SustiNet Health Partnership
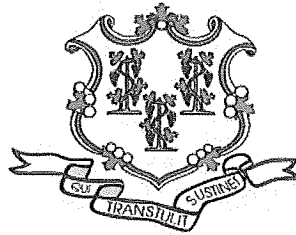
Healthcare Quality & Provider Advisory Committee

Agenda
Friday, March 26th, 8:00-9:30 am
Connecticut Hospital Association
Wallingford, CT

1. Welcome and introductions

2. Review of Minutes of February 18, 2010

3. Overview of Agenda

4. Key topic: 2nd meeting devoted to quality of care and reporting measures to monitor quality.

5. Principles for Quality Assessment Measures discussed at last meeting:

    a. Meaningful – relevant to providers and consumers, add value

    b. Vetted—measures should be previously vetted by recognized source, allowing for possibility that there are unique quality factors for Ct. to consider

    c. Validated

    d. Not onerous – accessible & affordable to track and report data

        i. POS/EHR data preferred; may need to start with claims data

        ii. Discussed possible use of chronic disease registry if no EMR

        iii. Need to identify support for practices to report data

SustiNet Health Partnership

6. Individuals with key assignment for recommending possible monitoring and reporting measures

7. Out-patient and preventive measures: Rodney Hornbake

8. In-patient: Allison Hong

9. Long term care and home care: Marcia Petrillo, Tom Meehan

10. Pediatric/Family planning: Clarice Begemann

11. Mental Health: Vicki Veltri, Jeff Walters

12. Special populations: Margaret Flinter, Sarah Long

13. Summary recommendations following discussion

14. Discussion: early thoughts on impact of passage of federal health reform on our work

15. Discussion: Board of Sustinet has indicated there are resources for bringing in expert assistance or guest speaker if we need it…thoughts?

16. Next meeting: April 22nd, 2010

SustiNet Health Partnership

Healthcare Quality & Provider Advisory Committee

Co-Chairs
Margaret Flinter
C. Todd Staub

Board of Directors Liaison
Paul Grady
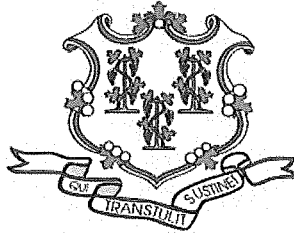
Phone:
866.466.4446

Facsimile
860.297.3992

E-Mail
SustiNet@CT.Gov

Post Office Box 1543
Hartford, CT 06144-1543
www.ct.gov/SustiNet

SustiNet Healthcare Quality and Provider Advisory Committee Regular Meeting
February 18, 2010
Meeting Minutes

Committee Attendees: *Margaret Flinter, Co-chair; Todd Staub, Co-chair; Christine Bianchi; Teresa Dotson; Rodney Hornbake; Tina Stevenson; Arthur Tedesco; Mark Thompson; Claudia Gruss; Steve Karp; Jeff Walter; Marcia Petrillo; Robert Scalettar; Jean Rexford; Lynne Garner; Linda Ross; Jerry Hardison; Sarah Long; Mike Hudson; Joseph Treadwell; Alison Hong; William Kohlhepp; Pieter Joost van Wattum; Matt Pagano; Robert McLean; Nelson Shub; Paul Grady; Tina Brown-Stevenson; Willard Kasoff; Clarice Begemann; (1 inaudible name)*

Office of the Healthcare Advocate: *Vicki Veltri; Africka Hinds-Ayala*

Absent: *Tom McLarney; Kathy Grimaud; Kevin Galvin; Jane Deane Clark; Francois de Brantes; William Handelman; Lisa Reynolds; Bryte Johnson; Richard Torres; Mark Thompson; Rick Liva; Jody Rowell; Sara Parker McKernan; Mark Belsky*

Margaret Flinter and Todd Staub, the co-chairs of the Committee, welcomed all members. Minutes from the January meeting were approved without any corrections and/or changes.

There was a discussion about Principles for Quality Assessment Measures, an outline that was created by a group of Committee members. This was distributed with the agenda and is posted on the SustiNet website as page two of this meeting's agenda. Robert McLean spoke positively about the outline, saying that he feels very strongly that electronic health records (EHRs) should be required for all practices, as data management is crucial. Jean Rexford mentioned that it was important to learn what other SustiNet Committees are working on, to avoid working on the same things. She said that she thinks this group should address fragmentation of care delivery and communication and how these things can support quality. Mike Hudson said that this Committee should also be considering how to adequately attribute patients to a physician. This is an area where EHRs would be especially valuable, because attribution is an area where purely claims-based quality reporting is often not clear.
Rod Hornbake said that he feels that relying on claims-based data would be a serious error. He said that while this Committee should build in added incentives for physicians to adopt EHRs, there is another option that falls between claims and full EHRs. There are existing registry methods which are in widespread use in CT. Rod gave as an example the Anthem AQI website, where physicians can add

SustiNet Health Partnership

patient data, so that not only tests ordered but also test results can be collected electronically. Additionally, Rod said that healthcare disparities should be tracked as part of quality measures.

