for Blacks and Hispanics compared to Whites** (AHRQ, 2018).	• Compared to adults without disability, **those with physical disabilities and those with cognitive limitations experienced more diabetes** (Reichard et al., 2010).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Controlling High Blood Pressure

Summary of Major Specification Changes	MY 2020: Revised the time frame to identify a diagnosis of hypertension. Eased telehealth requirements. Removed the requirements for remote monitoring devices and the exclusion of member-reported BP readings. MY 2018: Incorporated telehealth. Removed the requirement to confirm hypertension and the diabetes indicator.	
Alignment with National Measure Sets of Interest	**6** *(CMS eCQM, CMS Medicaid Adult Core Set, CMS MSSP/Next Gen ACO, CMS MIPS, CMS Core Quality Measures Collaborative, NCQA HEDIS)*	
Use by Connecticut Payers	**4** (4 of 4 commercial insurers)	
Addresses State Health Priorities/Needs?	Yes - this measure addresses medication for cardiovascular conditions. 30 percent of CT residents in 2018 had high blood pressure/hypertension.	
Opportunity for Improvement	**Commercial performance (2019):** 61.1%	**Medicaid performance (2019 - CMS):** 60.3%

Controlling High Blood Pressure

Overview of High Blood Prevalence in CT Adults (2025 CT State Health Assessment)	
• By **race**: Black (36%), White (32%), Hispanic (25%), Other (22%) • By **income**: <$25K (39%), $25K+ (28%) • By **age**: 55+ (51%), 35-54 (24%), 18-34 (10%) • By **education**: high school or less (35%), more than high school (28%)	
Race/Ethnicity	**Disability Status**
• The Medicaid managed care performance on this measure was **higher for Whites than for Blacks** by 4% in California and 9% in Minnesota, as well as for a MA ACO (state disparity and MA ACO research, 2021).	• **Individuals with physical disabilities and cognitive disabilities experienced more blood pressure than those without.** Age-adjusted prevalence rates of high blood pressure (per 1,000) without disabilities: 16.1%; cognitive limitations: 27.5%; physical disabilities: 67.3% (Reichard et al., 2010).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Use of Imaging Studies for Low Back Pain

Summary of Major Specification Changes	MY 2017: Added telehealth. Measure lost NQF endorsement in May 2017 because NQF said the measure did not pass the validity criterion (patients with trauma/ neurological impairment were sometimes excluded from the measure when using claims data).	
Alignment with National Measure Sets of Interest	**2** *(CMS Core Quality Measures Collaborative, NCQA HEDIS)*	
Use by Connecticut Payers	**2** (DSS PCMH+ [Reporting Only], 1 of 4 commercial insurers)	
Addresses State Health Priorities/Needs?	No	
Opportunity for Improvement	**Commercial performance (2019):** 75.7%	**Medicaid performance (2019):** N/A

Use of Imaging Studies for Low Back Pain

Race/Ethnicity	Income
• Compared to White patients, **Asian and Hispanic patients are less likely to be prescribed opioids... Black patients and patients of other race are more likely to receive an opioid prescription** to treat their back pain even after accounting for socioeconomic status, health insurance status and general health status (King and Liu, 2020). • **Blacks are more likely to report having low back pain** and corresponding physical functioning compared to Hispanics and Caucasians (Safo, 2012).	• Low back pain patients with **lower socioeconomic status may have higher health care costs** due to smaller benefit packages. Individuals receiving workers compensation due to low back pain in states with lower median household incomes and higher unemployment rates typically had longer length of disability, which were frequently associated with higher medical costs (Shraim et al., 2017).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis *(previously Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis)*

Summary of Major Specification Changes	MY 2019: Expanded the age range to members 3 months of age and older. Changed the measure from a member-based denominator to an episode-based denominator. Revised the Negative Competing Diagnosis time frame. Deleted cystic fibrosis from the Negative Comorbid Condition History test. MY 2018: Added telehealth.	
Alignment with National Measure Sets of Interest	**3** *(CMS MIPS, CMS Core Quality Measures Collaborative, NCQA HEDIS)*	
Use by Connecticut Payers	**2** (DSS PCMH+ [Scoring], 1 of 4 commercial insurers)	
Addresses State Health Priorities/Needs?	No	
Opportunity for Improvement	**Commercial performance (2019):** 34.1%	**Medicaid performance (2017):** 30.8%

Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis

Race/Ethnicity	Insurance Status	Housing
• Providers are **17% less likely to prescribe an antibiotic prescription for acute bronchitis when the provider and patient are of the same race** (Morgan et al., 2017). • The proportion of adults with acute bronchitis who received an antibiotic between 1996-2010 was relatively **similar for Whites and Blacks** (72% and 21%, respectively), but **significantly lower for Other** (51%), although the sample size was much lower (Barnett and Linder, 2014).	• The proportion of adults with acute bronchitis who received an antibiotic between 1996-2010 was **lower for Medicaid (63%), than for private (71%) and Medicare (74%)** [Barnett and Linder, 2014].	• Living in close proximity to high-volume roads / neighborhoods, or **areas with blight, increases rates of respiratory diseases.** Revitalizing abandoned lots can improve health (Taylor, Lauren 2018).

Appropriate Treatment for Upper Respiratory Infection *(previously Appropriate Treatment for Children with Upper Respiratory Infection)*

Summary of Major Specification Changes	MY 2019: Expanded the age range to members 3 months of age and older (previously ended at age 18). Changed the measure from a member-based denominator to an episode-based denominator. Removed the anchor date requirements. Removed the requirement to exclude episode dates where there was a diagnosis other than URI on the same data. Added the Negative Comorbid Condition History exclusion. Added telehealth.	
Alignment with National Measure Sets of Interest	**4** *(CMS eCQM, CMS MIPS, CMS Core Quality Measures Collaborative, NCQA HEDIS)*	
Use by Connecticut Payers	**2** (DSS PCMH+ [Reporting Only], 1 of 4 commercial insurers)	
Addresses State Health Priorities/Needs?	No	
Opportunity for Improvement	**Commercial performance (2019):** 80.6%	**Medicaid performance (2019):** N/A

Appropriate Treatment for Upper Respiratory Infection

Race/Ethnicity	Housing
• **White children were 1.5 to 2 times more likely than their minority counterparts to be prescribed unnecessary antibiotics** for viral respiratory infections. 3% of children discharged from pediatric EDs with a viral acute respiratory tract infection received antibiotics. This percentage was **higher among Whites** (4%), **lower among Blacks** (2%), and the **same among Hispanic and Other** (3%) [Bell et al., 2017].	• Living in close proximity to high-volume roads / neighborhoods, or **areas with blight, increases rates of respiratory diseases.** Revitalizing abandoned lots can improve health (Taylor, Lauren 2018).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Follow-Up Care for Children Prescribed ADHD Medication

Summary of Major Specification Changes	MY 2020: Added telehealth to the numerator for both rates.	
Alignment with National Measure Sets of Interest	**5** *(CMS eCQM, CMS Medicaid Child Core Set, CMS MIPS, CMS Core Quality Measures Collaborative, NCQA HEDIS)*	
Use by Connecticut Payers	**3** (DSS PCMH+ [Reporting Only], 2 of 4 commercial insurers)	
Addresses State Health Priorities/Needs?	No	
Opportunity for Improvement	**Commercial performance (2019):** **Continuation & Maintenance:** 51.3% **Initiation:** 43.7%	**Medicaid performance (2019 - CMS):** 44.4%

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Follow-Up Care for Children Prescribed ADHD Medication

Race/Ethnicity	Income
• **African-American and Latino children, compared with White children, had lower odds of having and ADHD diagnosis and taking ADHD medication**, controlling for sociodemographic, ADHD symptoms, and other potential comorbid mental health symptoms. Among children with an ADHD diagnosis or symptoms, African-American children had lower odds of medication use at fifth, seventh, and 10th grades, and Latino children had lower odds at fifth and 10th grades (Coker et al., 2016; Morgan et al., 2013).	• Overall, **children living in families at less than 100% of the federal poverty level (18.7%) were more likely to be diagnosed with ADHD** or a learning disability compared with children living in families at 100% or more of the federal poverty level (12.7%) and were more likely to be White and Black (CDC, 2020).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Metabolic Monitoring for Children and Adolescents on Antipsychotics

