Contents

Culture of Equity

Submitter	Measure Domain	Measure Subdomain	Numerator	Denominator	Data Source	Notes
Philip Alberti	Culture of Equity	Equity as Priority	Health / healthcare equity is explicitly mentioned in institution's mission statement and/or strategic plan	n/a	Mission / Strategic Plan	
Philip Alberti	Culture of Equity	Equity as Priority	Senior Leaders are accountable, through measureable goals and milestones, for narrowing health and healthcare gaps	n/a	Strategic Plan / Goal setting documents	
Philip Alberti	Culture of Equity	Equity as Priority	An individual at the institution is specifically charged with developing system-wide efforts to address health and health care gaps	n/a	Job description(s)	

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Philip Alberti	Culture of Equity	Equity as Priority / Advocacy	The institution has released statements, comment letters, etc. that explicitly discuss the impact of local/state/federal actions on community health and health inequities	n/a	Comment letters / press releases / public statements, etc.	
Philip Alberti	Culture of Equity	Safe and Accessible Environment	Faculty from underrepresented groups (REM, LGBT, PWD, etc.)	All faculty	HR data	
Bob Rauner	Culture of Equity		"Additionally, I am not enthusiastic about adding new measures. I think the main issue is making sure that our current measures in the domains of CV disease, diabetes, cancer, CKD, etc. are adjusted for sociodemographic factors. I think we should be focusing on how the measures that are currently in common use by the Medicare Shared Savings Program, commercial plans (e.g., BCBS ACO contracts) and FQHC UDS measures for value-based purchasing contracts are affected by SES. Lack of SES adjustment is likely to harm safety net providers in the immediate future."			

Structure for Equity

Submitter	Measure Domain	Measure Subdomain	Numerator	Denominator	Data Source	Notes
Christie Teigland	Structure for Equity	Capacity and resources to promote equity	# of members in denominator who completed the social risk factor survey	All health plan members enrolled for one or more months in the health plan during the measurement year.	New social risk factor survey with key questions such as income, home ownership, education, race/ethnicity, household size.	
Christie Teigland	Structure for Equity	Collection of data to monitor the outcomes of individuals with social risk factors	# of children ages 1-19 in the denominator with one or more PCP visits during the measurement year	All children ages 1 to 19 with continuous medical coverage during the measurement year with no more than one gap in enrollment of up to 45 days	Administrative claims; stratify by household income or living below federal poverty level indicator	
Christie Teigland	Structure for Equity		Similar measure as above but for members age 20-64 and members age 65+			
Christie Teigland	Structure for Equity	Population health management	• Identification of individual providers (physicians, specialists and facilities)	WITHIN A DEFINED COMMUNITY (e.g. a city	Variety of health plan, health information	

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			serving patients with the specific conditions of interest, and developing comparative data related to their patient outcomes, such as key performance measures. • Profiling pathways of care followed by patients with a condition of interest—such as congestive heart failure—to identify optimal interventions, treatments and settings based on the patient profile.	such as NYC or a county such as Miami or MSA): Identification of "hot spot" populations of interest—such as patients with asthma—including prevalence and profile of individuals with the condition by area, investigation of outcomes of interest in the population--such as hospitalizations and readmissions; emergency room use; frequency and intensity of office visits; medication adherence and persistence; emergence of condition related adverse events; and existence of co-morbidities and other diagnoses. These outcomes should be	exchange, hospital, community level and local/state government collected data and other available information.	

