

NATIONAL QUALITY FORUM
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HEALTHCARE DISPARITIES AND CULTURAL
COMPETENCY CONSENSUS STANDARDS
+ + + + +
MEETING OF THE STEERING COMMITTEE
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TUESDAY, JULY 12, 2011

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The Steering Committee met at the Liaison Hotel, 415 New Jersey Avenue, NW, Washington, D.C., at 8:00 a.m., Dennis Andrulis and Denice Cora-Bramble, Co-Chairs, presiding.

PRESENT:

DENNIS ANDRULIS, PhD, Co-Chair

DENICE CORA-BRAMBLE, MD, MBA, Co-Chair

EVELYN CALVILLO, DNSc, RN, California State University (via telephone)

MARSHALL CHIN, MD, MPH, FACP, University of Chicago

LUTHER CLARK, MD, Merck & Co., Inc.

LOURDES CUELLAR, MS, RPh, FASHP, TIRR-Memorial Hermann

COLETTE EDWARDS, MD, MBA, CIGNA HealthCare

LEONARD EPSTEIN, MSW, Health Resources and Services Administration

DAWN FITZGERALD, MBA, Qsource (via telephone)

ROMANA HASNAIN-WYNIA, PhD, Northwestern University Feinberg School of Medicine

EDWARD HAVRANEK, MD, Denver Health Medical

Center

ELIZABETH JACOBS, MD, MAPP, University of Wisconsin

FRANCIS LU, MD, University of California,
Davis

MARY MARYLAND, PhD, MSN, BC, APN, Chicago
State University

WILLIAM McDADE, MD, PhD, University of Chicago
ERNEST MOY, MD, MPH, Agency for Healthcare
Research and Quality

MARCELLA NUNEZ-SMITH, MD, MHS, Yale New Haven
Health System

SEAN O'BRIEN, PhD, Duke University Medical
Center

NORMAN OTSUKA, MSc, MD, FRCSC, FAAP, FACS, New
York University Hospital for Joint
Diseases

GRACE TING, MHA, CHIE, WellPoint

DONNA WASHINGTON, MD, MPH, VA Greater Los
Angeles Healthcare System

ELLEN WU, MPH, California Pan-Ethnic Health
Network

MARA YOUDELMAN, JD, LLM, National Health Law
Program

NQF STAFF:

HELEN BURSTIN

HEIDI BOSSLEY

KRISTIN CHANDLER

NICOLE McELVEEN

ELISA MUNTHALI

ROBYN NISHMIMI

ALSO PRESENT:

JOEL WEISMANN, PhD, Disparities Solutions
Center, Massachusetts General Hospital

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1 P-R-O-C-E-E-D-I-N-G-S

2 (8:08 a.m.)

3 MS. MCELVEEN: Good morning. Good
4 morning, everyone. Welcome back for our
5 second day of fun. No, I hope everyone had a
6 good night. We are going to provide a recap
7 of our accomplishments from yesterday, as well
8 as our agenda and goals, what we want to
9 achieve for our day today.

10 First, for those folks who do have
11 computers, again we have internet access
12 available. Just let me know if you need that
13 login information, and I pulled that up on the
14 screen. You do have a few additional handouts
15 that we've made copies of at your stations,
16 and we will address those later on in the
17 afternoon.

18 So, to provide a recap of what we
19 accomplished yesterday, if you recall, we had
20 four specific goals outlined for this meeting
21 as a whole, and we did accomplish quite a bit
22 yesterday. It was a very robust discussion.

1 We did receive your
2 recommendations on the criteria for
3 identifying disparity-sensitive measures. We
4 did go through that. We also talked about how
5 NQF should apply that criteria to our
6 portfolio of measures.

7 In addition, we did cover some of
8 the methodological considerations for
9 measuring disparities. We will continue that
10 conversation today, and we also received some
11 recommendations around broader implications
12 for measuring disparities, and some of those
13 conversation pieces came out a little bit in
14 the morning as we began to discuss the paper,
15 as well as in the afternoon.

16 So, more specifically, I'd like to
17 quickly review some of the key recommendations
18 that we feel were captured through the
19 conversations of our meeting yesterday. If
20 the Committee does not agree or if you have
21 something additional to add, now is the time
22 to let us know, but these are the outputs and

1 recommendations that we feel were captured.

2 So, in terms of guidelines for
3 identifying disparity sensitive measures, it
4 was clear that the Committee agreed that
5 prevalence and quality gap certainly were
6 important to distinguish when it came to
7 identifying disparity sensitive measures.

8 In addition, impact was very
9 strongly advised and recommended from the
10 group and really on different levels, so
11 talking about impact across stakeholders,
12 impact on the community level, impact on the
13 minority populations that you're addressing.

14 We felt that the Committee was
15 agreeable to the concept of disparity sentinel
16 measures. However, the term sentinel was not
17 something that you wanted to utilize, and you
18 suggested a different term.

19 We will explore another term to
20 use, but the concept of sentinel measures,
21 meaning if there is no -- if the data exists
22 for disparities measures, however, there is no

1 measure to address it, developing a new
2 measure is what we -- is what we're calling --
3 currently calling sentinel measures, but,
4 again, we will re-term that.

5 Finally, when we talked about
6 reference points, the Committee agreed that
7 the reference group should be the historically
8 advantaged group while considering other
9 geographical variations to that.

10 So, these key recommendations that
11 I've just stated, is everyone sort of in
12 agreement with that? Are there any -- yes, go
13 ahead.

14 DR. NUNEZ-SMITH: Good morning.
15 So, I just wanted to make sure for the
16 disparity sensitive measures that what was
17 also included were those other four criteria
18 that we talked -- and that didn't -- this was
19 a different --

20 MS. MCELVEEN: Ease and
21 feasibility, is that --

22 DR. NUNEZ-SMITH: No, in the areas

1 where disparities, where the data --

2 MS. MCELVEEN: For the sentinel
3 measures.

4 DR. NUNEZ-SMITH: No, I was
5 looking up to try to find the list of four,
6 and Joel could probably help me.

7 MS. MCELVEEN: Yes.

8 DR. NUNEZ-SMITH: But when it's
9 sort of -- when there is a lot of care
10 discretion --

11 MS. MCELVEEN: Yes.

12 DR. NUNEZ-SMITH: When there's
13 discretion by provider, when it's lifestyle,
14 behavior, so all of those criteria.

15 MS. MCELVEEN: Yes. Okay. Did we
16 have another question or comment? Okay.

17 DR. WASHINGTON: I just wanted to
18 make the same point.

19 DR. MARYLAND: And just in the
20 area of looking at the historically advantaged
21 group, I think there was a recommendation
22 around looking at terminology with that

1 advantaged group language, as well.

2 MS. MCELVEEN: Okay. So, moving
3 on, we did talk about our absolute and
4 relative disparities, and the key
5 recommendation was to calculate not only
6 absolute and relative but also trends, keeping
7 in mind providing some sort of narrative for
8 the end user to really understand what method
9 was used and how that relates to the data that
10 they're reviewing.

11 Paired comparisons and summary
12 statistics, there was no preference made for
13 one versus the other, but, again,
14 considerations were mentioned for
15 implementation and how that would relate to
16 the end user.

17 Around normative judgments, key
18 recommendation that it must be acknowledged,
19 and then, finally, for risk adjustments and
20 stratification, we heard from the group that
21 it's important to outline the implications for
22 the end user as it relates to risk adjustment

1 and stratification. Also, we felt that the
2 Committee generally agreed with the current
3 NQF policy but noted consideration should be
4 given where exceptions might be important.

5 Any comments or questions? Sure.

6 Donna?

7 DR. WASHINGTON: Yes. My
8 interpretation of the discussion regarding the
9 paired comparisons versus summary statistics
10 is that we discussed many of the disadvantages
11 of summary statistics.

12 I thought we agreed with the
13 comment or the recommendation as written,
14 which is should a pairwise comparison using a
15 historically advantaged group as a reference
16 point be checked to see if a positive finding
17 from the summary statistics reflects superior
18 care received by the disadvantaged group.

19 To me, that doesn't imply lack of
20 preference. In, fact, it's guidance for how
21 to use a summary statistic.

22 DR. HAVRANEK: Just with regard to

1 the last point there, the last three words,
2 instead of "might be important," my sense was
3 that what we were really concerned about is
4 might have unintended consequences. So I
5 would hope that you'd be a little bit less
6 vague, a little bit more specific.

7 MS. MCELVEEN: And, I'm sorry,
8 what was that relating to for the --

9 DR. HAVRANEK: The last three
10 words on that slide.

11 MS. MCELVEEN: Okay.

12 DR. WASHINGTON: In fact, we
13 actually didn't explicitly address the choice
14 of pairwise versus summary. The
15 recommendation, I think, in the report was for
16 a pairwise statistics whenever possible, which
17 I would agree with.

18 MS. MCELVEEN: We didn't feel the
19 group had reached a conclusion, but if that is
20 what you're proposing and the group agrees,
21 you know --

22 CO-CHAIR CORA-BRAMBLE: So, Donna,

1 I hear that as your proposal, but I'd like to
2 hear from the rest. I don't know if there's
3 alignment here in terms of whether that was
4 what the agreement was or whether it's
5 something that's being recommended. Ellen?

6 MS. WU: I agree with that.

7 CO-CHAIR CORA-BRAMBLE: Okay.
8 Anybody else? Does anyone have a counter-
9 argument regarding that? Okay, we'll consider
10 that an agreement. Thank you.

11 MS. MCELVEEN: So, our work for
12 today, of course, we'll continue to review
13 those methodological issues, that list that we
14 had started yesterday. We'd also like to then
15 go through and discuss Section 5 of the paper,
16 which talks about priorities and options for
17 quality improvement in public reporting.

18 Finally, we would like to receive
19 some recommendations from the Committee on
20 framing the Call for Measures around
21 disparities. Again, we've provided some
22 handouts to help you think through that

1 process, and we also have a few slides, as
2 well.

3 Lastly, continue to explore NQF's
4 approach for measuring disparities
5 prospectively. I know we did go through a few
6 concepts around that yesterday, and you all
7 did provide some recommendations, so I'd just
8 like to revisit that and make sure there
9 weren't any additional recommendations to add.

10 Any questions or additional
11 comments before we get started?

12 CO-CHAIR CORA-BRAMBLE: Okay, so,
13 big team, my goal is to take us all to the
14 finish line, to do it all in a timely way, so
15 let's rock-and-roll. Okay, so the three areas
16 that we still have to discuss in terms of
17 methodologic issues are interaction effects,
18 sample size consideration, and consideration
19 of socioeconomic and other demographic
20 variables.

21 Joel, I would ask you to at least
22 frame each of those sections. Perhaps we can

1 start with interaction effects, if you could
2 just give us a few sentences to sort of tee up
3 the discussion.

4 DR. WEISSMAN: Sure. The best way
5 I can describe the interaction effect is that
6 when we show disparities I point to the
7 Schulman article that was pretty famous and
8 got a lot of press, published about ten years
9 ago.

10 The media picked up on disparities
11 as being, you know, blacks and women have less
12 access to cardiac care when, in fact, if you
13 showed the four groups separately, black
14 women, black men, and so on, it was white
15 women, white men, and black males all received
16 equitable care. It was only black females
17 that were disadvantaged, and, you know, it's
18 an important point to make.