Nelson Shub emphasized the importance of standardization of care. He said that this should be a first step, and that then the cost issues could be tackled. Claudia Gruss said that certain chronic diseases make up the majority of healthcare spending. Focusing on these chronic diseases makes a big difference in cost savings and improved care, so this Committee may want to keep this in mind while looking at outpatient settings. Claudia said that the ongoing costs of EHRs will be significant, affecting the overhead of practices. She also said that the registry on the Anthem website previously noted has drawbacks, notably in how time consuming it is to enter data. She said that she thought an office based disease registry would work better.

Marcia Petrillo said that one more database should be added to the long term data set noted on 5c. within the outline, and that is home care. Jean wanted to add problems that have been noted with new technology as part of the outline. Tina Brown-Stevenson commented about claims based data, saying that quality of service and patient interaction cannot be assessed using this data, but that it is valuable for prescribing adherence and consistency of medication use. As a result of this, it proves to be a good marker of the health of certain patients. Robert McLean disagreed with this, saying that claims data is completely unreliable. Todd said that claims data is good for visit data, and that it deserves consideration because it's already in place and requires no added costs to utilize. It is also useful in looking at where quality is lacking. Jeff Walter said that there are two levels of quality measures. One is at the patient level to improve and measure quality within a practice or an institution, and the other is to look at quality from a population based or health plan membership level.

An unidentified speaker said that the category of special populations will need to be examined carefully, to ensure that the mental health and addiction population is included. Nelson said that it is time to connect quality of care, measurement and cost to what this Committee is trying to accomplish. He said that the Committee must address the many unnecessary tests that are being performed at great cost. Again he emphasized the importance of standardization. Claudia said that there could be an educational component put into place for physicians and patients to improve quality of care. Matt Pagano said that in looking at outcome measures, a survey tool is needed to assess patient satisfaction. This survey should also include the type of care being provided, because there are so many different levels of care, and this would accurately show how outcomes were achieved. He said that he would do some research to see what types of survey tools were available.

Robert McLean said that there are many survey tools available, and that this Committee needs to select which ones would work best for this effort. He said that the original SustiNet bill had liability protection, so that if providers followed liability standards, they would be protected. This was removed from the SustiNet bill, but Robert said that this was a crucial aspect of cost saving. He suggested that perhaps this Committee could endorse this important issue through pilot projects. Additionally, he said that when using EHRs in his own practice, he has found that there are standards and recommendations that include lifestyle counseling. When he makes recommendations such as to lose weight, for example, this data is entered, and he can then analyze this data to see how many patients received this counseling. Jerry Hardison stated the importance of not only gathering data, but also using it effectively.

Rod said that it is important to understand where PQRI is going. The next transition from PQRI is meaningful use of an EHR. Rod said that he has used the 2010 PQRI measures integrated into the

SustiNet Health Partnership

workflow process in a certified EHR, and it makes the process extremely easy, with constant prompts and reminders of things that must be done. Rod continued by saying that the obvious next step is to link payment to quality. He referred to what's been done in England and Wales, where the first step was to provide every family physician with an EHR system that featured a built-in quality data collection process that contained more than 120 quality measures. Year end bonuses that amounted to between 25 – 33% of physicians' salaries were offered based on the successful utilization of those measures. Almost all of the physicians submitted data, reported favorable experiences and received bonuses the first year, and the program is now in its fourth year. Rod said that CT could phase this in, using incentives for EHR and then using claims-based and registry reporting as interim steps to achieve the ultimate goal, which is quality measurement built in to the normal work flow inside an EHR.

The Committee reviewed the list of principles briefly, to clearly define each one and allow Committee members to comment. Claudia said that during this process, it will be important to use care with certain patient populations, or physicians may be driven away from caring for the most severely ill patients. She specifically mentioned inner city physicians, whose quality measures may be low due to patient noncompliance and access problems. An unidentified speaker said that measures would be risk adjusted, so that this would be taken into consideration. Alison Hong said that in her experience, certain quality measures can't be tied to outcomes, but rather should be used for quality improvement. There was a discussion about standards and measures. Willard Kasoff said that this plan will also need to decide how transparent it will be about reimbursements. Paul Grady said that he thinks physicians who are early adopters of changes that will result in better quality of care should be rewarded, and emphasized the urgency of this effort. Margaret agreed that urgency is of the utmost importance to this Committee, and she also emphasized clarity.