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				stratified by key socioeconomic and other characteristics at the near neighborhood or person, such as mental health conditions, alcohol/drug/substance abuse, and other risk factors.		
Christie Teigland	Structure for Equity	Systematic community needs assessments			Use the above “hot spot” analysis to identify key areas of need/focus.	
Christie Teigland	Structure for Equity	Policies and procedures that promote equity				
Christie Teigland	Structure for Equity	Transparency, public reporting, and accountability for efforts to advance equity	SUBSET OF MEASURES that focus on disparities assure common definitions and report across payor types (i.e., Medicaid, commercial, health insurance exchange, Medicare) to observe			

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			differences based on type of insurance			

Access to Care

Submitter	Measure Domain	Measure Subdomain	Numerator	Denominator	Data Source	Notes
David Nerenz	Access to Care	Availability	Percent of primary care visit slots held for same-day appointments or drop-in access	All primary care visit slots in the entity whose performance is being measured	Either formal policy documents or scheduling system used in primary care	
David Nerenz	Access to Care	Accessibility	Total number of outpatient or clinic practice locations (weighted by visit volume) within one block of a public transportation stop	Total number of outpatient or clinic practices locations (weighted by visit volume) in the entity whose performance is being measured	Web site listings of both practice locations and public transportation stops, or could be attestation by entity.	
David Nerenz	Access to Care	Affordability	Number of services (weighted by dollar value) billed on the basis of a sliding scale linked to patient income	Total number of services (weighted by dollar volume)	Billing system	
David Nerenz	Access to Care	Convenience	Number of appointments with wait times of 15 minutes or less, as reported by patients or patient caregivers	Total number of patient appointments, as defined by follow-up survey responses	Patient surveys (e.g., CAHPS, Press Ganey)	

High Quality Care

Submitter	Measure Domain	Measure Subdomain	Numerator	Denominator	Data Source	Notes
Traci Ferguson	High Quality Care	Person-Family Centeredness	# of adults >18 who had documented shared-decision making discussion with care provider (useful if had claim encounter code that could be submitted)	All patients >18 seen during measurement year with at least one annual well visit	Electronic health record, claims encounter data	
Traci Ferguson	High Quality Care	Person-Family Centeredness	# of patients who gave the highest rating for their provider when asked to rate their patient/care provider relationship	Total number of patients surveyed	CAHPS survey or other patient satisfaction survey	
Traci Ferguson	High Quality Care	Social Risk factors addressed in outcome performance measures	# of patients >18 with documented social risk factor assessment in medical record (process measure)	# of patients >18 who had at least one annual well adult visit in the measurement year	Electronic health record	
Traci Ferguson	High Quality Care	Effective interventions to reduce disparities	Both pediatric and adult measure: # of patients with community referral, case management referral,	# of patients (pediatric and adult) with self-identified disability, ICD10 code for developmental	Electronic health record	

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			consultation for social work/social services	delay/autism, etc., on SSDI, low income (using Dual Eligible as surrogate)		
Traci Ferguson	High Quality Care	Effective interventions to reduce disparities	# of patients 18-75 with end stage kidney disease not on hemodialysis or peritoneal dialysis or on HD/PD less than 90 days who had documented counseling regarding kidney transplantation or referral to kidney transplantation center (capture rural/urban, insurance status, race, gender, comorbidities, ethnicity, primary language	# of patients 18-75 with end stage kidney disease	Electronic Health Record, lab data and chart review	
Traci Ferguson	High Quality Care		Does the Activation Measure (PAM) cover these areas: 1. Ease with which patients can navigate provider website/health plan website/handbook/benefit manual; 2. Ease with which patient gets information about their health and treatment options; 3. How well member/patient understands what their care provider or health plan tells them; 4. How often does your care provider include you in decisions about your healthcare Are there any key risk factor tool/assessments that indicate transportation concerns, food/shelter concerns, request for help understanding how to take medications (including health literacy screens)			

Collaboration and Partnerships

Submitter	Measure Domain	Measure Subdomain	Numerator	Denominator	Data Source	Notes
Ninez Ponce	Collaboration and Partnerships	Improved integration of medical, behavioral, oral, and other health services: see (1) in footnote	# of patients seen in co-located or integrated practices	#of patients in population	EHR	
						See: SAMHSA-HRSA Center for Integrated Health Solutions, Assessment Tools for Organizations Integrating Primary Care and Behavioral Health http://www.integration.samhsa.gov/operations-administration/assessment-tools