19 So that is a classic interaction
20 effect where the effect of one variable
21 depends on the level of the other, and so, you
22 know, you can always go a little crazy with

1 this and look in a lot of -- and you get into
2 a sample size effect when you start reducing
3 the sample size and having more categories,
4 but at least probably race-ethnicity by gender
5 ought to be looked at just to see what's going
6 on.

7 CO-CHAIR CORA-BRAMBLE: Thank you,
8 Joel. So let's start the discussion among the
9 group members. Any counter-argument, or are
10 we in agreement with the recommendation? Do
11 we concur? Donna?

12 DR. WASHINGTON: I concur with
13 that, but I would also suggest considering
14 examining race-ethnicity by income.

15 CO-CHAIR CORA-BRAMBLE: Okay.
16 Other comments? Yes, Francis?

17 DR. LU: I'd add age, as well.

18 CO-CHAIR CORA-BRAMBLE: Okay, so
19 we'd add those other variables, income, age.
20 Anything else? Yes?

21 DR. MOY: Urban/rural effects.

22 CO-CHAIR CORA-BRAMBLE: Okay.

1 Just use a mic. Yes, so what he said -- Dr.
2 Moy said --

3 DR. MOY: Urban/rural.

4 CO-CHAIR CORA-BRAMBLE: Yes, urban
5 and rural effects. That is correct. Was that
6 a comment or not? Just wanted to make sure
7 that I acknowledge you. Anyone else?

8 DR. HAVRANEK: We just have to be
9 really careful with interaction just because
10 the statistical issues for one is that the
11 number of individuals and events that you need
12 to pick up any kind of meaningful signal, you
13 know, they're hard enough when we're looking
14 at just race and ethnicity, but when you start
15 looking at interactions it becomes very
16 complicated.

17 I think also there's a -- we have
18 to also be careful that there's not a lot
19 known about how these issues interact in terms
20 of some of the things like stereotyping and
21 bias and stuff like that.

22 I mean, to some extent they work

1 together. To some extent, they counteract
2 each other. So I'm really -- I mean, I think
3 we have to raise the issue that it's
4 important, but trying to deal with it
5 explicitly I think is clearly a problem.

6 CO-CHAIR CORA-BRAMBLE: So, just
7 to make sure that we -- that we understand the
8 comment is that you don't necessarily
9 disagree, but you think we have to be really
10 careful.

11 DR. HAVRANEK: I think we have to
12 be really -- no, I think it's important to
13 raise the issue that there are interactions
14 among these things, but in terms of turning
15 these into quality measures, things that get
16 measured, I don't think we're ready for --
17 those things are ready to be rolled out.

18 CO-CHAIR CORA-BRAMBLE: Okay.
19 Acknowledged. Yes, Romana?

20 DR. HASNAIN-WYNIA: So, this is
21 not so much about interaction, but I don't
22 think we ever discussed stratifying by payer,

1 and I think we should. The AHRQ report does,
2 doesn't it, a little bit?

3 DR. HAVRANEK: Could you expand on
4 that? I don't understand what you --

5 CO-CHAIR CORA-BRAMBLE: Does it go
6 beyond private and public, or is it --

7 DR. HASNAIN-WYNIA: Medicaid --

8 CO-CHAIR CORA-BRAMBLE: So
9 commercial versus Medicaid.

10 DR. HASNAIN-WYNIA: Right.

11 CO-CHAIR CORA-BRAMBLE: So it's
12 sort of a different measure --

13 DR. HASNAIN-WYNIA: Measure.

14 CO-CHAIR CORA-BRAMBLE: -- as it
15 relates to socioeconomic.

16 DR. HASNAIN-WYNIA: Right, because
17 we keep talking about socioeconomic. We talk
18 about income. We don't always have those
19 data. We do have payer, at least at the
20 provider level, so --

21 CO-CHAIR CORA-BRAMBLE: Unless
22 they're uninsured.

1 DR. HASNAIN-WYNIA: Right.

2 DR. HAVRANEK: You're talking
3 about using Medicaid as a proxy for low
4 income? Is that what you're proposing?

5 DR. HASNAIN-WYNIA: In some ways,
6 yes.

7 CO-CHAIR CORA-BRAMBLE: Yes.

8 DR. HAVRANEK: Okay.

9 DR. HASNAIN-WYNIA: Where we have
10 that, right.

11 CO-CHAIR CORA-BRAMBLE: Because of
12 availability of data.

13 MS. WU: Can I -- can we add
14 highest level of education? I think you guys
15 do that when it's available. I'm sure it's
16 not going to be available most times.

17 DR. WEISSMAN: I mean, that gets
18 into the discussion about adjusting for
19 socioeconomic status.

20 CO-CHAIR CORA-BRAMBLE: Correct.
21 Correct, but I'm not hearing explicit
22 disagreement in terms of the interaction

1 effects recommendation. All right. Romana,
2 do you have another comment or not? Okay,
3 please go ahead. I can't see everybody's
4 name, so forgive me if I just point to you.

5 DR. OTSUKA: I agree, but the only
6 other effect is perhaps generational. The
7 longer you're here, the more generations, the
8 effect of your race or ethnicity wears off, so
9 to speak, I think. Culturation, exactly.

10 DR. WEISSMAN: Something that
11 might help in the discussion about when you
12 look at a lot of interaction effects and you
13 get into very small groupings is that it's --
14 following on the point that Edward was making
15 was that you may not have enough to use as a
16 public reporting measure, but it might be
17 something that you want to look at, the
18 provider may want to look at internally as a
19 QI.

20 So, in other words, in this same
21 Schulman example, you know, a particular
22 provider may not have enough cases to reliably

1 report that black women were disadvantaged,
2 but internally they can sort of act on that
3 information, because when you're only a
4 provider, even a few cases are enough to kind
5 of change practice.

6 So that may be part of the
7 recommendation that consider these interaction
8 effects. If big enough, report them. If not,
9 you may want to consider them for internal QI
10 purposes.

11 CO-CHAIR CORA-BRAMBLE: Okay.
12 Thank you. Does anyone else have a comment?
13 Mara, yes?

14 MS. YOUDELMAN: And language,
15 which just wasn't brought up, but stratifying
16 by language.

17 CO-CHAIR CORA-BRAMBLE: Okay.
18 Anything else? Anything else about that?
19 Marshall?

20 DR. CHIN: So, there's Joel's
21 report, and then, I guess, there are the
22 recommendations. Could you tell us a little

1 bit about the difference in the sense that the
2 scenario where it's going to be a long list of
3 variables, which I think are important to
4 stratify by? There needs to be some type of
5 paragraph about sort of why or how you use or
6 -- a lot of this is based upon what is the
7 purpose for what you're doing.

8 CO-CHAIR CORA-BRAMBLE: Right.

9 DR. CHIN: So, Joel's paper can do
10 that. Is that also in the brief of
11 recommendations that's going to come out,
12 also?

13 CO-CHAIR CORA-BRAMBLE: You know,
14 I would think that we would have to have some
15 sort of companion document to explain some of
16 this. I don't think it needs to be, clearly,
17 as extensive and thorough as Joel's paper,
18 but, you know, if I were not a part of this
19 Committee and these -- and I was reading the
20 recommendations, I would need a little bit of
21 help in terms of, you know, to contextualize,
22 particularly certain sections that there was

1 a lot of debate and discussion. Yes, Romana?

2 DR. HASNAIN-WYNIA: So, this again
3 strays a little bit from measurement, but it
4 builds -- just Marshall's comment covered
5 this, though. In terms of NQF's charge, NQF
6 in my mind has always been kind of the measure
7 endorser, right, kind of the Good Housekeeping
8 seal of approval.

9 But we seem to be going beyond
10 that charge here, and I just -- I just want to
11 explicitly acknowledge that. In some ways, I
12 mean, we're going beyond just the measure
13 development endorsement, rather, and into
14 almost what I would consider standard setting.

15 CO-CHAIR CORA-BRAMBLE: I agree
16 with you. Some of these issues are so complex
17 and laden with multiple levels of, you know,
18 layers of issue. I'm not sure that we can do
19 just the standards in complete isolation, but
20 I acknowledge what you're saying.

21 DR. BURSTIN: I think also the
22 role of NQF has evolved, and I think it's not

1 just about endorsing standards at this point,
2 so, you know, to actually look at the mission
3 statement now it's building consensus on
4 national priorities and goals. Disparities
5 certainly fits there for performance
6 improvement and working in partnership to
7 achieve them, so I think there is a lot of
8 opportunity here.

9 Again, as Marshall pointed out
10 yesterday, there's ways for us both to help on
11 the national quality strategy side as they
12 promulgate what the national quality strategy
13 and the partnership of patients is, and NQF is
14 helping with that, as well as the measure
15 selection process. So I think this is very
16 useful.

17 CO-CHAIR CORA-BRAMBLE: Okay. Any
18 further discussion before we leave the
19 interaction effects section? So what I'm
20 hearing, just to make sure -- I'm sorry.
21 Luther?

22 DR. CLARK: I just have a

1 question. I guess this is for Joel. Could
2 you have the opposite effect? I mean, here
3 there was an attribution to the group males
4 and females. There was only females, but
5 could you have the opposite effect of missing
6 a disparity through this same type of
7 analysis?

8 DR. WEISSMAN: I'm not sure what
9 you mean.

10 DR. CLARK: Well, in the Schulman
11 study would it have been possible to have the
12 opposite effect, that he may have found no
13 difference when, in fact, there was a
14 difference?

15 DR. WEISSMAN: Oh, let's see.
16 Sean probably has a comment on this, but, you
17 know, when you -- it may be that I suppose you
18 could have a significant interaction effect
19 and not a significant main effect.

20 What would that mean? Would that
21 mean that there's still a disparity? I'm not
22 sure. That's when I tend to look at the four

1 groups and compare one against the other, so
2 would you go about it in a different way?

3 DR. O'BRIEN: I don't know. I
4 mean, I think it's possible that if you look
5 at an overall large group, you don't see any
6 differences, but within subgroups, then you
7 see stark differences, and so you could miss
8 something that you wouldn't see if you didn't
9 sub-stratify.

10 DR. WEISSMAN: I think he was
11 asking the opposite.

12 DR. CLARK: Yes. No, that's what
13 I asked. I think, you know, our concern would
14 be in not missing a disparity, although you
15 don't want to overstate the disparity, either.

16 DR. WEISSMAN: Oh, I see what
17 you're saying. Yes, so in some cases, if you
18 don't do the interaction effect, you could
19 miss an important effect within a group.
20 That's absolutely right, yes.

21 CO-CHAIR CORA-BRAMBLE: I think
22 that was sort of the reason why you wanted to

1 make sure that it was considered, no?

2 DR. WEISSMAN: Yes. Yes. Well,
3 yes, I mean, it's funny. The example I gave
4 was that there was also this main effect of
5 blacks and women, right, but it was not
6 telling the full story. It wasn't carefully
7 analyzed when, in fact, there was an
8 interaction effect, but that's true.

9 You could find not much
10 difference, but there might be differences
11 within one of the groups, so that's a good
12 point. It's another reason to do interaction,
13 but, you know, you can go -- they get pretty
14 complicated pretty fast.

15 CO-CHAIR CORA-BRAMBLE: Sure.

16 DR. WEISSMAN: So you want to take
17 a lot of care.

18 CO-CHAIR CORA-BRAMBLE: Okay. So,
19 not hearing any further comments, I would then
20 assume that it's consensus in terms of Joel's
21 assessment and recommendation for that
22 specific section as it relates to interaction

1 effects.