The following people agreed to research the key domains named and share findings at the next meeting.

Outpatient, focusing on prevention	Rodney Hornbake
Inpatient	Alison Hong
Long term/Home care	Marcia Petrillo
Pediatrics/Family Planning	Clarice Begemann
Special Populations	Margaret Flinter
Mental Health	Vicki Veltri

Paul Grady spoke briefly regarding SustiNet Board of Directors' activities. There is a Board retreat being planned for the Board and SustiNet Committee co-chairs, to provide a forum for various Committees and Task Forces to learn of each other's efforts. Paul encouraged all Committee members to access the SustiNet website to keep current on all events and meetings and to review minutes of others' meetings.

Meeting was adjourned.

Next meeting will be held on March 18, 2010.

Stan Dorn
Senior Fellow

202.261.5561
sdorn@urban.org

Memorandum

To: Frances, Kevin, Nancy
Re: Support needs for SustiNet committees
Date: March 25, 2010

This memorandum describes the support needs of each committee, as I understand them. Some priorities were suggested by committee chairs. Others reflect the sense I gained from my conversations with committee members. The goal of this memo is to inform decisions about how best to deploy the support resources that Connecticut foundations have so generously made available to SustiNet. Under the name of each committee, this memo lists key support needs.

Health information technology committee

This committee could benefit from the following types of support:

- Help writing the committee's report and recommendations;
- Help facilitating decision-making;
- Help conducting brief, focused research projects; and
- Some additional help with logistics (arranging meetings, etc.).

Medical home committee

- Help writing the committee's report and recommendations;
- Help facilitating decision-making;
- Administrative help; and
- Some substantive consulting assistance.

Provider advisory committee

- Help writing the committee's report and recommendations;
- Administrative help; and
- Using resources to bring in expert consultants on discrete issues (e.g., Ken Kizer, who led the VA's successful delivery system reform effort in the mid- to late-1990s could explain how data were used to manage the system to achieve quantified results).

Prevention committee

- Help writing the committee's report and recommendations;
- Administrative help;
- Permission to meet in the evening or on weekends; and
- Strategies for engaging the public in many different geographic areas within the state.

Equity committee

- Research assistance;
- Some additional administrative assistance; and
- Potentially some future facilitation of meetings.

From:	Hong MD, Alison L. [Hong@chime.org]
Sent:	Monday, March 08, 2010 1:45 PM
To:	Flinter, Margaret
Cc:	willard.kasoff@yale.edu; Clark, Jane
Subject:	List of FY 2011 Measures
Attachments:	List of FY 2011 Measures.doc

Hi-

Attached are the inpatient quality measures that are (or will be) publicly reported for participating hospitals. These are by no means all the measures that are available but reflect the validated measures that have been through the CMS/ Joint Commission vetting process and will be posted to the CMS Hospital Compare website. Many hospitals have many more additional metrics related to operations, and clinical indicators by department and/or service line. For discussion sake these measures are a jumping off point. All of the acute care hospitals in CT are Joint Commission accredited therefore they participate in the posting of these data already.

I would encourage us to stick to measures that are tried and true, and not additional measures that do not have processes in place to collect data, and of course validate them. I am copying Dr. Kasoff and Dr. Clark who are working with me on the subject.

At the next meeting I will have to leave at 8:30am due a conflict with a meeting that I am chairing. This can be included as a handout for the group if you like.

Alison

Alison L. Hong, MD
Interim Vice-President, Quality and Patient Safety
Connecticut Hospital Association
110 Barnes Road
Wallingford, CT 06492-0090

