CONNECTICUT
Policy and Management

Connecticut Health Equity Dashboards - Methods Documentation

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About the Connecticut Health Equity Dashboards

The Connecticut Health Equity dashboards were developed by the Office of Healthcare Strategy and Onpoint Health Data. The dashboards leverage Connecticut's all-payer claims database (APCD) and other state and federal sources to provide information and insights into how social factors like race, income, and education in communities across Connecticut impact population health and the correlations that exist between these social factors and health care use and access. The dashboards are intended to educate the public, health care professionals, policymakers, and other stakeholders in Connecticut on social drivers of health and to connect them with resources in their community.

The key goals of these dashboards include:

- Providing information to users about the overall impact of community social factors on population health and healthcare use and access.
- Exploring disparities in Connecticut and how those disparities are associated with community social factors that impact health.
- Providing insights around disparities in disease burden, preventive care, and management of chronic disease by area and identifying associations between community social vulnerability and these metrics.
- Contextualizing the challenges in disease burden, preventive care, and management of chronic disease in different areas by providing comparisons to state and national benchmarks.
- Connecting users to resources/services that could help address critical challenges in their communities.

Methods

The following sections provide information on the data sources that support the Health Equity Dashboards as well as the quality, cost, and access measures – including those from external sources like the CDC as well as those supplied by the State – that provide crucial insight into trends, regional variation, and the impact of social factors on community health. Additional information is given on the stratifications that enable analysis across age, sex, and chronic conditions.

Data Sources

Connecticut All-Payer Claims Database (APCD)

The primary source of data for the Health Equity Dashboards was the Connecticut APCD. Measures focused on chronic conditions, quality of care, appropriate care, and use of care were generated based on members' insurance eligibility in calendar year 2024. These measures included claims for services rendered between January 1, 2024, and December 31, 2024, and included three (3) months of run-out for claims adjudication. Claims were restricted to those paid as primary for members who were residents of Connecticut in 2024. Some measures include a lookback period to prior years.

In compliance with blinding rules from U.S. Centers for Medicare and Medicaid Services (CMS), any cell with a value of less than 11 was suppressed for this study. In accordance with HEDIS guidance, denominators less than 30 were also suppressed. Data from public sources like Census data were not suppressed.

Claims-Based Measures

Table 1 includes the claims-based measures – based on Connecticut APCD data from calendar year 2024 – available in the Connecticut Health Equity Dashboards.

Table 1. Claims-Based Measures Available for the Connecticut Health Equity Dashboards

Category	Measure	Description	Steward
Chronic Care Management	Asthma Medication Ratio	Percentage of adults and children 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	NCQA
Chronic Care Management	Follow-Up After ED Visit for Mental Illness	Percentage of emergency department (ED) visits for adults and children 6 years of age and older with a diagnosis of mental illness or intentional self-harm and who received a follow-up visit for mental illness by within 7 and within 30 days.	NCQA
Access to Care & Utilization	Timeliness of Prenatal and Postpartum Care	*Prenatal Care.* The percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. *Postpartum Care.* The percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery.	NCQA
Access to Care & Utilization	Child and Adolescent Well Care Visits	Percent of children and adolescents receiving routine well care visits.	NCQA
Access to Preventive Care & Screenings	Breast Cancer Screening	Proportion of eligible women (50–74 years) screened for breast cancer in the past two years.	NCQA
Access to Preventive Care & Screenings	Colorectal Cancer Screening	Proportion of the eligible population (45–75 years) screened for colorectal cancer.	NCQA
Increased Complications of Disease & Poor Outcomes	All-Cause Readmissions	Percent of unplanned readmissions following discharge.	NCQA
Cost of Care	Total Cost of Care (Per Member Per Year)	Aggregated costs (including both the member paid and plan paid) calculated from claims data per average member per year.	Onpoint

Additional Linked Measures from External Sources

In addition to the claims-based measures derived from data in the Connecticut APCD, the State supplied additional measures that provide additional information on healthcare utilization and outcomes. These measures, linked by town to the claims-based APCD measures, are listed in **Table 2.**