Summary of Major Specification Changes	None	
Alignment with National Measure Sets of Interest	**3** *(CMS Medicaid Child Core Set, CMS Core Quality Measures Collaborative, NCQA HEDIS)*	
Use by Connecticut Payers	**1** (DSS PCMH+ [Challenge])	
Addresses State Health Priorities/Needs?	Yes - the 2019 CT State Health Assessment and Healthy CT 2025 Framework includes suicide rate as a surveillance measure.	
Opportunity for Improvement	**Commercial performance (2019):** 37.5%	**Medicaid performance (2019 – PCMH+):** 40.4%

Metabolic Monitoring for Children and Adolescents on Antipsychotics

Disability Status
• Children with intellectual difficulty/autism were **more likely to be prescribed antipsychotics** (2.8% have been prescribed an antipsychotic [75% with autism] compared with 0.15% of children without intellectual difficulty). Those with intellectual disabilities/autism were **prescribed antipsychotics at a younger age and for a longer period**. Antipsychotic use was associated with a higher rate of respiratory illness for all (PERR of hospital admission: 1.55 [95% CI: 1.51–1.598] or increase in rate of 2 per 100 per year in those treated) [Brophy et al., 2018].
Other
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).

Depression Remission at Twelve Months

Summary of Major Specification Changes	MY 2019: Revised the age range to include adolescent patients 12-17 years (used to only be 18+). Revised the time frame to look at remission 12 months (+/- 60 days) after an index event (was +/- 30 days). Included patients with schizophrenia, psychotic disorder or pervasive developmental disorder to the exclusions. Included the PHQ-9M. MY 2018: Added telehealth.	
Alignment with National Measure Sets of Interest	**3** *(CMS eCQM, CMS MSSP/Next Gen ACO, CMS MIPS)*	
Use by Connecticut Payers	**0**	
Addresses State Health Priorities/Needs?	Yes - the 2019 CT State Health Assessment and Healthy CT 2025 Framework includes suicide rate as a surveillance measure.	
Opportunity for Improvement	**Commercial performance (2019):** N/A	**Medicaid performance (2019):** N/A

Depression Response at Twelve Months - Progress Towards Remission

Summary of Major Specification Changes	MY 2019: Revised the age range to include adolescent patients 12-17 years (used to only be 18+). Revised the timeframe to look at remission 12 months (+/- 60 days) after an index event (was +/- 30 days). Included patients with schizophrenia, psychotic disorder or pervasive developmental disorder to the exclusions. Included the PHQ-9M. MY 2018: Added telehealth.	
Alignment with National Measure Sets of Interest	**1** *(CMS Core Quality Measures Collaborative)*	
Use by Connecticut Payers	**0**	
Addresses State Health Priorities/Needs?	Yes - the 2019 CT State Health Assessment and Healthy CT 2025 Framework includes suicide rate as a surveillance measure.	
Opportunity for Improvement	**Commercial performance (2019):** N/A	**Medicaid performance (2019):** N/A

Equity Assessment

- See “Screening for Clinical Depression and Follow-up Plan” for an equity assessment for the following measures:
  - Depression Remission at Twelve Months
  - Depression Response at Twelve Months - Progress Towards Remission

Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment

Summary of Major Specification Changes	MY 2018: Added telehealth.	
Alignment with National Measure Sets of Interest	**2** *(CMS eCQM, CMS MIPS)*	
Use by Connecticut Payers	**0**	
Addresses State Health Priorities/Needs?	Yes - the 2019 CT State Health Assessment and Healthy CT 2025 Framework includes suicide rate and high school students who experienced sexual violence as surveillance measures.	
Opportunity for Improvement	**Commercial performance (2019):** N/A	**Medicaid performance (2017):** N/A

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Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment

Overview of CT Demographics	Disability Status
Percentage of High School Students who Seriously Considered Attempting Suicide • By **race**: Hispanic (14.7%), Black (14.1%), White (12.8%) • By **grade**: 9 (14.8%), 10 or 12 (14.1% or 13.7%)*, 11 (10.9%) • By **sex**: female (16.8%), male (10.3%) *Report lists Grade 10 twice Source: 2025 CT State Health Assessment	• Analyses using 2012 survey data from WI found that **youth in each disability category were 3-9 times more likely to report suicide attempts(s) (SA) relative to peers**, and having **multiple disabilities tripled the risk** of SA relative to youth reporting a single disability. • Some disability sub-groups, including youth reporting **autism spectrum disorder and hearing and vision impairments reported surprisingly high rates** of SA. **Disability status added unique risk for suicidal behavior** (Moses, Tally 2018).
Other	
• Buying Value identified this to be a "**disparities-sensitive measure**" using NQF's 2017 Disparities Project Final Report (NQF, 2017).	