Phone (203) 294-7266
Fax (203) 284-9318
hong@chime.org

List of FY 2011 Measures

Condition	Measure
Acute Myocardial Infarction (AMI)/Heart attack	Aspirin at arrival
	Aspirin at discharge
	Beta-blocker at discharge
	Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) for left ventricular systolic dysfunction (LVSD)
	Smoking cessation advice/counseling
	Thrombolytic medication received within 30 minutes of arrival
	Percutaneous Coronary Intervention (PCI) received within 90 minutes of arrival
	30 day mortality rate
	30 day readmission rate
Heart Failure	Left ventricular systolic function evaluation
	ACE inhibitor or ARB for LVSD
	Discharge instructions received
	Smoking cessation advice/counseling
	30 day mortality rate
	30 day readmission rate
Pneumonia	Initial antibiotic(s) received within 6 hours of arrival
	Pneumococcal vaccination
	Blood culture performed prior to administration of first antibiotic(s)
	Smoking cessation advice/counseling
	Received most appropriate antibiotic
	Influenza vaccination
	30 day mortality rate
	30 day readmission rate
Surgical Care Improvement	Prophylactic antibiotic(s) one hour before incision
	Prophylactic antibiotic(s) stopped within 24 hours after surgery
	Selection of antibiotic given to surgical patients
	Prophylaxis to prevent venous thromboenbolism ordered
	Prophylaxis to prevent venous thromboenbolism received
	Appropriate hair removal
	Cardiac surgery patients with controlled 6AM postoperative serum glucose
	Surgery patients on a beta blocker prior to arrival who received a beta blocker during the perioperative period
	Postoperative urinary catheter removal on post operative day 1 or 2 *
	Perioperative temperature management *

1

Patient Experience of Care	HCAHPS survey results on patient interaction with doctors, nurses, and hospital staff; cleanliness of the organization; pain control; communication about medicines; and discharge information
AHRQ Patient Safety Indicators	Iatrogenic pneumothorax, adult
	Postoperative wound dehiscence
	Accidental puncture or laceration
AHRQ Inpatient Quality Indicators	Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
	Hip fracture mortality rate
AHRQ Composite Measures	Mortality for selected surgical procedures (composite)
	Complication/patient safety for selected indicators (composite)
	Mortality for selected medical conditions (composite)
AHRQ Patient Safety Indicator and Nursing Sensitive Care	Death among surgical inpatients with treatable serious complications ^
Structural Measures	Participation in a systematic clinical database for cardiac surgery
	Participation in a systematic clinical database for stroke care *
	Participation in a systematic clinical database for nursing sensitive care *

* Indicates new measure finalized in the FY 2010 IPPS final rule.
^ Indicates measure harmonized for FY 2011 from two existing measures.

The Agency for Healthcare Research and Quality (AHRQ) Quality Indicators (QIs) are measures of health care quality that make use of readily available hospital inpatient administrative data.

The AHRQ QIs consist of four modules measuring various aspects of quality:

- **Prevention QIs** identify hospital admissions that evidence suggests could have been avoided, at least in part, through high-quality outpatient care. Download PQI Module.

- **Inpatient QIs** reflect quality of care inside hospitals including inpatient mortality for medical conditions and surgical procedures. Download IQI Module.

- **Patient Safety Indicators** also reflect quality of care inside hospitals, but focus on potentially avoidable complications and iatrogenic events. Download PSI Module.

- **Pediatric QIs** both reflect quality of care inside hospitals and identify potentially avoidable hospitalizations among children. Download PedQI Module.

Software and user guides for all four modules are available to assist users in applying the Quality Indicators to their own data.

Pediatric Quality Indicators: AHRQ

www.qualityindicators.ahrq.gov/downloads/pdi/pdi_measures_v31.pdf

Looks at "Area Level Indicator"
Asthma admission rate
Diabetes Short-term Complications admission rate
Gastroenteritis admission rate
Perforated Appendix admission rate
UTI admission rate

Children and Adolescent Primary Care, USPSTF recommendations for screening
www.ahrq.gov/clinic/tfchildcat.htm

Only about 12 items that USPSTF determined have sufficient research that provides evidence for screening:
Newborn hearing loss
Sickle cell, HypoT, PKU screening in newborns
Vision screening <5 y/o
Dental: prescribe fluoride if water source deficient
Obesity: screen 6 y/o and older – refer if obese
HTN: screen at 18 and older
Cervical cancer: (21y/o or 3 years after onset of sexual activity)
HIV: high risk
Major Depressive Disorder: if services are readily available
Alcohol use: pregnant women
Tobacco: pregnant women
CT/GC: high risk and pregnant women

Counseling: for high risk adolescents, but must be "high intensity behavioral counseling" – generally groups and for 30 minutes at least twice

research in progress: www.ahrq.gov/research/prevkids.htm

Didn't find anything for family planning.