Table 2. State Measures Available for the Connecticut Health Equity Dashboards

Category	Measure	Steward
Increased Complications of Disease & Poor Outcomes	Hospitalization Rates	CT OHS Patient Data, CHIME Data
Increased Complications of Disease & Poor Outcomes	Preventable Hospitalization Rates	CT OHS, AHRQ Quality Indicators
Increased Complications of Disease & Poor Outcomes	All ED Use Rates	CT OHS, CHIME Data
Increased Complications of Disease & Poor Outcomes	Avoidable ED Use Rates	CT OHS, CHIME Data
Increased Complications of Disease & Poor Outcomes	Low Birthweight Rates	CT-Department of Public Health
Increased Complications of Disease & Poor Outcomes	Infant Mortality Rates	CT-Department of Public Health
Increased Complications of Disease & Poor Outcomes	Mortality Rates	CT-Department of Public Health

Social Vulnerability Index & Census Measures

The Social Vulnerability Index (SVI) is a tool developed by the U.S. Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR). The Index is intended to help identify communities that may need higher levels of support before, during, and after disasters. Using census data, it assesses how various social factors affect a community's ability to respond to hazardous events. The index's underlying measures of vulnerability also can be used to identify communities that face additional health challenges.

The following metrics, listed below in **Table 3**, were pulled from Social Vulnerability Index data and rolled up to the town and Senate-district level.

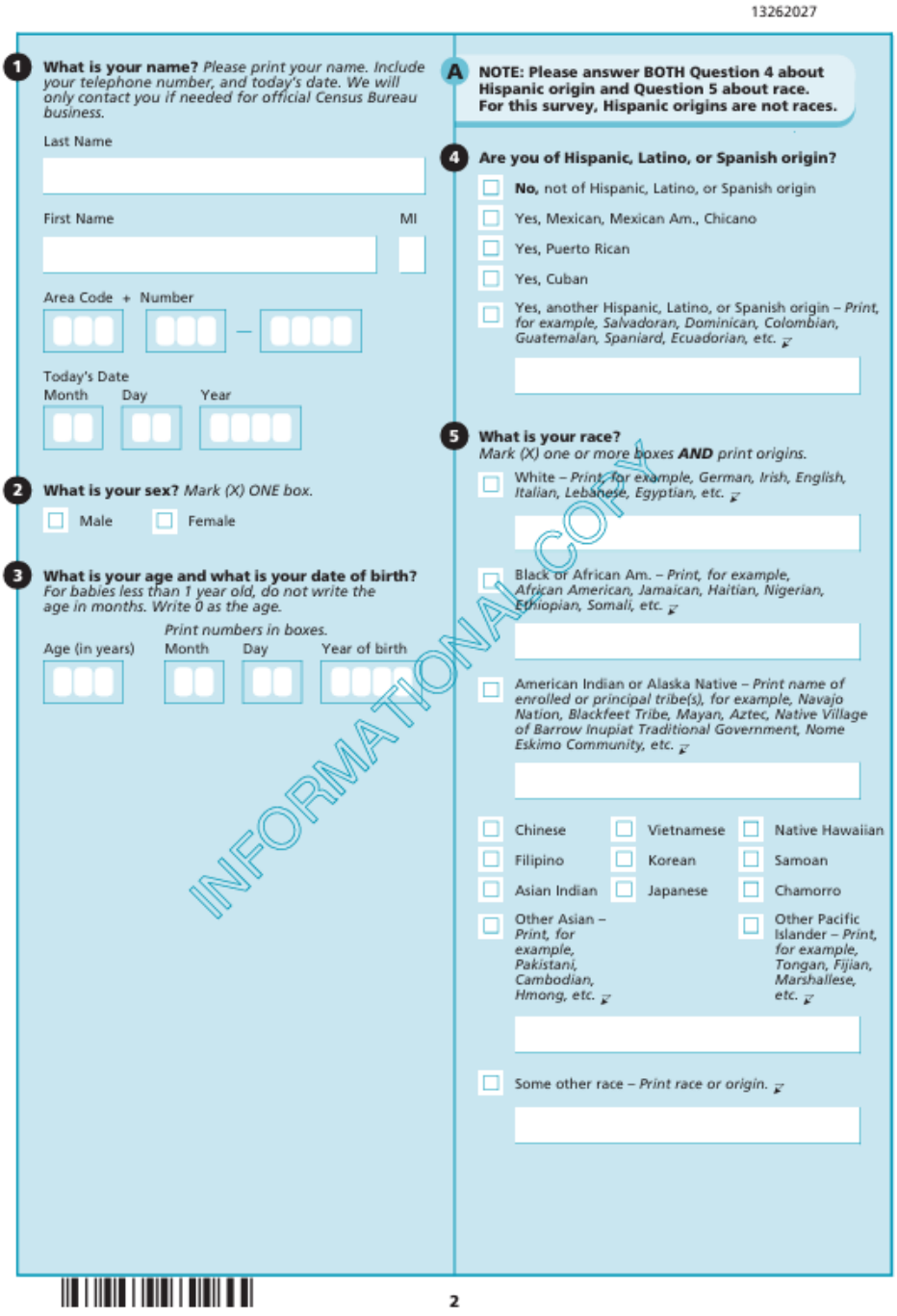
The % residents who are White SVI measure was calculated indirectly by subtracting the % residents non-White from 100%. This approach ensures that the % residents White measure is complementary to the % residents non-White measure.