2 All right. You all are on a roll
3 this morning, yes. Sample size consideration.
4 Joel, can you give us a few sentences about
5 that?

6 DR. WEISSMAN: Yes, just that as
7 we look at the different racial and ethnic
8 groups, especially when we approach a certain
9 amount of granularity, the sample sizes get
10 pretty small pretty fast.

11 Especially if you're considering,
12 you know, if you're looking at condition-
13 specific rates, it's one thing to have 30,000
14 members of a health plan, but when you talk
15 about those with AMI, you know, you have a
16 very small number very quickly, so you can
17 imagine that you can get very small.

18 So there are a number of options
19 that we suggested with pros and cons of each
20 of dealing with small sample size, you know,
21 including rolling up, including using
22 composite measures, and there were a couple

1 others. You know, looking, grouping over
2 several years is pretty common. You know, a
3 year is a pretty artificial number and that
4 kind of thing.

5 CO-CHAIR CORA-BRAMBLE: Okay.
6 Thank you. All right, so we'll open up the
7 floor for discussion on this specific topic in
8 terms of sample size consideration, whether
9 there are any additional pros and cons that
10 were not listed, comments in general. Yes?

11 MS. WU: I would just like to go
12 back to a comment you made before, Joel, about
13 even when you don't have a large sample size,
14 it still might be able to tell you something.
15 It's argument I always get when we advocate
16 for the stratification by, you know, analysis
17 by race.

18 It's like, "There's not enough."
19 It's like, "Yes, but it might tell you
20 something or have you look deeper into
21 something, might trigger something for you."

22 So if there's a way to add that

1 into the report and why that might be
2 important, anyway, I mean, it's not -- you
3 wouldn't report it out, and you wouldn't make
4 journalizations from it, but it's still
5 information that might be helpful.

6 DR. WEISSMAN: I think we mention
7 that in the report, and we talk about use for
8 internal QI activities. You know, there are
9 some clinicians in the room that could address
10 this better, but, you know, if you talk to
11 them and you want to report out results based
12 on very small numbers, they get very, you
13 know, a little antsy about that.

14 But when you say, "But, you know,
15 maybe you ought to look, see what's going on
16 internally," they tend to be comfortable with
17 that as long as it's kept internal. That's my
18 impression, speaking as a non-clinician.

19 CO-CHAIR CORA-BRAMBLE: Okay,
20 Donna?

21 DR. WASHINGTON: With respect to
22 the options for addressing the small sample

1 size, the options are listed on page 37. One
2 of them included using a summary statistic.

3 In keeping with the prior
4 agreement that paired comparisons are
5 preferable to summary statistics, then I would
6 modify the recommendation to say accept all
7 options except for the summary statistic. So
8 that wouldn't prevent someone from using a
9 summary statistic, but it wouldn't be listed
10 as one of the recommendations.

11 CO-CHAIR CORA-BRAMBLE: Thanks,
12 Donna. Marcella?

13 DR. NUNEZ-SMITH: Also, as far as
14 the options for dealing with the small sample
15 size, I think one of them was using composite
16 measures, and just to make the notation that
17 in cases where we're looking at measures that
18 are cross-cutting, those would probably not be
19 amenable to composites, which tend to be
20 condition-specific, so that in those cases we
21 may have to look at the other options such as
22 looking at data over two or more years.

1 CO-CHAIR CORA-BRAMBLE: Okay.

2 Thank you. Sean?

3 DR. O'BRIEN: With regard to the
4 summary statistics, I think there's another
5 issue. The summary statistics are the type
6 that we were talking about yesterday where
7 you're rolling up paired comparisons into a
8 single number.

9 If each of those paired
10 comparisons that are used to form the summary
11 statistic are highly variable and noisy
12 because of small sample sizes, your overall
13 summary may still have a sample size issue
14 that doesn't go away, so I think be careful
15 about that one. I may have had a second
16 point, but I --

17 CO-CHAIR CORA-BRAMBLE: Okay,
18 thanks. William and then Marshall?

19 DR. CHIN: I will say the
20 Committee started a powwow on composite
21 measures, but I want to give Joel the chance
22 to defend it in terms of your massive

1 experience, because you were basically in
2 government trying to do this. What's the best
3 case for summary statistics?

4 In other words, I get this
5 impression that when it came down to
6 practicality, it was like the only option a
7 number of times, but if you could talk a
8 little bit more about what you thought were
9 the pros, or are you agreeing in terms now
10 with these measures you're comparing against
11 composite measures?

12 DR. WEISSMAN: Yes, I spent a
13 couple years as a Health Policy Advisor to
14 Secretary Bigby in Massachusetts, and while I
15 was there we spent a lot of time on
16 disparities issues. One of the things we
17 dealt with was a state report card on
18 disparities, and it was in development when I
19 left after my two years there.

20 We were considering a number of
21 summary -- we tried to break it down by the
22 major OMB categories, and that's, I think,

1 where we left it, but in some cases we were
2 considering other kinds of summary indexes.
3 Where it really came into play was in the pay-
4 for-performance program that, actually,
5 Medicaid developed while I was there.

6 There, they just didn't have the
7 numbers, and so they, as a practical approach,
8 they used -- they used composites. You know,
9 they had a composite over all the conditions,
10 and they used a summary statistic, and they
11 came up with one number per hospital.

12 In that case, you know, I thought
13 it didn't really work that well, and we
14 actually ended up writing an article saying
15 that that doesn't work that well, but just,
16 you know, when you come back to --

17 You know, we can make all these
18 recommendations about how granular to get, how
19 to stratify, and all that kind of stuff, but
20 when you start churning out these numbers, you
21 get a lot of numbers very quickly.

22 I don't think there's a right

1 answer, unfortunately, but in some cases a
2 summary statistic may really efficiently
3 summarize what's going on, that there is a
4 disparity, and I guess the recommendation
5 we're making is don't use it blindly, that it
6 can be -- that it can be a useful tool, that
7 it can really -- to use Sean's term, you know,
8 a data reducer, right.

9 It can really reduce a lot of
10 stuff, but, you know, but use it carefully and
11 understand that's going on. If there's stuff
12 that makes you uncomfortable such as
13 directionality issue or there are value
14 judgments that are being made in terms of how
15 those things are created, then those ought to
16 be made explicit and transparent, just like,
17 I think, any of the composite type of
18 statistics that are used in public reporting.

19 CO-CHAIR CORA-BRAMBLE: Thank you.
20 William and then Norman.

21 DR. MCCADE: That was what my
22 confusion was, because it seems like the first

1 three of the four options are all summary
2 statistics, tools, at least, and I wasn't
3 really quite sure as to Donna's comment that
4 if we were going to choose one and exclude
5 summary statistics that we would be also using
6 summary statistics in any of it.

7 The only one that doesn't seem to
8 be that way is the combined data from two or
9 more years where you're actually using the
10 true data set, and although it's slow to
11 accumulate, it seems like it's probably the
12 truest measure.

13 CO-CHAIR CORA-BRAMBLE: Norman?

14 DR. OTSUKA: I don't want to sound
15 like too much of a contrarian, but I'm not a
16 statistician. I'm a clinician in the
17 grassroots, and this is a national forum. If
18 you present me with some data with small
19 sample size, I wouldn't really look too
20 closely at it, so I'd be careful about getting
21 too granular in reporting small sample sizes
22 like you suggest. As a clinician, busy

1 clinician seeing X number of patients, I
2 wouldn't give that a second thought.

3 CO-CHAIR CORA-BRAMBLE: Okay.
4 Noted. Any other comments? Sean, did you
5 have a comment?

6 DR. O'BRIEN: Yes, I mean, I think
7 I more or less agree with these
8 recommendations, but at some point we need a
9 recommendation that is more specific to what
10 this group is doing. When there is a Call for
11 Measures, measure proposals will come in, and
12 they need to be evaluated for basically their
13 -- on different criteria, including validity
14 and reliability.

15 There needs to be some type of
16 framework for assessing when is sample size
17 adequate or not adequate. I'm not sure we'll
18 come up with anything that's really strict and
19 operational, but that will be the issue is
20 when do we say the sample size is too small.

21 I think another -- for NQF
22 guidelines there are specific measure

1 developers that are supposed to provide
2 evidence regarding the reliability and
3 validity of the measures you're submitting,
4 and reliability does include some type of
5 assessment, I think, some type of assessment
6 of whether the data are precise enough to be
7 useful for some purpose.

8 I mean, I think -- so I don't know
9 exactly any threshold or how to -- at some
10 point, that's what I think we'll be grappling
11 with when measures come in.

12 CO-CHAIR CORA-BRAMBLE: Okay. Any
13 other comments from the group regarding sample
14 size considerations?

15 CO-CHAIR ANDRULIS: Just, Joel, in
16 your section on --

17 CO-CHAIR CORA-BRAMBLE: I don't
18 think I acknowledged you.

19 (Laughter.)

20 CO-CHAIR ANDRULIS: I'm sorry.

21 Oh, okay.

22 CO-CHAIR CORA-BRAMBLE: Go ahead.

1 CO-CHAIR ANDRULIS: Just a minor
2 note, because you did include in this section.
3 You talk about Weinick's work and the
4 reference to even anecdotal evidence maybe
5 useful, and I'm thinking of the -- it may be
6 in the inclusion and guidance whether there is
7 a need also to acknowledge that there are
8 these kind of exceptional or circumstantial
9 issues that should also be added or considered
10 to accent these points with regard to sample
11 size.

12 In other words, you may lose, but
13 there may be some really singular events that
14 point out something about what happens. So
15 that so-called anecdotal evidence that you
16 raise in reference to Weinick's work, I just
17 wanted to get your thought about where you saw
18 that fitting in the mix, since it is in that
19 section.

20 DR. WEISSMAN: Well, I think it
21 was the point I was making earlier about
22 internal QI activities. What was the -- I

1 mean, I think, you know, I hesitate to use the
2 word, but the sentinel case, right, the
3 exceptional case. What was the famous book,
4 Falling Down, the Hmong family? You remember
5 that?

6 CO-CHAIR CORA-BRAMBLE: The Spirit
7 Catches You, and You Fall Down.

8 DR. WEISSMAN: Thank you. The
9 Spirit Catches You, and You Fall Down, right.
10 I mean, you know, isn't that what got us all
11 started on this? I mean, it was a single
12 case, you know, well written up and well
13 researched, and, by the way, if anybody hasn't
14 read it, they should.

15 You know, I think that changed a
16 lot of places, so I think the point about
17 making that, you know, there are times when
18 statistical stability doesn't tell the whole
19 story, where, you know, we have to throw the
20 statistics out the window and kind of look at,
21 take a very patient-centered approach and
22 learn something from it.

1 So I think that as a
2 recommendation, you know, following on what
3 Helen said, you know, this is more about just
4 measure reporting and public reporting but
5 also trying to change practice, and one way to
6 do that is even if you don't have enough
7 cases, these are -- these may be -- some
8 exceptional cases may be worth investigating.

9 CO-CHAIR CORA-BRAMBLE: Yes,
10 Romana?

11 DR. HASNAIN-WYNIA: I just want to
12 follow up on that and really kind of support
13 Joel's comment. So, you know, I use this
14 example from a few years ago in terms of some
15 work that we were doing looking at the
16 Hospital Quality Alliance measures,
17 particularly the measure to door-to-balloon
18 time PCIs.