Home health quality measures (submitted by Tom Meehan)

Home Health Quality Measures (OBQI Outcomes)

Utilization Outcomes
Discharged to Community
Acute Care Hospitalization (lower values preferred)
Any Emergent Care (lower values preferred)

End-Result Outcomes
Improvement in Grooming
Stabilization in Grooming
Improvement in Upper Body Dressing
Improvement in Lower Body Dressing
Improvement in Bathing
Stabilization in Bathing
Improvement in Toileting
Improvement in Transferring
Stabilization in Transferring
Improvement in Ambulation/Locomotion
Improvement in Eating
Improvement in Light Meal Preparation
Stabilization in Light Meal Preparation
Improvement in Laundry
Stabilization in Laundry
Improvement in Housekeeping
Stabilization in Housekeeping
Improvement in Shopping
Stabilization in Shopping
Improvement in Phone Use
Stabilization in Phone Use
Improvement in Management of Oral Medications
Stabilization in Management of Oral Medications
Improvement in Dyspnea
Improvement in Urinary Tract Infection
Improvement in Urinary Incontinence
Improvement in Bowel Incontinence
Improvement in Pain Interfering with Activity
Improvement in Number of Surgical Wounds
Improvement in Status of Surgical Wounds
Improvement in Speech and Language
Stabilization in Speech and Language
Improvement in Confusion Frequency
Improvement in Cognitive Functioning

Stabilization in Cognitive Functioning
Improvement in Anxiety Level
Stabilization in Anxiety Level
Improvement in Behavior Problem Frequency

Downloads

OASIS B-1 to OASIS-C Transition Reporting Matrix 031710 [PDF 127 KB]

Overview of Risk Adjustment and Outcome Measures for Home Health
Agency OBQI Reports [PDF 313 KB]

Comparison of OBQI Outcome Report and HH Compare [PDF 54 KB]

TABLE 4: PATIENTS BY SOCIOECONOMIC CHARACTERISTICS

State Summary for Connecticut for 2008 : 10 Grantees

Universal

Data as of: 07/31/2009

Income as Percent of Poverty Level		Number of Patients (a)	% of Total	% of Known
1.	100% and Below	157,287	65.0%	69.4%
2.	101 - 150%	43,020	17.8%	19.0%
3.	151 - 200%	14,322	5.9%	6.3%
4.	Over 200%	11,938	4.9%	5.3%
5.	Unknown	15,467	6.4%	
6.	Total (sum lines 1-5)	242,034	100.0%	

Principal Third Party Medical Insurance Source		Ages 0 - 19 (a)	Ages 20+ (b)	TOTAL	%
7.	None/Uninsured	14,440	44,630	59,070	24.4%
8a.	Regular Medicaid (Title XIX)	63,592	44,952	108,544	44.8%
8b.	CHIP Medicaid	7,626	5,947	13,573	5.6%
8.	Total Medicaid (Sum lines 8a+8b)	71,218	50,899	122,117	50.5%
9.	Medicare (Title XVIII)	7	13,108	13,115	5.4%
10a.	Other Public Insurance non-S-CHIP	62	18,863	18,925	7.8%
10b.	Other Public Insurance S-CHIP	0	0	0	0.0%
10.	Total Public Insurance (Sum lines 10a+10b)	62	18,863	18,925	7.8%
11.	Private Insurance	9,562	19,245	28,807	11.9%
12.	Total (Sum Lines 7+8+9+10+11)	95,289	146,745	242,034	100.0%

MANAGED CARE UTILIZATION

Payor Category	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid S-Chip (c)	Private (d)	Total (e)
13a. Capitated Member months	75,529	0	0	0	75,529
13b. Fee-for-service Member months	301,582	696	35,733	8,376	346,387
13c. Total Member Months (Sum lines 13a+13b)	377,111	696	35,733	8,376	421,916

Characteristics - Special Populations		Number of Patients (a)	%
14.	Migrant (330g grantees Only)	0	0.0%
15.	Seasonal (330g grantees Only)	0	0.0%
	Migrant/Seasonal (non-330 g grantees)	1,656	100.0%
16.	Total Migrant/Seasonal Agricultral Worker or Dependent (All Grantees Report This Line)	1,656	-
17.	Homeless Shelter (330h grantees Only)	4,899	35.5%
18.	Transitional (330h grantees Only)	1,172	8.5%
19.	Doubling Up (330h grantees Only)	2,465	17.9%
20.	Street (330h grantees Only)	273	2.0%
21.	Other (330h grantees Only)	2,990	21.7%
22.	Unknown (330h grantees Only)	821	6.0%
23.	Total Homeless (All Grantees Report This Line)	13,787	100.0%
24.	Total School Based Health Center Patients (All Grantees Report This Line)	9,192	
25.	Total Veterans (All Grantees Report this Line)	14,087	

