

TO:  
Connecticut State Innovation Model (SIM) Project  
Quality Council – Core Measurement Group  
Office of the Healthcare Advocate, Hartford CT

From:  
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**REF: SIM – Quality Council Measure Set – Public Comments**

The SIM PMO and the Quality Council has commendably put together the Core Measure Sets for use in Value-Based Payment arrangements. It has also defined the Quality Measure Evaluation Process which has flexibility to identify additional and alternative measures that can be reviewed and recommended for Measure Sets, Reporting, Alignment plan & implementation.

I would like to submit the following points for consideration for the SIM QC Measure Sets:

- **Health Equity – Addressing current disparities**
- **Health Equity – Uniformity in capturing Race, Ethnicity, Language & Status (RELS) data**
- **Health Equity - Inclusion for Social & Behavioral data into EHR**

**Health Equity – Addressing current disparities**

Currently, there are 7 Equity-related measures in the Core Measure Set. There are two recent publications that portray health disparities in Connecticut. Re-examining the following and reconsidering its inclusion into the Measure Set will go far to address these prominent disparities that are present –

1. Racial, Ethnic Disparities Common in Connecticut Hospital Readmissions  
<http://csms.org/2015/02/05/racial-ethnic-disparities-common-in-ct-hospital-readmissions/>
2. Despite Efforts, Black Women Deliver More Preterm Births  
<http://c-hit.org/2016/02/23/despite-efforts-black-women-deliver-more-preterm-births/>

**Health Equity – Uniformity in capturing Race, Ethnicity, Language & Status (RELS) data**

Of the 7 Equity-related measures in the Core Measure Set – 1 is sourced from PCMH-CAHPS, 2 are sourced from Claims data and 3 are derived from EHR sources. It is unclear how Race, Ethnicity, Language & Status (RELS) data is acquired, assessed and inserted into the Measure Sets. While there are several approaches:

geocoding by race & ethnicity (e.g., CENSUS), deduction by 'last name', and cross-tabulation of external database (e.g., birth records) – it would be more beneficial to undertake a more precise manner of gathering RELS data. Similarly, the ALL Payer Claims Database (APCD) can substantially benefit by the systemic and proper utilization of RELS data but currently, only ~3% of its data reflects it. RELS data collection is also mandated by Federal healthcare programs including the Patient Protection and Affordable Care Act (Section 4302). RELS data utilization in operations, analysis, and planning can provide insights into more efficient and effective care management. It is well substantiated that it can contribute to improving the quality of care and well integrated systems have helped reduce healthcare disparities and also provide for more precise measurement for Value-Based outcomes.

I would like to suggest to promote a more systematic and uniform process of capturing RELS data across the SIM implementation using predefined guidelines and categorizations. CT-SIM plans to deploy community health workers, implement population health management and leverage 'cultural competency' of its participatory organizations to achieve its goals. But, this may be difficult to achieve without a standardized manner of addressing RELS data and tracking the outcomes during the various phases of value-based care. A minimum standard REL data-set can traverse across the various participatory systems within CCIP and PCMH, to assure uniformity and make interoperability across various entities more harmonious. It would be beneficial to encourage patients in their self-reporting of their RELS data. This could be achieved via healthcare literacy programs, cooperation of Community Health Workers and Provider staff that are closer to the patients.

### **Health Equity - Inclusion for Social & Behavioral data into EHR**

There is ample evidence that addressing social and behavioral determinants of health can bring achievement in health equity. Linkages between these determinants and disparities are important to identify conditions and contribute to the diagnosis and treatments. Recently, the Institute Of Medicine (IOM) released recommendations to incorporate measures of Social and Behavioral determinants of health into EHRs. It provides standard measures with clinical usefulness and is conducive to the clinical workflow. This approach of including Social and Behavioral data provides several opportunities and benefits for value-based care:

1. It can permit greater precision in diagnoses and improve treatment
2. This approach can facilitate more effective shared decision making

3. The measures can help clinicians to identify risk factors
4. The information can prompt the clinical team to refer a patient to a public health department or a community agency to address problems
5. Information on social and behavioral factors can expand health systems' capacity to tailor services to their population's needs
6. Use of these measures can broaden the patient context available to researchers for EHRs, which would store standard measures of social conditions and behavioral risk alongside clinical data

I would like to suggest that the above approach be considered for a Reporting Measure set and it can also supplement the operations in Community health settings and Population Health management.

Please let me know if there are any questions.

Thank you,

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