19 So we started to look internally
20 at Northwestern at our numbers, and, you know,
21 we ran into small sample size issues,
22 especially when we started to look at

1 different racial and ethnic groups, but we
2 started to see some patterns where Hispanic
3 women, it was taking them longer in terms of
4 meeting that measure -- let me just use that
5 term -- as well as African-Americans.

6 We continued to kind of ask
7 whether that story was holding in other
8 regions, in hospitals on the West Coast and in
9 Florida and Texas and so forth, and we saw
10 that pattern repeating. That was really
11 informative, and for many of the hospitals the
12 sample size was quite small, but it revealed
13 a story, and it revealed a story that actually
14 led to further research to look at it more
15 empirically.

16 So those anecdotes are really
17 important, and I do think, you know, the
18 comment that Norman made in terms of if you
19 see really small numbers, you start -- you
20 know, a small sample size, you may question
21 the validity of that information, but in terms
22 of internal information and internal quality

1 improvement and trying to understand the story
2 internally, I think those numbers are
3 important no matter how small they are. So I
4 don't want to lose sight of that in terms of
5 what we put forward in this Committee.

6 CO-CHAIR CORA-BRAMBLE: Good
7 observation. Thank you. Any further comments
8 before we leave this section? Yes?

9 DR. MOY: Listening to the
10 conversation, I think it's important to know
11 when it's a sample and when it's not. So we
12 don't mind for QI purposes, because they're
13 really not samples.

14 We have the hospital population or
15 the health plan population, and in truth
16 that's how these measures will often be used.
17 They're populations. They're not subject to
18 sampling error.

19 CO-CHAIR CORA-BRAMBLE: Okay. If
20 there are no other comments, then we'll move
21 on to the next section, and we've already done
22 -- we've spent, actually, a fair amount of

1 time talking about other socioeconomic
2 variables and considerations. We sort of
3 backed into that discussion, but I'd like,
4 Joel, if you can tee that up, and then we'll
5 have a discussion about that.

6 DR. WEISSMAN: Yes, I think it's
7 important to differentiate this risk -- this
8 adjustment activity from the earlier risk
9 adjustment activity. So before we were
10 talking about risk adjusting an outcome or a
11 measure for race and ethnicity, and you have
12 to consider the use.

13 So the idea there would be that if
14 you were going to use it for high-stakes
15 reporting, for public incentives, you know,
16 the question was should you risk adjust for
17 the underlying racial and ethnic population,
18 and the position of NQF and this Committee, I
19 think, was that stratification is a better way
20 to go.

21 This is about one step down, and
22 now you are focused on characterizing the

1 disparities in a population, and so you're
2 looking to make it simple, black-white
3 differences. The question is if you find
4 black-white differences, should you further
5 adjust for socioeconomic status, say, for
6 payer or income?

7 What often happens is if you do
8 that, the disparities go away. Sometimes they
9 remain, and I think that's what, you know, the
10 IOM report was about, that you can do that in
11 a lot of cases, but a lot of times, especially
12 in small sample sizes, you know, these
13 significant differences go away.

14 The question we ask is if they go
15 away when you adjust for socioeconomic status,
16 does that mean that the disparity doesn't
17 exist? We were uncomfortable with saying yes
18 to that question, answering yes to that
19 question, so we recommended that racial and
20 ethnic and language disparities not be
21 adjusted for socioeconomic status.

22 CO-CHAIR CORA-BRAMBLE: All right.

1 Comments? Thank you, Joel. Go ahead.

2 MS. WU: This is more what I
3 understand it as control for socioeconomic
4 status, Joel. Is that -- yes. Okay.

5 CO-CHAIR CORA-BRAMBLE: That's a
6 question, Joel, for you.

7 MS. WU: I got the answer. Anyway
8 --

9 DR. WEISSMAN: Yes.

10 MS. WU: So, I actually agree with
11 that, and it also addresses the concern I
12 think some of us have in working in the field
13 where a lot more folks are focused on the
14 socioeconomic status as a disparities
15 indicator and trying to address, and that's an
16 important issue, income disparities, and not -
17 - and using that as a proxy for race-ethnicity
18 and language, which, you know, is a concern,
19 so I definitely would agree with the
20 recommendation with the report.

21 CO-CHAIR CORA-BRAMBLE: Thank you.
22 I do have one question. There is some

1 literature that looks at wealth, as opposed to
2 income, as a better indicator, and I just
3 wanted comments from you, Joel, and then some
4 of the other folks in the group whether that's
5 something we need to look at.

6 DR. WEISSMAN: Yes, I think there
7 are some experts in the room that are better
8 than me at using various measures of
9 socioeconomic status, but wealth is certainly
10 one of them. They each have pluses and
11 minuses in terms of ability to get the
12 information, stability over time, you know,
13 generational effects, and so on.

14 Wealth is certainly better, for
15 example, for the elderly, right? I mean, they
16 don't work, so their incomes are low, and some
17 of them may have very high wealth, so there
18 are different ways to go about it.

19 CO-CHAIR CORA-BRAMBLE: Okay.
20 Marcella?

21 DR. NUNEZ-SMITH: So just one
22 quick follow-up point to that, which is true.

1 I mean, David Williams and others have written
2 extensively about using wealth rather than
3 income or other measures.

4 Some of what we're going to end up
5 discussing is going to be related to what's
6 limited in the databases people will be
7 looking at nationally where to date we don't
8 have wealth and other measures like that, so
9 that's going to be one of the issues there.

10 I think, just to clarify the
11 recommendations, so I also agree we should not
12 be further adjusting and controlling for those
13 other variables, but is there a second part of
14 the recommendation that says we should be
15 doing separate stratification by some of these
16 other indicators such as payer or anything,
17 any other --

18 DR. WEISSMAN: I thought it was --
19 you know, it's worth -- it's worth, you know,
20 further stratifying it and looking at the
21 differences. There's a difference between, I
22 guess, some of the contributory factors and

1 sort of mitigating the thing, which explains
2 it away, right.

3 So income, wealth, insurance
4 status, those are all contributory factors,
5 and if you find differences, say, between
6 Latinos and whites, chances are it's going to
7 be because of wealth, income, and insurance
8 status. It's worth looking at that.

9 If you're trying to improve
10 quality of care, it's worth acknowledging that
11 those factors contribute to the differences,
12 but to say, "Well, you know, Latinos are more
13 likely to be uninsured and have lower incomes,
14 and that explains everything, and therefore
15 there are no racial-ethnic disparities in my
16 health plan," I don't think is where we want
17 to go. So I'm not sure I'm articulating it as
18 well as I can, and maybe somebody can work on
19 that better, but that was where we were coming
20 from.

21 DR. NUNEZ-SMITH: Right, so is it
22 -- so then is it, in terms of operationalizing

1 it, it's sort of you have multiple independent
2 analyses. Is that the understanding? So you
3 have one analysis, race-ethnicity only.
4 That's your stratification.

5 Then you take the data set, do
6 another stratification by payer, let's say,
7 but that's what you're looking at in that
8 analysis is just payer. You're not looking at
9 race-ethnicity and payer. I mean, I'm just
10 trying to understand if that's the --

11 DR. WEISSMAN: Well, no, you could
12 do both. I think we -- I think we had some
13 cool graphs from RWJ that did a very nice job.
14 I don't know where they are now. Anybody know
15 where they are, what page?

16 CO-CHAIR CORA-BRAMBLE: What page
17 are you on, Joel?

18 DR. WEISSMAN: That's what I'm
19 looking for. There were some nice graphs from
20 RWJ that showed --

21 MS. WU: But, Joel, isn't it --

22 DR. WEISSMAN: It broke down --

1 CO-CHAIR CORA-BRAMBLE: So pages
2 43 and 44?

3 DR. WEISSMAN: Oh, maybe.

4 MR. WU: But, Joel, isn't it
5 different? Isn't it different statistically
6 when you stratify by certain indicators versus
7 control for? I'm not a statistician.

8 DR. WEISSMAN: You know, it is
9 different, but it has the same purpose,
10 because you're showing how different -- and
11 I'm not a statistician, either.

12 DR. NUNEZ-SMITH: Right, I mean,
13 yes, I mean, I think the point where I -

14 DR. WEISSMAN: So it's always
15 dangerous.

16 DR. NUNEZ-SMITH: Right. I mean,
17 I'm not actually saying something different.
18 What I'm saying is instead of you looking at
19 race and income together in an analysis you're
20 looking at them separately. I mean, that's
21 the way that it's presented in the --

22 DR. WEISSMAN: Well, except on

1 page 43 and 44 you can see that you can also
2 look at them together, right, so not just
3 separately, but you can, in fact, look at them
4 together.

5 I think maybe where this Committee
6 needs to sort of focus on is I was simply
7 illustrating different ways of approaching
8 this, but in terms of your recommendations to
9 how to use the measures, it may be, you know,
10 just because you can do it doesn't mean you
11 should.

12 CO-CHAIR CORA-BRAMBLE: Okay, so I
13 want to -- there are a few people that I want
14 to acknowledge. I know you had a comment.
15 Elizabeth, do you have one? Okay, so let me
16 do this. Let me start. Let me start with
17 you, Elizabeth, then you, Dennis, and then
18 you, Edward. Yes?

19 DR. JACOBS: The one thing I was
20 going to say about wealth is I'm not sure how
21 practically you'd measure that in this
22 context. I mean, people don't even want to

1 answer questions about their race-ethnicity,
2 and I don't think a lot of healthcare
3 organizations collect that information. I
4 mean, while it might be good to think about
5 it, I think it really raises questions in
6 people's minds, as Romana has shown, about why
7 you're asking that information.

8 CO-CHAIR CORA-BRAMBLE: Thank you.
9 Dennis?

10 CO-CHAIR ANDRULIS: Before we
11 decide not to risk adjust for SES, just I
12 guess I'm a little haunted by some of the more
13 powerful studies that have come out to show
14 that even when you control for SES that there
15 are still disparities related to race and
16 ethnicity.

17 You know, I think some of the work
18 we did in Prince George's County where we
19 looked at the SES within Prince George's and
20 we were reminded over and over again about how
21 it's one of the wealthier African-American,
22 primarily African-American counties. We said,

1 you know, we're still finding disparities
2 within that county.

3 I talked to some folks about this,
4 and they said there are all sorts of
5 conjectures as to why this was happening.
6 While I generally agree with the discussion
7 around the SES, I'm concerned about those
8 aspects, those findings being lost or being
9 not potentially considered should we just
10 blanketly say SES shouldn't be controlled.

11 CO-CHAIR CORA-BRAMBLE: Okay, so
12 Edward, and then there's a comment on the
13 phone, and then you, Grace. Yes?

14 DR. HAVRANEK: I think this is the
15 first time that I disagree with your
16 recommendations. So if you show a black-white
17 difference and then you adjust for
18 socioeconomic position and you show that those
19 differences --

20 Let's say first you show that they
21 don't go away, which is, I think, what Dennis
22 just alluded to. That to me implicates

1 mechanisms such as bias and prejudice as being
2 really important and leads us in an important
3 direction in terms of trying to address the
4 disparity. To me, that's a really useful
5 finding.

6 The opposite case, that you adjust
7 for socioeconomic position and the bias goes
8 away, to me suggests that the primary driver
9 of the disparity is socioeconomic position, so
10 that's what we should be focusing on, and
11 that's the source of the disparity.

12 I think we are discounting the
13 possibility that there is, you know, bias and
14 prejudice and stereotyping based on
15 socioeconomic position that is itself
16 producing a disparity. So it may be that, you
17 know, poor whites are being -- are subject to
18 a disparity here in this by the same mechanism
19 by which poor African-Americans or poor
20 Latinos are.