Percents may not equal 100% due to rounding

Date Requested: 12/09/2009

TABLE 5: STAFFING AND UTILIZATION

State Summary for Connecticut for 2008 : 10 Grantees

Universal

Data as of: 07/31/2009

	PERSONNEL BY MAJOR SERVICE CATEGORY	FTEs (a)	Encounters (b)	Patients (c)
1.	Family Physicians	43.13	141,848	
2.	General Practitioners	0.96	2,771	
3.	Internists	30.52	109,378	
4.	Obstetrician/Gynecologists	9.84	36,155	
5.	Pediatricians	30.80	116,912	
7.	Other Specialty Physicians	2.45	10,185	
8.	**Total Physicians (Sum lines 1-7)**	**117.70**	**417,249**	
9a.	Nurse Practitioners	59.37	153,668	
9b.	Physician Assistants	13.12	34,245	
10.	Certified Nurse Midwives	11.74	30,065	
10a.	**Total Mid-Levels (Sum lines 9a-10)**	**84.23**	**217,978**	
11.	Nurses	128.06	34,030	
12.	Other Medical Personnel	226.50		
13.	Laboratory Personnel	10.49		
14.	X-Ray Personnel	0.10		
15.	**Total Medical (Sum lines 8+10a through 14)**	**567.08**	**669,257**	**179,035**
16.	Dentists	49.69	135,444	
17.	Dental Hygienists	39.33	74,279	
18.	Dental Assistance,Aides,Techs	79.99		
19.	**Total Dental Services (Sum lines 16-18)**	**169.01**	**209,723**	**78,890**
20a.	Psychiatrists	12.09	30,474	
20a1.	Licensed Clinical Psychologists	10.85	14,075	
20a2.	Licensed Clinical Social Workers	53.20	37,153	
20b.	Other Licensed Mental Health Providers	11.08	10,915	
20c.	Other Mental Health Staff	30.98	22,465	
20.	**Mental Health (Sum lines 20a-c)**	**118.20**	**115,082**	**17,496**
21.	**Substance Abuse Services**	**47.42**	**51,888**	**7,850**
22.	**Other Professional Services**	**21.51**	**17,684**	**7,733**
23.	**Pharmacy Personnel**	**11.77**		
24.	Case Managers	67.87	45,494	
25.	Patient/Community Education Specialists	25.62	14,069	
26.	Outreach Workers	45.84		
27.	Transportation Staff	1.00		
27a.	Eligibility Assistance Workers	7.63		
27b.	Interpretation Staff	7.53		
28.	Other Enabling Services	34.67		
29.	**Total Enabling Services (Sum lines 24-28)**	**190.16**	**59,563**	**24,601**
29a.	**Other Programs/Services**	**4.00**		
30a.	Management and Support Staff	122.35		
30b.	Fiscal and Billing Staff	125.05		
30c.	IT Staff	23.91		
30.	**Total Administrative Staff (Sum lines 30a-30c)**	**271.31**		
31.	Facility Staff	27.72		
32.	Patient Support Staff	404.63		
33.	**Total Administrative & Facility (Sum lines 30-32)**	**703.66**		
34.	**Grand Total (Sum lines 15+19+20+21+22+23+29+29a+33)**	**1,832.81**	**1,123,197**	

Encounters are shown only for personnel that generate reportable encounters
Subtotals may differ from the sum of cells due to rounding

Date Requested: 12/09/2009

TABLE 6A: SELECTED DIAGNOSES AND SERVICES RENDERED

State Summary for Connecticut for 2008 : 10 Grantees

Universal

Diagnostic Category	Applicable ICD - 9 - CM Code	Number of Encounters by Primary Diagnosis (a)	Number of Patients with Primary Diagnosis (b)	Encounters Per Patient
Selected Infectious and Parasitic Diseases				
1. Symptomatic HIV	042.xx; 079.53	9,671	1,762	5.49
2. Asymptomatic HIV	V08	1,265	208	6.08
3. Tuberculosis	010.xx - 018.xx	239	87	2.75
4. Syphilis and other veneral Diseases	090.xx - 099.xx	1,073	837	1.28
Selected Diseases of the Respiratory System				
5. Asthma	493.xx	20,349	11,224	1.81
6. Chronic bronchitis and Emphysema	490.xx - 492.xx	3,449	2,443	1.41
Selected Other Medical Conditions				
7. Abnormal Breast Findings,Female	174.xx; 198.81; 233.0x; 793.8x	855	734	1.16
8. Abnormal Cervical Findings	180.xx; 198.82; 233.1x; 795.0x	2,406	1,629	1.48
9. Diabetes Mellitus	250.xx; 775.1x;	54,036	15,703	3.44
10. Heart Disease (selected)	391.xx - 392.0x 410.xx - 429.xx	4,604	2,149	2.14
11. Hypertension	410.xx - 405.xx;	49,322	22,009	2.24
12. Contact Dermatitis and other Eczema	692.xx	5,210	4,366	1.19
13. Dehydration	276.5x	509	327	1.56
14. Exposure to Heat or Cold	991.xx - 992.xx	56	43	1.30
Selected Childhood Conditions				
15. Otitis Media and Eustachian Tube Disorders	381.xx - 382.xx	9,008	6,599	1.37
16. Selected Perinatal Medical Conditions	770.xx; 771.xx; 773.xx; 774.xx - 779.xx (Excluding 779.3x)	990	688	1.44
17. Lack of Expected Normal Physiological Development (Such as delayed milestone;Failure to gain weight;Failure to thrive)- does not include sexual or mental development;Nutritional Deficiencies	260.xx - 269.xx; 779.3x; 783.3x - 783.4x;	3,165	1,960	1.61

