CONNECTICUT STATE INNOVATION MODEL QUALITY COUNCIL
HEALTH EQUITY DESIGN GROUP
RECOMMENDATIONS FOR PRIORITIZING AMONG EHR-BASED MEASURES AND AMONG CLAIMS-BASED MEASURES

Members of the Health Equity Design Group (HEDG):

- Ignatius Bau, JD, Health Policy Consultant
- Aileen Broderick, Anthem Blue Cross Blue Shield
- Dora Hughes, MD, MPH, Health Policy Consultant, Sidley Austin
- Kathleen Lavorgna, MD, Connecticut State Medical Society
- Elizabeth Krause, ScM, Connecticut Health Foundation, HEDG Chairperson
- Theanvy Kuoch, MA, Khmer Health Advocates, SIM Consumer Advisory Board
- Wayne Rawlins, MD, MPH, ConnectiCare (formerly Aetna)

Charge:
The HEDG was charged with providing recommendations to the Quality Council to ensure that health equity is advanced in the implementation of Connecticut's State Innovation Model's (SIM) quality improvement and value-based payment program.

While the HEDG has drafted a more comprehensive set of recommendations for SIM as a whole, the recommendations at hand are focused on prioritizing among two subsets of measures for their potential contribution to measurably advancing health equity: 1) the subset of measures under consideration by the Quality Council (as of June 2015) that are based on electronic health records (EHR) and 2) the subset of measures under consideration by the Quality Council (as of July 2015) that are based on claims.

What has become clear is that a pathway will be necessary over the SIM years to arrive at the point where EHR measures can be stratified by race/ethnicity and be included as weighted elements for value-based payment. For example, the first implementation year may involve developing health information technology capacity and establishing benchmarks through reporting. Until that EHR-based measurement and reporting capacity is developed, the Quality Council is likely to focus initially on selecting measures for quality improvement and value-based payments that rely more heavily on claims-based measures where available with inconsistency across and even within payers.

The HEDG offers the following recommended health equity measures for the Quality Council's consideration. The measures are prioritized in rank order because of the understanding that some measures may not make it onto the final common measure set and that some may not be feasible for stratification and payment calculations at this time. The HEDG recommends that, if only a subset of EHR-based measures and only a subset of claims-based measures are ultimately selected, that these high health equity impact measures be among the ones selected because health equity is an overarching goal of CT SIM.

Process:
The HEDG members reviewed the SIM plan and available disparities and equity data identified by the SIM Program Management Office for each of the EHR-based measures, and then each of the claims-based measures under consideration. Members individually rank ordered the EHR-based measures, and then individually ranked ordered the claims-based measures. The HEDG members then came together to come to consensus on the group's recommendations for prioritizing among the EHR-based measures, and then among the claims-based measures.

Selection and Prioritization Criteria:

- From the universe of the EHR-based measures in the SIM Quality Council's provisional measure set (June 2015) or from the universe of the claims-based measures in the SIM Quality Council's provisional measure set (July 2015)
- Evidence of racial/ethnic gaps for each measure
- Clinically important from multiple vantage points, but especially to consumers and populations that bear disproportionate inequities
- Aligned with other national and state improvement efforts for leverage and efficiency
- Likely to have adequate base rates (to be determined down the line)

Note: In some cases, robust racial and ethnic disparities data were not available. HEDG members, however, had reason to suspect the measures and clinical issues they address might be important from a health equity standpoint. Reporting and monitoring over time may be necessary to determine whether the measure is suited for value based payment calculations on the basis of racial and ethnic health disparities quality improvement.