Wrap-up & Next Steps

Meeting Wrap-Up & Next Steps

- Continue review of the 2019 Core Measure Set
- Perform a gap analysis of the Core Measure Set to assess comprehensiveness and measure set size

- Review the Quality Council's measure proposals for addition, removal and/or replacement to address the needs identified in the gap analysis (e.g., maternity care, oral health)

- Begin the final review of the Core Measure Set, which includes scoring the measures against the Quality Council's criteria, to identify whether any changes should be made
- Finalize recommended changes to the Core Measure Set

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Appendix

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.

Data Sources for the Five Considerations

1. **Have there been any major changes to the measure specifications?**
   - We reviewed major changes to the measure specifications by each measure's "steward" and the measure's endorsement status with NQF since 2016.
2. **What is the measure status in the national measure sets of interest?**
   - We identified whether the measure is currently in any of the following 7 measure sets that were previously indicated to be of interest to the Quality Council in 2016:
     - CMS Electronic Clinical Quality Measures (eCQMs)
     - CMS Medicaid Child Core Set
     - CMS Medicaid Adult Core Set
     - CMS Merit-based Incentive Payment System (MIPS)
     - CMS Medicare Shared Savings Program ACO and Next Generation ACO
     - Core Quality Measures Collaborative Core Sets
     - NCQA HEDIS

Data Sources for the Five Considerations (Cont'd)

3. **Is the measure currently utilized by Connecticut payers?**
   - We identified whether the measure is:
     - included in the DSS PCMH+ Measure Set,
     - in use by the state employee health plan (no response received yet), and/or
     - in use by commercial insurers (we surveyed 6 insurers and have received 2 responses thus far on measures included in VBP contracts).
   - The current max score for this field is 3 (DSS PCMH+, 2 commercial insurers).

4. **Does the measure address any of the state's health priorities?**
   - We identified the primary state health priorities using the following sources:
     - America's Health Rankings and Commonwealth Fund's Scorecard (2020)
     - 2019 CT State Health Assessment and Healthy CT 2025
     - DataHaven (2018)

CT State Health Priorities: Needs and Opportunities

1. chronic conditions
   - hypertension: 30%
   - asthma: 15%
   - diabetes: 10%
2. access to substance use disorder (SUD) treatment
   - 29.9 drug deaths per 100,000 (*CT ranks 42nd*) and 30.7 drug poisoning deaths (*CT ranks 41st*) in 2018
3. childhood obesity
   - 17% of children are obese and 15% are overweight
4. behavioral health treatment
   - suicide is the leading cause of intention injury and death in the state.
5. lead screening/prevention
   - 26.6% of housing stock has a lead risk (*CT ranks 46th*)
6. low birthweight racial gap
   - increased 19% from 5.4 to 6.4 (2017-18)
7. emergency room (ER) use
   - 22% of individuals received care in an ER one to two times in the last year

Sources include: 2020 America's Health Rankings, 2020 Commonwealth Fund's Scorecard, 2019 CT State Health Assessment, Healthy CT 2025 and DataHaven.

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Data Sources for the Five Considerations (Cont'd)

5. **Is there opportunity for improvement?**
   - **Commercial**: We created a 2019 statewide average of the four largest CT payers using data from Quality Compass 2020.
   - **Medicaid**: We obtained 2019 data for DSS' PCMH+ program (PCMH+) and statewide data for FFY2019 from CMS for the Medicaid Core Sets.
   - We compared commercial and Medicaid performance to national 2019 percentile data obtained from Quality Compass.*

Key:				
<25th	Between 25th and 50th	Between 50th and 75th	Between 75th and 90th	≥90th

* "Developmental Screening for the First Three Year of Life" is a non-HEDIS measure and therefore national FFY 2019 data were obtained from CMS.