21 So I think that, you know, it's
22 all in how you interpret it, but to me I think

1 the potential to interpret the results of the
2 adjustment in a meaningful way that moves us
3 forward really can't be discounted.

4 DR. WEISSMAN: Can I?

5 CO-CHAIR CORA-BRAMBLE: Joel?

6 DR. WEISSMAN: Yes, I'd like to
7 respond in a couple of ways. One is -- one is
8 to kind of push back directly. Let's say, you
9 know, let's say you didn't stop at adjusting
10 for socioeconomic status. You adjusted for
11 quality, the housing stock. You adjusted for
12 availability of bus lines, you know, whether
13 they have time to get off from work.

14 You can have all these
15 contributory factors, and the more you adjust,
16 these are things that could make the
17 disparities go away. And I would say that as
18 you go deeper and deeper, you know, it becomes
19 less and less justified.

20 Then, the other answer I would
21 give is that let's say you're black or Latino,
22 and you're trying -- and you're looking at a

1 health plan, and you're trying to -- among
2 other things, based on NQF measures, that
3 health plan is reporting on its equitable
4 care. You want to know whether or not they
5 treat blacks and Latinos equitably to others.

6 If you adjust for socioeconomic
7 status and the differences go away, and,
8 Dennis, I understand that there are some --
9 you're thinking like a researcher, but, you
10 know, the differences go away. Then you're
11 going to say, "Oh, okay." I don't think
12 that's going to fly, so that's --

13 DR. HAVRANEK: Okay, I mean, I can
14 see that. I mean, I think you're right.
15 Thinking as a researcher is very different
16 than thinking as public reporting, so in
17 regards --

18 DR. WEISSMAN: Yes, it's hard to
19 take off the researcher hat, yes.

20 DR. HAVRANEK: No, I think that's
21 right, but, yes, I concede.

22 CO-CHAIR CORA-BRAMBLE: Okay,

1 thank you. There's a comment on the phone.
2 Please identify yourself before speaking. A
3 comment on the phone? Evelyn? Okay, we'll go
4 on to Grace, and then we'll come back to
5 Evelyn.

6 MS. TING: Thank you. So, I am
7 actually in agreement from kind of the very
8 practical application insights you're offering
9 in that, you know, I do agree that when you do
10 adjust for socioeconomic status, sometimes
11 that goes away.

12 I do support Edward's comment that
13 that may lead to a very different type of
14 intervention from a standpoint in that by not
15 looking at it. So we actually do look at both
16 in looking at our data, but I think that, you
17 know, where there are trends to be
18 investigated, then we would delve further.

19 But I think it's also very
20 important to know that I personally observe in
21 our own data among commercially insured -- you
22 know, specifically it was a population

1 specific to Wellpoint employees, so all
2 employees could all speak English, because you
3 have to work at Wellpoint, have insurance
4 coverage, because it was our house account,
5 and still we uncovered health disparities.

6 So, you know, I wouldn't totally
7 say that socioeconomic is everything and the
8 cause of disparity, because, you know, here is
9 a population where we're all fairly
10 comfortable, at least, for the most part, and
11 so we saw the disparities.

12 So that, I think, argues what Joel
13 is pointing to, non-stratified, but
14 occasionally you do find the patterns where it
15 tends to be more strongly socioeconomic, and
16 that takes a completely different type of
17 intervention than, say, something that's
18 purely racial and ethnic. So I think that
19 there is room for both. I don't want to say
20 let's not stratify them all or adjust for
21 socioeconomic.

22 DR. WEISSMAN: Yes, I mean, that's

1 absolutely right when you're trying -- the
2 classic approach to access research, and I've
3 done this with the uninsured and, you know,
4 racial and ethnic disparities is you control
5 for everything you can think of.

6 If you still have a disparity left
7 over, then that's sort of considered, you
8 know, the "R" word, racism, right, that
9 something else is going on, but, in fact,
10 there may be other things that are going on
11 that you still will want to address so that
12 you can reduce those racial and ethnic
13 disparities.

14 MS. TING: Right. If the ultimate
15 goal is to really truly reduce health
16 disparities, you need to be practical. Like,
17 I mean, we can talk about these measures and
18 studying the effects, but at the end of the
19 day, if your interventions don't speak to the
20 target population and has no impact, then
21 you're never going to impact or move these
22 measures in a positive manner. So I would say

1 that let's not discount that.

2 CO-CHAIR CORA-BRAMBLE: Okay.

3 Ernest?

4 DR. MOY: I just wish that we
5 actually could make disparities go away with
6 adjustment. Then we'd solve all our problems
7 very easily, but I think the point is that we
8 don't make disparities go away when we adjust.

9 We simply are identifying the
10 mechanisms by which they are created, but I
11 think from the conversation, because so often
12 people do this adjustment and say, "Oh,
13 there's no disparity. It went away," that
14 that's the main reason why not to do it.

15 You get the same information by
16 stratification, but then you still see the
17 different groups there and the differences
18 across the groups now stratified by whatever
19 mechanism you're postulating is the affecter.
20 So I think, you know, this conversation to me
21 is an argument not to do the adjustment but
22 rather to show the information as

1 stratification where you do see the -- still
2 see the different racial contrasts.

3 CO-CHAIR CORA-BRAMBLE: William?

4 DR. MCCADE: Well, this harkens
5 back to a previous conversation about small
6 sample size. When you try to stratify, you
7 actually reduce your sample size that's
8 available to you, as well, and so that has an
9 adverse effect on those populations that have
10 very small numbers and makes it even harder to
11 collect the data when you do more
12 stratification that way. I think SES is
13 certainly an important thing, but I think if
14 it adversely affects your ability to collect
15 numbers, then you might want to rule it out.

16 CO-CHAIR CORA-BRAMBLE: Okay.

17 Thank you. Any other -- do you have a
18 comment, Grace?

19 MS. TING: I do, and just in terms
20 of, I think, looking at wealth or income, it's
21 possible not to actually physically collect
22 that information but to derive that through

1 geocoding.

2 CO-CHAIR CORA-BRAMBLE: Correct.

3 MS. TING: So I wouldn't
4 completely rule that out if you wanted to look
5 at it that way, but, you know, the primary
6 source collection is not necessarily the way
7 to go if you want that kind of information.

8 CO-CHAIR CORA-BRAMBLE: Thank you.
9 The individual on the phone?

10 MS. MCELVEEN: Yes, Operator, if
11 you can hear me on the phone, can you unmute
12 and open the lines if they're --

13 OPERATOR: All lines are open.

14 MS. MCELVEEN: Yes, Evelyn, if you
15 are still on the line, yes, you can proceed
16 with your question, and please introduce
17 yourself.

18 MS. CALVILLO: Hello, I'm Evelyn
19 Calvillo calling about the sampling, the
20 sample size. Nobody has mentioned the
21 sampling plan except stratification, and, you
22 know, I think you need to consider even with

1 stratification.

2 So I think it needs to be
3 mentioned somewhere that the sampling plan is
4 very important. I mean, if you do a
5 stratification based on convenience, there are
6 going to be some differences in your outcomes.
7 That was my comment.

8 CO-CHAIR CORA-BRAMBLE: Okay.
9 Thank you so much, Evelyn. Any further
10 comments about this? Yes?

11 DR. WEISSMAN: Actually, it's
12 interesting. I thought that the person on the
13 phone was going to say something different,
14 which brings to mind I don't -- when she
15 talked about the sampling plan, I don't know
16 if NQF makes recommendations about how to
17 sample cases, because you don't do the entire
18 population, but if you're going after -- if
19 you're planning on identifying racial and
20 ethnic disparities, would a recommendation be,
21 and this was not in our report, to over-sample
22 minorities?

1 DR. BURSTIN: At times, depending
2 on the measure, there is a sampling. There is
3 always that aspect of the submission form
4 which asks for sampling information if
5 appropriate, so if there is sampling to be
6 done, it would be part of the measure specs.

7 DR. WEISSMAN: And would you make
8 the recommendation to over-sample minorities?

9 DR. BURSTIN: Not necessarily, but
10 that might be something for this group to
11 consider.

12 CO-CHAIR CORA-BRAMBLE: Ellen?

13 MS. WU: That actually came --

14 CO-CHAIR CORA-BRAMBLE: I do
15 acknowledge you, Ellen, sure.

16 MS. WU: Sorry.

17 CO-CHAIR CORA-BRAMBLE: Go ahead.

18 MS. WU: I actually noted that in
19 my report. It's interesting that it only came
20 up now, but I definitely think that that's
21 really, really critical. You know, California
22 has our California Health Interview Survey in

1 five different languages, and they over-
2 sample.

3 They over-sample in rural areas,
4 in different populations, and I think that
5 given the small sample size issue but really
6 trying to understand the populations and sub-
7 populations that we really should encourage
8 over-sampling.

9 CO-CHAIR CORA-BRAMBLE: So, am I
10 hearing, then -- I hear that there are
11 individuals that are recommending that. Is
12 that sort of the consensus in terms of the
13 group that we should specifically recommend
14 over-sampling of specific populations?

15 MS. YOUDELMAN: I certainly was
16 going to support, and I think since we're
17 focusing on race-ethnicity language I would
18 certainly make the recommendation that those
19 three be over-sampled, and then there might be
20 some suggestions about even over-sampling some
21 of the subgroups.

22 If you're talking about, you know,

1 Asian-Pacific Americans, Pacific Islanders, do
2 you over-sample some of the subgroups, as
3 well, depending on maybe geography or other
4 factors that come into play where you might be
5 able to get broader sample sizes?

6 CO-CHAIR CORA-BRAMBLE: Okay.
7 Colette?

8 DR. EDWARDS: This conversation to
9 me is reminiscent of what we were talking
10 about yesterday in terms of absolute and
11 relative and trending, so is this another
12 situation where the answer might be to do --
13 to look at both ways and at the trend and then
14 come to some conclusion after that?

15 CO-CHAIR CORA-BRAMBLE: Comments
16 from the group? You know, my counter argument
17 to that has to do with the feasibility of
18 doing all of this when you get to the
19 practical level.

20 DR. EDWARDS: I think that once
21 you put that filter, a lot of this is going to
22 melt away, but if you have that as a starting

1 point, if you can do it or do it to some
2 extent, is there still value?

3 CO-CHAIR CORA-BRAMBLE: Sure.

4 DR. EDWARDS: A lot of this is
5 just going to be totally not doable any time
6 soon or something that is derived from some
7 other measure as a proxy.

8 CO-CHAIR CORA-BRAMBLE: Any other
9 comments -- excuse me -- from the group?
10 Okay, I then am going to pass on the baton to
11 you, Nicole.

12 MS. MCELVEEN: So, we are going to
13 move on to Section 5. Section 5 is on page 47
14 of the comprehensive report.

15 Specifically within this section
16 we're going to be looking at 5a, 5b, and 5e,
17 so that's what should be achieved from
18 disparities measurement, what should be
19 avoided, and some challenges in program
20 design, as well as the policy implications.

21 Mass General had a nice slide
22 where they kind of summarized this, and, Joel,

1 I'm going to just ask that you provide that
2 recap, and we have some additional questions
3 for the Committee to consider around those
4 sections. I have teed up that slide for you.