TABLE 6A: SELECTED DIAGNOSES AND SERVICES RENDERED

State Summary for Connecticut for 2008 : 10 Grantees

Universal

Diagnostic Category	Applicable ICD - 9 - CM Code	Number of Encounters by Primary Diagnosis (a)	Number of Patients with Primary Diagnosis (b)	Encounters Per Patient
Selected Mental Health and Substance Abuse Conditions				
18. Alcohol Related Disorders	291.xx, 303.xx; 305.0x; 357.5x	14,454	2,618	5.52
19. Other Substance Related Disorders (Excluding Tobacco Use Disorders)	292.1x - 292.8x; 304.xx; 305.2x - 305.9x; 357.6x; 648.3x	50,119	5,225	9.59
20a. Depression and Other Mood Disorders	296.xx; 300.4 301.13; 311.xx	63,537	10,603	5.99
20b. Anxiety Disorders Including PTSD	300.0x; 300.21; 300.22; 300.23; 300.29; 300.3; 308.3; 309.81	20,416	4,666	4.38
20c. Attention Deficit and Disruptive Behavior Disorders	312.8x; 312.9x; 313.81; 314.xx	18,210	2,457	7.41
20d. Other Mental Disorders,Excluding Drug or Alcohol Dependence (includes mental retardation)	290.xx; 293.xx - 302.xx (Excluding 296.xx; 300.0x; 300.21; 300.22; 300.23; 300.29; 300.3; 300.4; 301.13); 306.xx - 319.xx (Excluding 308.3; 309.81; 311.xx; 312.8x; 312.9x; 313.81; 314.xx)	37,946	7,403	5.13

Diagnostic Category	Applicable ICD - 9 - CM Code	Number of Encounters (a)	Number of Patients (b)	Encounters Per Patient
Selected Diagnostic Tests/Screening/Preventive Services				
21. HIV Test	CPT - 4: 86689; 86701 - 86703; 87390 - 87391	8,471	7,465	1.13
22. Mammogram	CPT - 4: 77055 - 77057 OR ICD - 9:V76.11; V76.12	9,546	8,299	1.15
23. Pap Test	CPT - 4: 88141 - 88155; 88164 - 88167 OR ICD - 9:V72.3; V72.31; V76.2	25,593	19,713	1.30
24. Selected Immunizations (Hepatitis A, Hemophilus Influenza B (HiB), Influenza virus, Pneumococcal Diptheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child)	CPT - 4: 90633 - 90634, 90645 - 90648; 90657 - 90660; 90669; 90700 - 90702; 90704 - 90716; 90718; 90720 - 90721; 90723; 90743 - 90744; 90748	82,474	60,406	1.37
25. Contraceptive Management	ICD - 9: V25.xx	18,826	10,425	1.81
26. Health Supervision of Infant or Child (ages 0 through 11)	CPT - 4: 99391 - 99393; 99381 - 99383; 99431 - 99433 OR ICD - 9:V20.xx;V29.xx	68,347	43,019	1.59

TABLE 7: HEALTH OUTCOMES AND DISPARITIES

State Summary for Connecticut for 2008 : 10 Grantees

	Asian (a)	Native Hawaiian (b1)	Pacific Islander (b2)	Black/ African American (c)	American Indian/ Alaska Native (d)	White (e)	More than One Race (f)	Unreported/ Refused to Report (g)	Total (h)
HIV Positive Pregnant Women:									6
									100.0%

SECTION A: DELIVERIES AND LOW BIRTH WEIGHT BY RACE
Deliveries and Babies by birth weight

