



**MEMORANDUM**

**Date: August 1, 2016**  
**To: Connecticut State Innovation Model (SIM) Program Management Office**  
**Fr: Tekisha D. Everette, Executive Director, Health Equity Solutions**  
**Re: SIM Quality Measures**

Thank you for the opportunity to comment on the SIM Draft Report of the Quality Council on A Multi-Payer Quality Measure Set for Improving Connecticut's Healthcare Quality. Health Equity Solutions values the importance of stakeholder input and applaud the SIM PMO on its efforts to engage consumers and the public in this worthy and complicated endeavor.

Health Equity Solutions, Inc. (HES) is a new non-profit organization centered in Hartford, CT. Our mission is to promote policies, programs, and practices that result in more equitable health care access, delivery, and outcomes for all people in Connecticut. We are keenly focused on eliminating health disparities as a measure of success; we look forward to a Connecticut where every resident can obtain optimal health regardless of race, ethnicity, or socioeconomic status. We accomplish our work through education, advocacy, and organizing- all with a focus on systemic policy change in Connecticut.

HES is pleased to see the great thought and detail that has gone into developing the quality measure set. I can only imagine the arduous process the Quality Council went through to land on the draft recommendations and I would like to take a point of privilege in my comments to express appreciation for the hard work involved in getting to this point.

The comments on the draft report are below in a subheading and bullet-point format for ease of review.

**Health equity**

- If we are going to make any impact on the health of Connecticut residents, health equity has to be a part of measuring quality outcomes. It is our view that if payers align measures in such a way that value is placed in improving the health of disparately impacted populations we will not only see an improvement in health outcomes but the health system itself will save on costs. That said, I am concerned that the voluntary nature of payers aligning with the measures, coupled with the number of core measures, leaves

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room for self-selection that may exclude some of the core equity measures in the set. While I applaud the inclusion of language on page 60 that encourages payers with race/ethnicity data to include a focus on health equity in the VBP contracts, it seemingly contradicts the strong language to move forward with inclusion of the equity specific measures as noted on page 8. I have a preference for the language on page 8 and would encourage that if the phrasing remains as is in both sections, that the draft go a step further and encourage payers to begin to collect this data in a uniform, inclusive, non-discriminating, and reportable manner going forward.

- There is a missing measure. On the SIM PMO Consumer Advisory Board website, there are slides posted from a webinar on July 28<sup>th</sup> (the July 27<sup>th</sup> slides are not accessible using the weblink). The Health Equity Design Group Recommended Measures Summary slide (slide 10) includes Diabetes mellitus HbA1c screening as an equity measure. However, in the draft report, this is not recorded as an equity measure in any chart listing in the measure set (charts located on pages 7, 47, and 59). I am not sure if this is an oversight but argue that given the disparate impact of diabetes on racial and ethnic populations and the importance of screening populations with risk factors to prevent complications (and often full conversion to type 2 diabetes), this measure should be included as an equity measure.
- There are additional measures in the provisional core set that should be included as equity measures because of the disparate impact on racial and ethnic populations. They are as follows:
  - Breast cancer screening
  - Cervical cancer screening
  - Chlamydia screening in women

#### Core measure set:

- As previously mentioned, I have concerns about the number of core measures. However, beyond this concern, it is troubling that the initial set of measures – the claims-based measures – only contain three measures identified as equity measures by the HEDG.\* Thought of differently, only three out of seventeen measures (17%) relate to closing health equity gaps. The HEDG group put forth eight total recommendations and while

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\* This is only accurate if the omission of the HEDG recommendation of Diabetes HbA1c as an equity measure is in fact an oversight and not purposefully excluded.

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several rely on electronic health record (EHR) data, I am concerned that focusing on closing the health equity gaps in quality and outcomes is tied to a challenging process to build this level of technological capability.

## **Voluntary alignment**

- There is an overall concern with creating a tiered system of quality. The voluntary nature of aligning the measure set will improve the quality of care for some and not for others. High quality care with optimal outcomes for disparately impacted populations, regardless of carrier, should be widely available. Ideally, all payers should be convinced that this is the right way to proceed and the state should mandate this in any way possible.

## **Technical items**

This section outlines a few “technical” issues with the document that may or may not be directly tied to health equity.

- In the core measure set, it is unclear which two measures are recommended for Medicaid only.
- In the final version of the document, it would be helpful to repeat the chart headings on each page for ease of following what category the measures are for (equity vs MQISSP).
- Acronyms not appearing in the acronym list on page 3 but appearing on the core measure chart: OHSU (core measure#10); CMMC (core measure#11); AMA/PCPI (core measure #14,31,32); MNMCM (core measure#29 & 30)

Please do not hesitate to contact me if further clarification of our comments is needed or if Health Equity Solutions can be helpful going forward.