Submitter	Measure Domain	Measure Subdomain	Numerator	Denominator	Data Source	Notes
	(1)	Information technology	Numerator: Availability of patient information that is equally accessible for all providers (medical, behavioral, oral, others) involved,	Denominator: N/A		
			Numerator: Availability of a platform to exchange information between providers,	Denominator: N/A		
			Numerator: Availability of integrative clinical guidelines or standards of care for all providers (medical, behavioral, oral, others)	Denominator: N/A à maybe add whether there are cultural competency elements integrated into decision tools and guidelines for providers?		
		Standard of care	Numerator: Presence of a system that tracks clinical outcomes across the spectrum for shared accountability & with goal of improving quality of care for patient,	Denominator: N/A à maybe add whether social determinants data are available along with clinical outcomes data?		

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			Numerator: Presence/percentage of social determinants data available along with clinical outcomes data,	Denominator all data		
Ninez Ponce	Collaboration and Partnerships	Collaboration across health and non-health sectors	# of partnerships and active projects with non-health sector organizations (e.g. schools, transportation, environment, food)	all partnerships		Involvement in Health in All, Health Impact Assessment https://www.ncbi.nlm.nih.gov/books/NBK241406/
Ninez Ponce	Collaboration and Partnerships	Community and health system linkages	(1) culturally tailored community health workers (e.g. prometoras), (2) Use of digital technology platforms (e.g. social media) to connect community to health discussions à outreach to special populations, e.g. communities of disadvantage (3) # of partnerships and active projects with community,	(1) all community health workers (2) N/A (3) all partnerships (4) All care (5) N/A or total # of low-income/uninsured/Medicaid patients		Forging Community Partnerships to Improve Health Care: The Experience of Four Medicaid Managed Care Organizations http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2013/apr/16

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			(4) In home care management and treatment, telehealth (5) Vouchers for local markets to promote healthy behaviors			87_silowcarroll_forging_community_partnerships_medicaid_managed_care_ib.pdf
Ninez Ponce	Collaboration and Partnerships	Community engagement and long-term partnerships and investments	(1) Availability of physical/community space at healthcare sites for gatherings of community members to discuss health topics (e.g. support groups), (2) Financial investment in community organizations, projects (3) Community outreach gatherings, public health screenings in community	(1) N/A (2) All financial investments (3) N/A		http://www.uky.edu/ie/sites/www.uky.edu.ie/files/uploads/BP_Models%20of%20Community%20Investment%20and%20Partnership.pdf https://www.ncbi.nlm.nih.gov/books/NBK221228/
Ninez Ponce	Collaboration and Partnerships	Build and sustain social capital and social cohesion	(1) Use of family based programs to encourage family communication, bonding, lifestyle improvements	(1)(2)(3)(4)(5)(6)(7) N/A		http://www.aecf.org/resources/the-role-of-social-capital-in-building-healthy-communities/

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			(2) Use of school programs to encourage parent, teacher, student involvement (3) Use of community based programs in socially disadvantaged communities (e.g. gang rehabilitation, church based health programs) (4) Involvement in neighborhood improvement programs (e.g. parks, social space, sidewalk improvements) (5) Involvement in neighborhood safety, personal safety programs (6) Involvement in financial literacy, retirement, homeownership programs (7) Outreach to marginalized communities (e.g. immigrants, undocumented, LGBQ), communities living in fear of discrimination, deportation			

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Tom Sequist	Collaboration and Partnerships	Improved integration of medical, behavioral, oral, and other health services	Number of primary care visits occurring in clinics with co-located behavioral health providers	Number of primary care visits		
Tom Sequist	Collaboration and Partnerships	Collaboration across health and non-health sectors				
Tom Sequist	Collaboration and Partnerships	Community and health system linkages	Presence of community health benefits program/office	Each hospital		
Tom Sequist	Collaboration and Partnerships	Community engagement and long-term partnerships and investments				
Tom Sequist	Collaboration and Partnerships	Build and sustain social capital and social cohesion				