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HEDG Priority Rank	EHR-BASED MEASURE	NQF	ACO	RATIONALE AND HEALTH EQUITY-RELATED DATA
1	Diabetes Mellitus: hemoglobin A1c poor control (>9%)	0059	27	Outcomes measure, addressing diabetes is a state and national priority, diabetes care quality prioritized in SIM Plan p.55, racial and ethnic disparities in diabetes, SIM Plan p.26 Diabetes in adults: CT overall: 6.4%; CT white: 5.7%; CT Black: 14.9%*; CT Hispanic: 10.5%*;CT low income: 12.3% Premature mortality from diabetes (males): CT overall: 134/100K; CT White: 119/100K; CT Black: 261/100K; CT Hispanic: 178/100K Premature mortality for diabetes (females): CT overall: 72/100K; CT White: 60/100K; CT Black: 175/100K; CT Hispanic: 102/100K DM related Lower extremity amputation: CT overall 23/100K; CT white: 17.4/100K; CT Black: 75.5/100K; CT Hispanic: 47.0/100K Adults w diabetes who took diabetes class: CT overall: 41.6%
2	Hypertension: controlling high blood pressure	0018	28	Outcome measure; hypertension care quality prioritized in SIM Plan p.55 Prevalence of HTN among adults: U.S. overall: 31.4%; CT overall: 31.3%; CT White; 32.5%; CT Black: 35.7%; CT Hispanic: 25.8%; CT low income approx. 39%* *statistically significant
3	Screening for clinical depression & follow-up plan	0418	18	Behavioral health part of whole person-centered care; screening already required for PCMH; racial disparities in depression screening, SIM Plan p.30
4	Colorectal cancer screening	0034	19	Racial and ethnic disparities in colorectal cancer screening, SIM Plan p.27 50+ with colonoscopy/sigmoidoscopy: U.S. overall: 67.3%; CT overall: 74.5%; CT low income: ~ 65%*; CT White: 75.9%; CT Black: 66.1%*; CT Hispanic: 69.5% *statistically significant
5	Tobacco use screening & cessation intervention	0028	17	Screening already required for PCMH; tobacco cessation quality prioritized, evidence of effectiveness of immediate provider intervention, in SIM Plan p.55; income, racial, and ethnic disparities in smoking, SIM Plan p.25-26 % cigarette smokers: U.S. Overall: 21.2%; CT overall: 17.1%; CT White: 16.8%; CT Black: 20.8%; CT Hispanic: 17.1%; CT low income: 25.0%* *statistically significant
6	Preventative care & screening: Body Mass Index (BMI) screening & follow up	0421	16	Screening already required for PCMH; obesity care quality prioritized in SIM Plan p.55; income, racial, ethnic disparities in obesity, SIM Plan p.25-26 % adults obese: U.S. overall: 27.8%; CT overall: 24.5%; CT White: 23.0%;CT Black :32.8%*; CT Hispanic: 32.6%*; CT low income:~ 30%* % adults overweight: U.S. overall: 35.7%; CT overall: 35.2%; CT White: 35.4%; CT Black: 39.2%; CT Hispanic: 32.2%; CT low income: ~ 35% Adults meeting 150minutes/wk physical activity: CT overall: 52.6%; CT low income: 40.7%* Adults consuming 5+ servings fruits/veggies: CT overall: 20.5% *statistically significant
7	Diabetes Mellitus: diabetes eye exam	0055	41	Adults w diabetes reporting eye exam in past year: CT overall: 72.8%; CT White: 75.6%; CT Black: 73.8%; CT Hispanic: 63.3%*; CT low income.: 68.7% *statistically significant

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1	Hospital admission for asthma, adult	0283		Asthma care quality prioritized in SIM Plan p.55; racial and ethnic disparities in asthma, SIM Plan p.26 Prevalence of asthma, adults: U.S. overall: 8.6%; CT overall: 9.2%; CT White: 8.1%; CT Black: 15.5%*; CT Hispanic: 11.7%; CT low inc: ~ 14%* *statistically significant Hospitalization for adults asthma as primary dx: CT overall: 15/10,000; CT White: 8/10,000; CT Black : 39/10,000; CT Hispanic: 43/10,000 No significance test performed
1	Hospital admission for asthma, pediatric	0728		Asthma care quality prioritized in SIM Plan p.55; racial and ethnic disparities in asthma, SIM Plan p.26 Prevalence of asthma in children: U.S. overall: 8.4%; CT overall: 13%; CT White: 10%; CT Black: 18%; CT Hispanic: 12%; CT low inc: ~ 18%* *statistically significant Hospitalization for children asthma as primary dx.: CT overall: 18.9/10,000; CT White: 11/10,000; CT Black: 46/10,000; CT Hispanic: 31/10,000 No significance test performed
1	Pediatric ambulatory sensitive condition composite			Prevention Quality Indicators Hospitalizations PEDIATRIC: CT overall: 132/100K; CT White: 73/100K; CT Black: 328/100K; CT Hispanic: 175/100K Based on DPH Prevention Quality Indicator Report which follow AHRQ method No significance tests performed
1	Adult ambulatory sensitive condition composite			Prevention Quality Indicators Hospitalizations ADULTS: CT overall: 1365/100K; CT White: 1525/100K; CT Black: 2146/100K; CT Hispanic: 1091/100K Based on DPH Prevention Quality Indicator Report which follow AHRQ method No significance tests performed
1	Potentially avoidable ER rate			Racial and ethnic disparities in ER visits for diabetes and asthma, SIM Plan p.29
1	Annual dental visit – Medicaid and CHIP			Racial and ethnic disparities in dental decay, SIM Plan p.26
2	All-cause unplanned admissions for diabetes mellitus		36	Diabetes care quality prioritized in SIM Plan p.55; racial and ethnic disparities in diabetes, SIM Plan p.26 Diabetes in adults: CT overall: 6.4%; CT white: 5.7%; CT Black: 14.9%*; CT Hispanic: 10.5%*; CT low inc: 12.3% Premature mortality from diabetes (males): CT overall: 134/100K; CT White NH: 119/100K; CT Black NH: 261/100K; CT Hispanic: 178/100K Premature mortality for diabetes (females): CT overall: 72/100K;CT White NH: 60/100K; CT Black NH: 175/100K; CT Hispanic: 102/100K
2	Diabetes medical attention for nephropathy	0062		Diabetes care quality prioritized in SIM Plan p.55, racial and ethnic disparities in diabetes, SIM Plan p.26 Diabetes in adults: CT overall: 6.4%; CT white: 5.7%; CT Black: 14.9%*; CT Hispanic: 10.5%*; CT low inc: 12.3% Premature mortality from diabetes (males): CT overall: 134/100K; CT White NH: 119/100K; CT Black NH: 261/100K; CT Hispanic: 178/100K Premature mortality for diabetes (females): CT overall: 72/100K;CT White NH: 60/100K; CT Black NH: 175/100K; CT Hispanic: 102/100K