Table 3. Metrics Available from the Social Vulnerability Index Data

Domain	Component
Household Composition	% single parent households
	% civilians with disabilities
	% residents aged 65 and older
	% residents aged 17 and younger
	% residents speaking limited English
Racial & Ethnic Status	% residents who are African American or Black
	% residents who are American Indian or Alaska Native
	% residents who are Asian
	% residents who are Hispanic or Latino
	% residents who were Native Hawaiian or Pacific Islander
	% residents who are non-White
	% residents who are White
Housing Type & Transportation	% households with no Internet
	% households with no vehicle available
	% households that are crowded
	% households that are mobile homes
	% households that are multi-unit
Socioeconomic Status	% households with housing cost burden
	% residents below 150% poverty level
	% residents who are unemployed
	% residents with no health insurance
	% residents with no high school diploma

The Racial & Ethnic Status domain was calculated using data from 5 years of American Community Survey data, collected between 2018-2022. As of 2022, ACS data collection on race had one question for Hispanic ethnicity and one question for race with a check all option in **Figure 1**. SVI used mutually exclusive categories calculated from the ACS race/ethnicity data, with yes to 'Hispanic or Latino' trumping all reports of race data. As a result, all other race/ethnicity groups are 'non-Hispanic or Latino' groups.

Figure 1. Informational copy of the American Community Survey



Area Deprivation Index Data

The Area Deprivation Index (ADI) is a scientifically validated measure of the adverse social exposome (i.e., neighborhood disadvantage) that can be used to evaluate and improve factors that impact health across populations.

The ADI data, which is reported at the census block group level, was mapped to neighborhoods using geographic data from the **National Historical Geographic Information System** (NHGIS). NHGIS provides a GISJOIN identifier, a unique key for census geographies, which was used to link ADI ranks to the corresponding neighborhood block groups.

Stratifications

The following section offers supporting detail regarding the multiple population stratifications used in the reporting and analysis for the Connecticut Health Equity Dashboards.

Age Group & Sex

The following age stratifications were included in the analysis of claims-based measures:

- 1–14 years
- 15–25 years
- 26–45 years
- 46–64 years
- 65+ years

Data on the sex of patients (male and female) also are included in the study.

Some measures were not based on claims but instead were provided from existing State data sources. For those measures, age groups varied based on the data available and, in some cases, no age stratifications were available for those measures.

Major Payer

The data are stratified by the following major payer types:

- Commercial
- Medicare (includes Medicare Fee for Service and Medicare Advantage plans)
- Medicaid

Member Town of Residence

Members were assigned to towns based on their reported ZIP code of residence in the eligibility file provided by their insurance. A crosswalk was used to map ZIP codes to Connecticut towns and Senate districts.

