Health Equity and Quality Committee
Focus Areas Reference Document

Committee Goal: The goal of the Health Equity and Quality Committee is to make recommendations to the DMHC for standard health equity and quality measures, including annual benchmark standards for assessing equity and quality in health care delivery.

Background: Focus areas may be thought of as the overarching theme of specific measures identified through this process and as a way to organize and group similar areas of measurement. A measure is an activity or outcome that is to be monitored and evaluated to determine whether it conforms to standards. For each of the priority focus areas identified for the Committee's consideration, measures that fall under each focus area and California specific disparities will be provided. New measures brought forth by Committee members will also be considered throughout this process when raised by Committee members. Measures may fall into four categories:

1. **Structural:** Measures conditions or infrastructure of a practice (e.g., number of nurses per patient, percentage of physicians who are board certified).
2. **Process:** Measures that assess whether an action took place (e.g., percentage of patients with asthma for whom appropriate medications are ordered, number of times adolescents are provided guidance on smoking).
3. **Outcome:** Measures actual results of care. Outcome measures are often multifactorial and can take time to improve on (e.g., number of patients successfully treated, number of avoidable complications and death).
4. **Patient Experience:** Records patients' perspective on their care. Additional details on patient experience below. (Understanding Quality Measurement, Agency for Healthcare Research and Quality (AHRQ)).

Please note, measures identified may overlap focus areas. An example of this is the Child and Adolescent Well-care Visits measure, which could be considered for prevention, mothers and children, and utilization focus areas.

The following focus areas have been identified for the Committee's consideration; however, focus areas are not limited to this list. For additional explanation of each focus area, please see the brief descriptions and examples of measures that fall within each focus area listed below:

1. **Health equity** refers to reducing and ultimately eliminating disparities in health, and mitigating the social and other determinants/drivers of health that adversely affect excluded or marginalized groups; health equity measures monitor health disparities and assess interventions known to reduce disparities (A New Definition Of Health Equity To Guide Future Efforts And Measure Progress, Health Affairs and A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for

Health Equity, National Quality Forum (NQF)). Examples of health equity measures include but are not limited to measures of language access, disability access, and composite measures of disparities reduction.

2. **Access** refers to the ability of having timely use of personal health services to achieve the best health outcomes. Access to health care consists of four key components, coverage, services, timeliness, and workforce (Healthy People 2020, Office of Disease Prevention and Health Promotion). Examples of access measures include but are not limited to Adults' Access to Preventative/Ambulatory Health Services (process) and Prenatal/Postpartum Care (process).

3. **Prevention** refers to routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems (Prevention Services, Healthcare.gov). Examples of prevention measures include but are not limited to Childhood Immunization Status (CIS 10) (process), Breast Cancer Screening (process), and Care for Older Adults (process).

4. **Coordination of care** refers to a "function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time" (Care Coordination Endorsement Maintenance, NQF). Examples of coordination of care measures include but are not limited to Medication Reconciliation Post-Discharge (process), Transitions of Care (process), and Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (process).

5. **Mothers and children** refers to maternal, infant, and child health addressing a wide range of conditions, health behaviors, and health system indicators that have an impact on health, wellness, and overall quality of life for women, children, and families (Maternal, Infant, and Child Health, HealthyPeople.gov). Examples of measures that are within the mothers and children focus area include but are not limited to Well Child Visits (process) and Prenatal/Postpartum Care (process).

6. **Chronic conditions** refers to the set of quality measures that focus on a variety of chronic conditions including but not limited to diabetes, cancer, cardiovascular disease, and respiratory disease (Quality of Care: Chronic Conditions, California Health Care Foundation). With this being the case specific measures include but are not limited to comprehensive Diabetes Care for High Blood Pressure (outcome) and Statin Therapy for Patients with Diabetes (process).

7. **Behavioral health** refers to, mental health and substance abuse conditions, life stressors and crises, stress-related physical symptoms, and health behaviors. Behavioral health conditions often affect medical illnesses (What is Integrated Behavioral Health?, AHRQ). Examples of measures that are within the behavioral health focus area include but are not limited to Antidepressant Medication Management (process), Follow-up Care for Children Prescribed ADHD Medication

(process), Diabetes and Cardiovascular Disease Screening and Monitoring for People with Schizophrenia or Bipolar Disorder (process).

8. **Substance use** refers to the utilization of alcohol, marijuana, opioids, heroine, or other illegal substances that leads to significant impairment, such as health problems or disability (Substance Use Disorders, CMS.gov). Examples of substance use measures include but are not limited to Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (process) and Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (process).

9. **Population health** refers to the health outcomes of a group of individuals, including the distribution of outcomes within a group. Measures related to population health include but are not limited to Tobacco Use: Screening and Intervention (process) and Emergency Department Visits per 1,000 (outcome).

10. **Specialty** refers to care received by a specialist (e.g., neurologists, oncologists, cardiologist, long-term services and supports, etc.). Examples of measures related to specialties include but are not limited to HIV Viral Load Suppression (outcome), Annual Dental Visit (process), and Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (process).

11. **Utilization** is associated with volume of services (A Global Approach to Evaluation of Health Services Utilization: Concepts and Measures, Healthcare Policy). Examples of utilization measures include but are not limited to Child and Adolescent Well-Care Visits (process) and Frequency of Selected Procedures (process).

12. **Patient experience** encompasses the range of interactions that patients have with the health care system, including their care from health plans, and from doctors, nurses, and staff in hospitals, physician practices, and other health care facilities. Patient experience includes several aspects of health care delivery that patients value highly when they seek and receive care, such as timely appointments, easy access to information, and good communication with health care providers (What is Patient Experience?, AHRQ). Examples of patient experience measures include but are not limited to Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey 5.0 Interpreter Services and CAHPS Item Sets for People with Mobility Impairments.