5 DR. WEISSMAN: Oh, good. Well,
6 the first thing in terms of what to achieve we
7 shamelessly stole from a previous NQF report
8 by Eric Schneider and just thought that it
9 applied directly to what we were trying to
10 achieve here with disparities reductions.

11 You know, so these are kind of
12 what do you want to achieve with this, with
13 the outcome of this group, and it's to monitor
14 progress, inform consumers and purchasers, and
15 I think, you know, you really think about the
16 minority patient choosing among different
17 health plans, different hospitals, different
18 health insurance exchanges in the future.

19 They're all going to rely on this
20 kind of information, and I think that's an
21 important thing to keep in our heads to
22 stimulate competition among providers, the

1 idea being that you shouldn't be able to be
2 successful via risk selection.

3 You ought to be successful by
4 competing on providing the highest quality of
5 care to minority populations, stimulate
6 innovation, and really promote the values of
7 the health system. I thought Eric in that
8 earlier report did a great job of explaining
9 those things.

10 Then what to avoid, you know, we
11 sort of went through the literature and
12 brainstormed a bit on all of the unintended
13 consequences mostly of high-stakes kind of
14 reporting like this, either public reporting
15 or pay-for-performance or other kinds of
16 incentive programs.

17 There's the idea of cherry-picking
18 or the opposite of that, which is my new
19 favorite term, lemon-dropping, which everybody
20 is familiar with. The rich get richer.
21 People understand that early analyses of the
22 pay-for-performance programs have shown that

1 the better resourced providers do better and
2 then get those incentives and then do even
3 better still.

4 Teaching to the test means that
5 you kind of just focus on the specific measure
6 and nothing else. Sometimes you over-focus on
7 that, and I think Joe gave the example of if
8 the idea is to give pneumonia patients
9 antibiotics in an appropriate time frame,
10 well, anybody that comes in with a cough, you
11 give them antibiotics first and ask questions
12 later, and that's a scary thing.

13 Gaming the system, you know,
14 everybody talks about gaming the system.
15 Since I'm not a provider and I don't see a lot
16 of examples of it, it's hard to come up with
17 some examples. I mentioned one in the report
18 about an interesting phenomenon out in Kaiser
19 in -- was it Washington or Oregon?

20 Dave Campbell was telling about
21 it, and he actually presented it at a session
22 that I ran at Kennedy Health where he said

1 that, you know, the young Asian female
2 physicians were leaving the practice, which
3 was heavy in minorities, and going to a more
4 white community, because their scores got
5 better, and they were eligible for more
6 incentives. It was -- you know, he was really
7 trying to work on that sort of thing.

8 You want to avoid a situation that
9 encourages that sort of gaming, the ability of
10 minorities to benefit from color-blind QI
11 activities. So you may have, you know, a
12 quality improvement activity that you think
13 benefits everybody, but for some reason or
14 another minorities -- and this kind of comes
15 into play.

16 Is it -- you know, are the
17 underlying socioeconomic issues or cultural
18 issues that might explain some of these
19 differences, do they make -- do they reduce
20 the ability of minorities to benefit from that
21 program?

22 Then this last one is actually

1 sort of a bigger topic. I don't know how it
2 comes into play with the NQF's recommendations
3 around this, but, you know, Romana and I have
4 done a lot of work on this area, and it's the
5 between-and-within phenomenon.

6 Basically, that says that if you
7 look at a wide, say, geographic-wide numbers
8 on disparities, you've got two things going
9 on. One is the within phenomenon, meaning
10 within a provider or an organization
11 minorities may be treated differentially.
12 That's the who you are.

13 But as other researchers have
14 shown and we've shown, a big part of that is
15 also where you go, and it may be -- it's often
16 that minorities tend to go to high minority
17 providers that are under-resourced and have
18 lower quality of care for everybody and that
19 the extreme cases that everybody is treated
20 equitably. It's just that minorities go to
21 lousy places.

22 You know, it turns out to be a mix

1 of that, and there are different policy
2 responses to each of those phenomena, right?
3 I mean, if it's within, then that's kind of a
4 cultural competency issue, and that's a pay-
5 for-performance issue, because you're dealing
6 with the providers within an organization, but
7 if the -- if it's really a between phenomenon,
8 meaning that minorities tend to go to overall
9 lower minority providers, then that's a
10 resource issue.

11 You know, that gets back to my
12 idea of maybe paying those high minority
13 hospitals more money up front, because they
14 have a more challenging population and so on.
15 So there are some -- that's a bigger topic,
16 but that's what you want to avoid.

17 MS. MCELVEEN: Thank you, Joel.
18 So the question that we are proposing to the
19 group is if there are any additional issues or
20 even solutions that should be included and the
21 Committee's views of the options that have
22 been presented thus far.

1 CO-CHAIR CORA-BRAMBLE: Okay, so
2 we'll start with Dennis, and then we'll just
3 go around the table.

4 CO-CHAIR ANDRULIS: I don't quite
5 know how to phrase this, but one other issue
6 that is at least around the edges of this is,
7 for lack of a better phrase, kind of almost a
8 geographic -- it's a combination of geographic
9 preference and redlining that's going on among
10 providers where there is kind of a self-
11 fulfilled prophecy that comes about.

12 So, for example, especially in
13 some of the inner-city hospitals, I know
14 Denver has had this example where hospitals
15 have been moved out of the city into more
16 affluent suburbs. Also, the poor -- we've
17 done tons of research on this. We have poor
18 suburbs. People aren't so interested in
19 providing care in that area.

20 By that measure, by that
21 indicator, it creates an inherent, at least a
22 challenge if not a potential major impact on

1 quality, because either services aren't there
2 or the services are not well linked,
3 coordinated. Quality of care becomes an
4 issue.

5 So, to me, one of the points of --
6 I don't know whether I'd call it avoidance,
7 but to me there is a geographic characteristic
8 set that's emerging among a lot of provider
9 systems that is likely to compromise quality
10 of care for poor and a lot of minority
11 populations as providers say, "You know, I'm
12 not so interested in that area. I'm
13 interested in more affluent areas."

14 CO-CHAIR CORA-BRAMBLE: Okay.
15 Thank you. Ernest and then Francis.

16 DR. MOY: This relates to what we
17 want to achieve from disparities measurement,
18 and I think that one thing not on the list is,
19 I think, in theory, this measuring disparities
20 should make quality improvement more
21 efficient.

22 So if you're a health plan or a

1 geographic area and you have a quality
2 problem, you could apply resources everywhere
3 to try to improve performance everywhere, but
4 if it happens to load on a particular
5 population, you can then target that
6 population and, in theory, improve quality
7 more efficiently. So I think that shouldn't
8 be lost as one thing that we hope to achieve
9 with disparities measurement.

10 CO-CHAIR CORA-BRAMBLE: Okay.

11 Thank you. Francis?

12 DR. LU: Yes, perhaps this will be
13 covered, I think, in the sections following,
14 but in terms of the 5a, and I don't know how
15 comprehensive you're meaning these bullets to
16 be for this report or for the eventual rollout
17 aspects here, but I think another obvious
18 bullet point would be, in addition to
19 informing consumers and purchasers, I think
20 it's also to inform accreditation agencies or
21 government regulators or other oversight
22 bodies that are concerned about disparities

1 that they are also informed about how
2 providers are performing in this area.

3 CO-CHAIR CORA-BRAMBLE: Okay.
4 Thank you. Marshall?

5 DR. CHIN: Joel, this was a very
6 strong part of the report. Just a sort of
7 subtle point. When you're talking about sort
8 of the between versus within difference, you
9 mentioned that there are different policy
10 implications depending upon where the lesion
11 is.

12 You said if it was within, then
13 it's sort of a provider competency issue. It
14 could also be, perhaps, even more powerfully,
15 assuming it's an institutional racism issue,
16 so it has to be very careful in terms of
17 perhaps raising that as another possibility,
18 as opposed to being a cultural competency
19 issue. It's probably not as important as the
20 institutional organizational barriers put in
21 place.

22 DR. WEISSMAN: And when you're

1 using the term cultural competency, you're
2 implying that it's the individual provider,
3 the individual practitioner, and I guess, you
4 know, you could also apply cultural competency
5 to the institution as a whole.

6 DR. CHIN: Right. It probably
7 goes beyond cultural competency in terms of
8 potentially basically economic barriers or
9 other ways subtly put into the system that is
10 not so much provider-directed but it's an
11 organizational policy that leads to
12 differential outcome.

13 CO-CHAIR CORA-BRAMBLE: Okay. I'm
14 sorry, I can't see your card right next to
15 you.

16 MS. CUELLAR: Lourdes.

17 CO-CHAIR CORA-BRAMBLE: Lourdes.

18 MS. CUELLAR: My focus is on the
19 motivating providers to improve performance.
20 One of the things that really hasn't been
21 brought up is, for lack of a better term, a
22 middle person where you have either physician

1 practices, hospitals, clinics that partner
2 with -- an example, church groups have been
3 effective. Promotoras de Salud have been
4 effective, but measuring when you have
5 sometimes the voices of few sometimes can
6 really raise awareness from the consumer
7 standpoint.

8 Those have begun to be measured,
9 but there's not a whole lot out there, but in
10 certain communities church groups I know for
11 sure and the Promotoras de Salud in Texas are
12 very effective, particularly with prenatal
13 care, immunizations, so that's just something
14 to consider as a potential measurement.

15 CO-CHAIR CORA-BRAMBLE: Thank you.
16 Elizabeth?

17 DR. JACOBS: Yes, I just want to
18 follow up on what Marshall said in thinking
19 about unintended consequences, because I
20 worked for 12 years at this institution, which
21 is one of these organizations that didn't, I'm
22 sure, on all sorts of quality measures we

1 didn't meet them, weren't even close, but that
2 doesn't mean that the institution wasn't
3 trying really hard. It was just working under
4 limited resources.

5 I think one of the unintended
6 consequences of this is sort of -- I mean, I
7 sort of bristle sometimes when I read these
8 papers where someone, you know, does these big
9 analyses and say, "Look it. Eighty percent of
10 African-Americans go to these poor performing
11 hospitals."

12 And it's like it's not because --
13 it's because those hospitals actually don't
14 have the right resources to actually provide
15 the care, and so if there is some way that
16 these measures can also indicate -- I mean, I
17 don't know if there is some way to actually
18 reflect --

19 This may be very pie in sky but
20 some way to reflect what are some of the
21 issues that contribute to some of these
22 disparities. Are there -- it's not --

1 I don't think it's necessarily
2 institutions aren't trying hard. It's just
3 that they can't -- or the doctors aren't good
4 enough. It's just, you know, if your patients
5 can't get a colonoscopy, then can't get a
6 colonoscopy because there's no appointments.
7 I mean, that happened at my institution.

8 So I think this is one of these
9 unintended consequences, things that I'm not
10 sure I have a lot of ideas for how to resolve
11 right now, and maybe I'll come up with some on
12 the plane ride home, but it's just something
13 I'd like us to be aware of.

14 I don't want to necessarily
15 penalize organizations working for these
16 people, for people who are traditionally
17 disadvantaged, because I think a lot of them
18 are just trying. They just can't do it under
19 the current environment.

20 CO-CHAIR CORA-BRAMBLE: Okay. So
21 Colette and Mary, and then I have a comment.
22 Colette?

1 DR. EDWARDS: With regard to the
2 goals, do we want to explicitly call out
3 cultural competency and health literacy and
4 then, kind of to Liz's point, allocation of
5 resources?