Race & Ethnicity

It was not possible to stratify claims-based measures by race because the Connecticut APCD data on race and ethnicity is not well populated. Other measure sources, however, do have

sufficient data for race and ethnicity reporting. For measures on ED use, all-cause mortality, hospitalization, and infant mortality provided by the State, the following race and ethnicity categories were available:

- Asian Non-Hispanic
- Black Non-Hispanic
- Hispanic
- Other Non-Hispanic
- White Non-Hispanic

The low birthweight measure included two additional categories:

- Two or More Races Non-Hispanic
- American Indian and Alaska Native Non-Hispanic

Chronic Condition

Members with chronic conditions were identified using algorithms from the Chronic Conditions Data Warehouse (CCW) from the U.S. Centers for Medicare and Medicaid Services (CMS). The logic for these algorithms is available at the CCW website.

Onpoint's chronic condition flags were used to identify members with the following chronic conditions:

- Asthma
- Breast cancer
- Chronic kidney disease
- Colorectal cancer
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- Depression, bipolar disorder, or other mood disorders
- Hypertension
- Ischemic heart disease (or heart disease overall)
- Rheumatoid arthritis
- Obesity
- Stroke / transient ischemic attack
- Multiple conditions (3+)

Framework with Key Questions

The dashboards address four domains and the key questions in **Figure 2**. Each domain is described below.

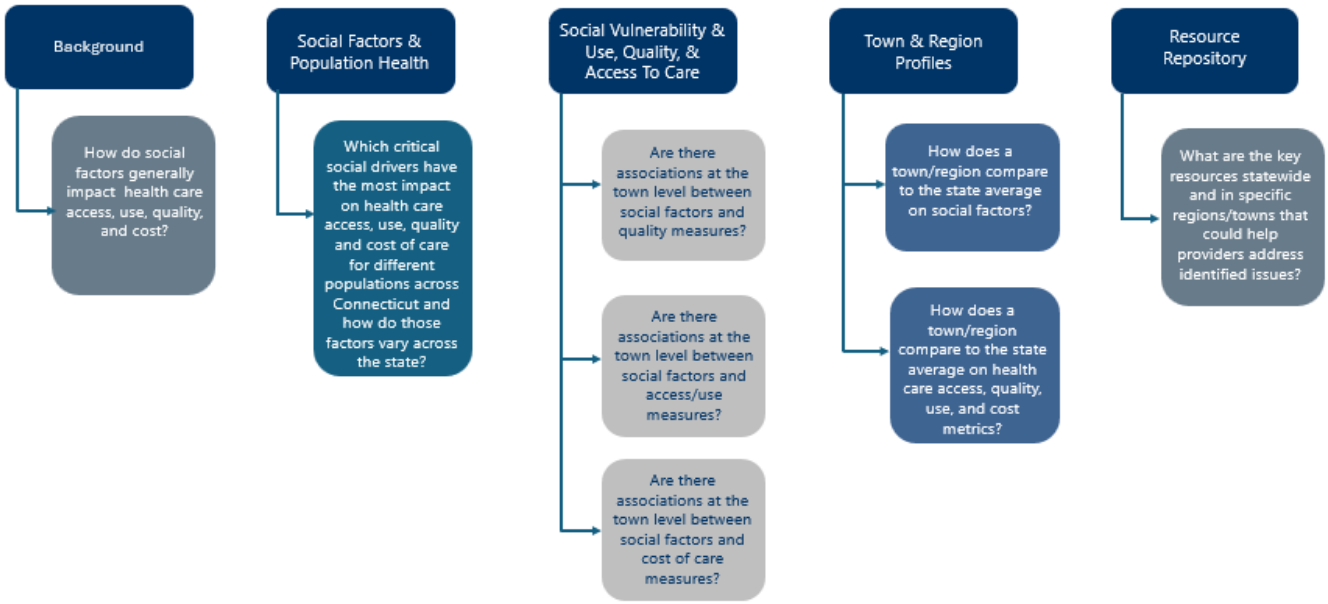



Figure 2. Draft Framework for the Connecticut Health Equity Dashboards