	Asian (a)	Native Hawaiian (b1)	Pacific Islander (b2)	Black/ African American (c)	American Indian/ Alaska Native (d)	White (e)	More than One Race (f)	Unreported/ Refused to Report (g)	Total (h)
1. Prenatal care patients who delivered during the year	44	0	1	395	2	333	327	789	1,891
	2.3%	0.0%	0.1%	20.9%	0.1%	17.6%	17.3%	41.7%	100.0%
2. Deliveries performed by grantee provider									912
									100.0%
3. Live Births < 1500 grams	0	0	0	9	0	9	6	7	31
4. Live Births 1500 - 2499 grams	4	0	0	32	0	23	19	57	135
5. Live Births ≥ 2500 grams	40	0	1	358	2	300	303	734	1,738
% Low and Very Low Birth Weight	9.1%	-	0.0%	10.3%	0.0%	9.6%	7.6%	8.0%	8.7%

SECTION D: DELIVERIES AND LOW BIRTH WEIGHT BY ETHNICITY
Deliveries and Babies by birth weight

	Hispanic or Latino (i)	All Other Including Unreported/Refused to Report (j)	Total (k)
1. Prenatal care patients who delivered during the year	1,172	719	1,891
	62.0%	38.0%	100.0%
3. Live Births < 1500 grams	15	16	31
4. Live Births 1500 - 2499 grams	71	64	135
5. Live Births ≥ 2500 grams	1,084	654	1,738
% Low and Very Low Birth Weight	7.4%	10.9%	8.7%

Percents may not equal 100% due to rounding

TABLE 7: HEALTH OUTCOMES AND DISPARITIES

State Summary for Connecticut for 2008 : 10 Grantees

Universal

	Asian (a)	Native Hawaiian (b1)	Pacific Islander (b2)	Black/ African American (c)	American Indian/ Alaska Native (d)	White (e)	More than One Race (f)	Unreported/ Refused to Report (g)	*Total (h)
SECTION B: HYPERTENSION BY RACE									
Patients diagnosed with hypertension whose last blood pressure was less than 140/90									
6. Total patients aged 18 + with hypertension	185	2	-	6,202	4	8,499	1,106	3,487	19,641
7a. Estimated # patients with controlled blood pressure									12,047
7b. Estimated % patients with controlled blood pressure**									61.3%

SECTION E: HYPERTENSION BY ETHNICITY

Patients diagnosed with hypertension whose last blood pressure was less than 140/90

	Hispanic or Latino (i)	All Other Including Unreported/Refused to Report (j)	*Total (k)
6. Total patients aged 18 + with hypertension	10,040	9,601	19,641
7a. Estimated # patients with controlled blood pressure			12,047
7b. Estimated % patients with controlled blood pressure**			61.3%

* Totals col (h) and col (k) are for all patients, including those patients excluded due to reporting problems (and not shown) in the race and ethnicity columns.

** %'s shown are rounded to the .1% level for table display purposes; calculations are made using %'s to 8 decimal places

Date Requested: 12/09/2009

TABLE 7: HEALTH OUTCOMES AND DISPARITIES

State Summary for Connecticut for 2008 : 10 Grantees

Universal

		Asian (a)	Native Hawaiian (b1)	Pacific Islander (b2)	Black/ African American (c)	American Indian/ Alaska Native (d)	White (e)	More than One Race (f)	Unreported/ Refused to Report (g)	*Total (h)
				SECTION C: DIABETES BY RACE						
			Patients diagnosed with Type I or Type II diabetes: Most recent test results							
9.	Total patients aged 18 + with diabetes	158	-	12	3,608	11	5,615	1,053	3,316	13,909
10a.	Estimated # patients with Hba1c < or= 9%									11,253
10b.	Estimated % patients with Hba1c < or= 9%**									80.9%
11a.	Estimated # patients with Hba1c < 7 %									6,525
11b.	Estimated % patients with Hba1c < 7 %**									46.9%

		Hispanic or Latino (i)	All Other Including Unreported/Refused to Report (j)	*Total (k)
		SECTION F: DIABETES BY ETHNICITY		
	Patients diagnosed with Type I or Type II diabetes: Most recent test results			
9.	Total patients aged 18 + with diabetes	6,915	6,994	13,909
10a.	Estimated # patients with Hba1c < or= 9%			11,253
10b.	Estimated % patients with Hba1c < or= 9%**			80.9%
11a.	Estimated # patients with Hba1c < 7 %			6,525
11b.	Estimated % patients with Hba1c < 7 %**			46.9%

* Totals col (h) and col (k) are for all patients, including those patients excluded due to reporting problems (and not shown) in the race and ethnicity columns.
** %'s shown are rounded to the .1% level for table display purposes; calculations are made using %'s to 8 decimal places