6 CO-CHAIR CORA-BRAMBLE: I mean,
7 I've heard the allocation of resources issue
8 raised time and time again, and I could not
9 agree with it more, you know, wholeheartedly,
10 so I definitely think we should include it.

11 DR. EDWARDS: Because we don't --
12 we aren't officially calling any of those
13 things out, and I think it may be worthwhile.

14 CO-CHAIR CORA-BRAMBLE:
15 Understood. Mary?

16 DR. MARYLAND: Along the same
17 thought process in terms of thinking about
18 allocation of resources, and, I believe, to
19 capture Lourdes's point that some version of
20 what in the cancer world is called a
21 navigator, so how do you connect what it is
22 you need to the person who needs it and do it

1 efficiently, so if there's a way to maybe
2 identify that type of a resource, because I
3 think that can help take care of the gap
4 process.

5 CO-CHAIR CORA-BRAMBLE: And akin
6 to the Promotora de Salud that was mentioned,
7 it's similar, the patient navigator. Two
8 things that at least in the pediatric world
9 it's worth mentioning.

10 That has to do with the children
11 with special healthcare needs and how that
12 works is sort of a confounder, because these
13 kids require an incredible amount of time and
14 resources. And if you measure the outcomes,
15 it's still maybe low, but it has to do with
16 what you're dealing with in terms of patient
17 population.

18 The other one has to do with
19 access to subspecialty services. Many of our
20 patients are Medicaid-enrolled patients,
21 cannot get the services they need, because the
22 community providers basically said, "We do not

1 accept Medicaid patients," so I think somehow
2 that needs to be included in the report.

3 I'm sorry. Elizabeth? I'm sorry,
4 you said it was Liz.

5 DR. JACOBS: I just have --

6 CO-CHAIR CORA-BRAMBLE: Liz or
7 Betsy, which one?

8 DR. JACOBS: Liz.

9 CO-CHAIR CORA-BRAMBLE: Liz.

10 There you go.

11 DR. JACOBS: I have one follow-up
12 to what you were saying, Mary, and Lourdes,
13 too. Are there NQF measures of use of patient
14 navigation systems, because that might be
15 something? That might be a -- sorry to use
16 the word -- sentinel measure, so that just
17 came to mind as we were having this
18 discussion.

19 CO-CHAIR CORA-BRAMBLE: Mara?

20 MS. YOUDELMAN: And I'll add to
21 that use of language services, and I think
22 that's --

1 CO-CHAIR CORA-BRAMBLE: Use of
2 what?

3 MS. YOUDELMAN: Language services.

4 CO-CHAIR CORA-BRAMBLE: Right.

5 MS. YOUDELMAN: And that may be
6 another piece that we want to bring in with
7 sort of the cultural competency, as well, as
8 one of the things that -- well, not this
9 slide, the other slide -- but to encourage the
10 planning for and provision of language
11 services so that if you are identifying that
12 there are disparities based on language.

13 That also goes back -- I think,
14 Mary, you were talking yesterday or Colette
15 about, you know, we need to make the rationale
16 for why we're doing this. Then Romana said
17 sometimes it's easier on language services,
18 because if you collect that data and you
19 analyze that data, there's a direct
20 intervention of you need to get the language
21 services in place, and it helps with planning,
22 so if we can also make that point in this

1 process, it might be useful.

2 CO-CHAIR CORA-BRAMBLE: Thank you.
3 Luther?

4 DR. CLARK: I've been listening to
5 this issue of the resources, which is a --
6 which is a real problem, and I was wondering
7 in the goals could one of them be looking at
8 the impact of reducing disparities on reducing
9 healthcare costs, because if there is some
10 indicator that this is really saving money,
11 perhaps there would be some increased
12 incentive to invest, you know, in these
13 facilities or in these efforts to reduce the
14 disparities further.

15 CO-CHAIR CORA-BRAMBLE: I think
16 that's a great point. If I try to apply it in
17 terms of practical terms and looking at, for
18 instance, the obesity problem in the District,
19 we haven't really been able to convince the
20 payers that they need to increase payment or
21 have a different payment methodology because
22 of the cost associated with obesity.

1 So, I mean, I hear you. I agree
2 with you. You know, I just wonder how
3 successful it is as a strategy, but I agree
4 with you.

5 DR. CLARK: But maybe that's the
6 opportunity for innovation, because if we
7 could do that -- I mean, it's not easy to do,
8 and --

9 CO-CHAIR CORA-BRAMBLE: Agreed.
10 Agreed.

11 DR. CLARK: -- I may not know how
12 to do it, but I think teeing it up in some way
13 is important, particularly in this current
14 environment.

15 CO-CHAIR CORA-BRAMBLE: Agreed.

16 DR. CLARK: That may help.

17 CO-CHAIR CORA-BRAMBLE: Okay, so
18 we're going to --

19 MS. YOUDELMAN: Can I just pick up
20 specifically on that, because there was some
21 research done by the Joint Center that
22 specifically is looking at the cost of

1 healthcare disparities. It was done through
2 health reform, so that might be a report that
3 folks can refer to, and we can get that link
4 around to folks. Dennis, you worked on that?

5 CO-CHAIR ANDRULIS: Yes, that's
6 Tom LaVeist's work.

7 CO-CHAIR CORA-BRAMBLE: Okay. All
8 right, so Norman, and then we'll start around
9 this side of the table. Yes?

10 DR. OTSUKA: I think Francis
11 mentioned something about going beyond these
12 goals, but of interest to me is education,
13 particularly of residents, and culturally
14 competent care is part of the ACGME, one of
15 the six core competencies, but it's sort of in
16 the fine print in the last line. So in
17 reporting I think consumers -- I think it
18 mentions something about consumers and buyers,
19 but I guess education, residents, physicians
20 or consumers, as well.

21 CO-CHAIR CORA-BRAMBLE: Thank you.
22 Len and then Francis.

1 MR. EPSTEIN: Yes, at HRSA we
2 really focus on integrating culture, language
3 issues, and health literacy, and we roll it up
4 in the term unified or, as Dennis wrote,
5 integrated health communication. Perhaps
6 there's something wrong with me, but I can't
7 separate the three.

8 I think they're very, very
9 interactive, and I think that's -- in terms of
10 the future, I think we can -- hopefully, the
11 present. I'm trying to push this, and
12 interpreters, you know, the whole nine yards,
13 and it comes together in provider level,
14 institutional level. It's both structural and
15 individual providers.

16 CO-CHAIR CORA-BRAMBLE: Thank you,
17 Len. Francis?

18 DR. LU: Yes, this last ten
19 minutes or so I think has been a very
20 stimulating conversation, and I think what
21 we're getting at here is that this work on
22 establishing disparities measurements at such

1 a precise and concrete way can provide
2 legitimacy to another yardstick, another
3 measurement, critical measurement as part of
4 the quality healthcare, you know, equitable
5 care, disparities reduction.

6 But to really give traction,
7 serious traction to this issue, which can be
8 a yardstick that these various things that
9 we've been talking about, cultural competency,
10 health literacy, communication, language
11 services, other things we've all mentioned
12 here, this provides yet another yardstick that
13 could be then translated to cost effectiveness
14 issues that could really bring home this
15 aspect of quality care.

16 So I think something like that
17 needs to be put in this 5a section beyond what
18 was mentioned in the next-to-the-last bullet,
19 stimulate innovation and providing culturally
20 sensitive care. I think that a number of
21 things we've been talking about here really
22 speak to that.

1 CO-CHAIR CORA-BRAMBLE: thank you.

2 Yes?

3 MS. CUELLAR: The other thought I
4 just had, too, that could lead to inequitable
5 care is diminished numbers of lack of
6 minorities in clinical research, and that
7 indirectly might lead to some -- just to the
8 numbers being so low, just like it is in
9 pediatrics.

10 CO-CHAIR CORA-BRAMBLE: Any
11 further comments? Yes, Colette?

12 DR. EDWARDS: I had a question
13 about do we want to also explicitly put
14 something out there to the effect that if you
15 want to call yourself a quality provider, you
16 need to be looking for and addressing
17 disparities? I mean explicitly make that
18 statement, because otherwise it's --

19 CO-CHAIR CORA-BRAMBLE: I think
20 that's a good suggestion, yes. People will
21 pass, will take a pass, yes. Any other
22 comments? Yes, Grace, I'm sorry. I missed

1 it.

2 MS. TING: I should just put it
3 up. So I'm actually not quite sure where this
4 comment should go, but I would like to see as
5 a goal a stronger tie between the measurements
6 that we find or at least some of the
7 measurements that we identify to the best
8 practice recommendations that NQF had endorsed
9 in the last couple of years.

10 Internally where I work, I've been
11 struggling as to how to assign metrics to some
12 of these best practices, and I think that
13 without a stronger linkage there we're not
14 going to be able to really push those best
15 practices as quickly as I would like.

16 I know that we focused a lot on
17 clinical quality measures and some of the
18 other measurements. There are some best
19 practices that I think could really be ripe
20 for trying to explore some of the exploratory
21 sentinel measures to see how we can measure
22 those and put forth that linkage. Thanks.

1 CO-CHAIR CORA-BRAMBLE: Thank you.
2 Romana?

3 DR. HASNAIN-WYNIA: So, I found
4 this last 15 minutes a very interesting
5 conversation, and in some ways, you know, we
6 talked about under-resourced institutions
7 really struggling to provide high quality of
8 care. We spoke about cultural competence. I
9 mean, you know, there are a number of issues
10 that we brought up.

11 The thing that I think that really
12 stands out for me is that when we use the
13 language cultural competence, whether we put
14 it in reports or we say that organizations
15 need to focus on providing more culturally
16 competent care, I think that what happens is
17 that when we put that language out into the
18 field without actually showing how to
19 operationalize that, it becomes very, very
20 confusing to the end users, whether they are
21 the C-suite people, you know, the CEOs, the
22 CMOs of hospitals or practices.

1 So one of the things that I would
2 really like to see in this section, when we
3 speak about cultural competence, maybe we
4 should provide some key examples of what that
5 means in practice.

6 So one thing in particular, and
7 we've heard the language of navigators and
8 community health workers, is really using a
9 team-based approach, because I think, given
10 that there is language in the ACA for
11 reimbursing on team-based approach and really
12 focusing on primary care, and it ties directly
13 to kind of overstretched institutions and
14 overstretched providers, especially those who
15 are caring for vulnerable populations, I
16 really feel that it's important for that
17 language to be there under the umbrella of
18 cultural competence, because you can really
19 work with community health workers to provide
20 care that is culturally competent.

21 I just have an issue with that
22 language, because I do think that it resonates

1 for all of us here and for many of the people
2 that we speak to but not necessarily out in
3 the field. I still think you kind of get
4 this, "Oh, that's kind of nice, but, yes, of
5 course, we'll do that."

6 CO-CHAIR CORA-BRAMBLE: Agreed.

7 So, Grace, are you -- Dennis.

8 CO-CHAIR ANDRULIS: I just want to
9 respond.

10 CO-CHAIR CORA-BRAMBLE: Oh, go
11 ahead.

12 CO-CHAIR ANDRULIS: I very much
13 agree, but if you're going to go down that
14 path, then it's more than that. You know,
15 it's not just teams, or you can be a bit
16 prescriptive or suggestive, but there is kind
17 of a group of, extensive group of
18 recommendations you might make. That's a
19 solid one, but that is one of many.

20 DR. HASNAIN-WYNIA: And I
21 completely agree with you, so I guess I
22 support what you say, Dennis, but I also would

1 like to see explicit language about team-based
2 care and using examples of community health
3 workers and patient navigators and such.

4 CO-CHAIR CORA-BRAMBLE: Okay,
5 Grace and then Marshall.

6 MS. TING: Right, and to Romana's
7 point, maybe specifically adding language that
8 says, you know, a part of the team should draw
9 from the community that it serves. I think
10 that's very critical.

11 And I think, Dennis, to your
12 point, that's exactly the way that NQF has
13 offered it in putting forth some of those best
14 practice -- preferred -- preferred practice
15 standards in that they did actually cite some
16 examples of, "Here's what we mean by this
17 particular standard," so maybe the team-based
18 approach is certainly one, and I'm sure that
19 we can brainstorm and generate some others as
20 examples.

21 CO-CHAIR ANDRULIS: And I think if
22 you're going to -- again, another key example

1 is in use of electronic health records. You
2 know, what kind of information can be loaded
3 in with regard to tracking and monitoring
4 disparities and cultural competence-related
5 language, language related to priorities?

6 CO-CHAIR CORA-BRAMBLE: Okay, so
7 --

8 MS. TING: And Joe Bedencourt and
9 his team have all sorts of really good
10 languages on cultural competency that they can
11 pull from.

12 CO-CHAIR CORA-BRAMBLE: So we're
13 going to start back over here. We're going to
14 go Marshall, Francis, and then we'll go down
15 the other side.

16 DR. CHIN: So I think Romana's
17 suggestion to be more specific about cultural
18 competency makes a lot of sense. I think
19 there's sort of a general caution that we need
20 to keep in mind, also. It's also reflected in
21 the title of this Committee, Health
22 Disparities and Cultural Competency Consensus

1 Standards.

2 I think when we all started years
3 ago in this area, you know, it was really sort
4 of cultural competency, language services, I
5 mean, really just sort of a limited number of
6 things that we concentrated upon, whereas now
7 I think we're realizing those are key
8 components.

9 But it's much broader than that,
10 so quality improvement, for example, or like
11 cultural competency classes like in medical
12 schools. I mean, the best ones are now sort
13 of brought in to talk about disparities in
14 which cultural competency is one component.

15 So I think like it's sort of
16 woven, probably, in Joel's text, but we'll
17 have to be careful that it comes across as
18 this broad sort of front in terms of the
19 solutions and attacks so that we're not in
20 some ways trapped by our language and baggage
21 of the past, because we have a whole range of
22 effective policies and implementations of

1 which cultural competency is one component.

2 CO-CHAIR CORA-BRAMBLE: Okay.

3 Francis, and then we'll start with you,

4 Edward.

5 DR. LU: Again, very stimulating
6 conversation here, and I think another target
7 audience that the disparities measures -- this
8 is 5a again, another bullet. Another group
9 that we could be targeting here really are the
10 researchers, because by providing these
11 measures, hopefully we can stimulate
12 researchers to use them to help measure
13 impact, outcomes along these disparity
14 parameters for exactly the interventions we're
15 talking about in terms of cultural competence,
16 literacy, and so forth.

17 I think these are all, I think --
18 you know, I think we all generally agree here
19 that these are good things, and there has been
20 research shown to varying extents about how
21 this might reduce disparities, but I think
22 that hopefully by providing these measures we

1 can stimulate researchers to further amplify
2 the information that we have. So I think
3 that's another target group.

4 CO-CHAIR CORA-BRAMBLE: Thank you.
5 Edward and then Donna.

6 DR. HAVRANEK: There's been in the
7 last five or ten minutes here a lot of
8 enthusiasm expressed for things like patient
9 navigators and increased translation services,
10 and I'd just like to put a couple notes of
11 caution on those very admirable
12 recommendations.

13 The first is that these things are
14 really expensive, right. It's expensive to
15 hire a cadre of translators or to deploy
16 translation over the phone or anything like
17 that.

18 When you do that, when you hire
19 navigators and translators to get people in
20 to, say, colon cancer screening, some of the
21 money you spend on those access things
22 directly can take away from your ability to do

1 colonoscopies, because you can't afford a
2 colonoscope anymore. So any calls for these
3 sorts of things have to be tempered by the
4 fact that there needs to either be
5 reimbursement for it or at least
6 acknowledgment that these things are -- we're
7 potentially asking for unfunded mandates here.

8 The second thing is we have to be
9 cognizant that these things, yes, they work,
10 but they are imperfect solutions, right, that
11 you could have a really good translator
12 working with you, but you still don't provide
13 the same quality of medical care as if you
14 speak the patient's language, right.

15 It just doesn't -- that's an
16 imperfect solution and the same with
17 navigators. Navigators help, but, you know,
18 there are limits to what they can do in
19 overcoming the widespread effects of poverty
20 and race and ethnicity and all that sort of
21 stuff. So just a little bit of caution on
22 these, on the enthusiasm for these.

1 CO-CHAIR CORA-BRAMBLE: I want to
2 take sort of the Chair's prerogative, because
3 I think some of the things you've raised, some
4 of us around the table feel that there are
5 some alternative models that are cost-
6 effective as it relates, for instance, to
7 interpretive services.

8 So I just wanted to have a few
9 people respond to you, and, Donna, I'm just
10 going to ask you just to hold off on your
11 comment for a minute. I think, Liz, as soon
12 as he said something your thing went, so I'm
13 going to -- I'm going to interpret your body
14 languages to mean that you have an ardent
15 comment to share with all of us.

16 Everybody else who has their names
17 up, you know, I just couldn't pass on that.
18 It's totally subjective, but I just couldn't
19 pass. I just couldn't pass.

20 DR. JACOBS: Howard, you probably
21 don't know this about me, but I've been
22 working for the past 12 years on looking at

1 the cost-effectiveness of interpreter
2 services.

3 CO-CHAIR CORA-BRAMBLE: Yes, I
4 thought so.

5 DR. JACOBS: So I just -- I want
6 to let you know that I bring those years of
7 experience to the table here, and your
8 concerns are actually frequently expressed.
9 Unfortunately, they're not well documented,
10 and, actually, I've shown that they are quite
11 small expenses of actually healthcare and do
12 bring benefit.

13 In addition, when we talk about
14 these things as unfunded mandates, people talk
15 about the -- we forget that there are so many
16 unfunded mandates in healthcare that we pay
17 for, and no one complains about them.

18 Really, you can't ethically
19 provide a colonoscopy or you can't reduce
20 disparities. You can't do anything that we're
21 talking about around this table unless you're
22 able to adequately communicate with a patient

1 in a language they can understand.

2 So I would say that it's not
3 really an unfunded mandate, but it's actually
4 the only way you can actually provide the
5 standard of care that everyone else gets in
6 this country to someone who doesn't speak
7 English well. It is not -- there are cost-
8 effective ways, and Mara, I'm sure, is going
9 to actually talk about that.

10 There are cost-effective ways to
11 provide them, and they reduce other costs in
12 terms of liability, et cetera. I'm going to
13 let Mara go on on that, but I just wanted to
14 let you know that if you actually do a Medline
15 search on me you can look at some of the
16 information about their actual costs.

17 CO-CHAIR CORA-BRAMBLE: So, it may
18 be helpful for the rest of the group. I know
19 you did some work with Hablemos Juntos and all
20 that. Maybe you can share some of your --
21 some of the research regarding the cost of
22 interpretive services. Counter argument? Is

1 that -- am I interpreting that correctly?

2 DR. HAVRANEK: Yes, absolutely.

3 So, to say that it's cost-effective, is that
4 from a societal perspective?

5 DR. JACOBS: It's from both,
6 actually.

7 DR. HAVRANEK: Both. What do you
8 mean by both? What's the other half of both?

9 DR. JACOBS: So there's three ways
10 you look at cost-effectiveness, right, and you
11 can jump in here, Joel, if you want, but
12 society, the organization or an institutional
13 standpoint, as well as the person.

14 I would say for all three of those
15 people it's cost-effective. For all three of
16 those standpoints, if you look at it, it's
17 cost-effective.

18 CO-CHAIR CORA-BRAMBLE: Let me ask
19 that we do this, because this is a hot button
20 --

21 DR. HAVRANEK: Yes, I just -- it
22 really is. I mean, I disagree. I just -- I

1 think, you know, if you were to ask hospital
2 administrators or people who have to actually
3 pay for this sort of stuff how they pay for it
4 and where that money is coming out of and the
5 disproportionate burden it places on safety
6 net providers, I think that there would be a
7 lot of pushback.

8 CO-CHAIR CORA-BRAMBLE: Let me ask
9 that we --

10 DR. JACOBS: The one thing I want
11 to say is that I think that you raise a really
12 important point, which I think everyone around
13 this table would agree with, is that there
14 should be a reimbursement for those services,
15 actually. That's one way in which we're going
16 to actually promote the use of those services.

17 So I think it would -- I think
18 that you're right that some people do perceive
19 it as a burden. I can tell you I've done
20 qualitative work, and Mara can talk about
21 this, too. There are many organizations.
22 There are --

1 There's Alameda Health Alliance
2 that actually pays people to use interpreters,
3 because they recognize their value and what it
4 does to actually reduce their costs. I mean,
5 so it's actually not true that all healthcare
6 organizations actually experience this as a
7 burden, but they see it as a value, and so I
8 just -- so I'm just --

9 I mean, I think that we're
10 probably going to agree to disagree on this
11 point, but the point where I think we can
12 agree is that there should be reimbursement,
13 but I also think there is no way, absolutely
14 no way you can reduce disparities in LEP
15 populations without providing them services in
16 a language that they can understand.

17 I mean, you can't -- we can't have
18 any standards here on that unless that's the
19 first step, so I'll --

20 CO-CHAIR CORA-BRAMBLE: Okay, so
21 let me ask that we do this, that we just park
22 that one for right now, and maybe we can have

1 a sidebar regarding this issue. I think it is
2 a hot button issue.

3 I think a lot of people around the
4 table may have done extensive work in this
5 area, so I want to give other people the
6 opportunity to comment, but I do think it's an
7 important issue and one that, yes, we may have
8 to agree to disagree, but it is critical.

9 So, let me start with Donna, Mara,
10 Norman, and Grace, and then after that we're
11 going to take a break and a deep breath.
12 We're going to do both. Go ahead, Donna.

13 DR. WASHINGTON: Hopefully, my
14 recommendation is less controversial. Though
15 cultural competence is within the title of the
16 Steering Committee, then other related terms
17 are cultural sensitivity and cultural
18 humility, and my recommendation is that
19 whenever we're referring to cultural competent
20 type concepts within our recommendations we
21 instead use the term cultural sensitivity.

22 CO-CHAIR CORA-BRAMBLE: Okay. I

1 think there are -- there is an alphabet soup
2 of cultural language that is used. I think
3 people will -- different terms can be used,
4 you know, health equity. There's different
5 things, so we have to probably decide on what
6 would be the appropriate term, but --

7 MS. NISHIMI: I just feel the need
8 to chime in that notwithstanding the need to
9 make a decision about what you want to call
10 it, previous NQF Committees and
11 organizationally have made decisions, so we do
12 have full account on that.

13 CO-CHAIR CORA-BRAMBLE: Okay. All
14 right. Duly noted.

15 MS. NISHIMI: We can expand and --

16 CO-CHAIR CORA-BRAMBLE: I
17 understand. I understand. Maybe an
18 acknowledgment that there are other terms that
19 are used to refer to it.

20 MS. NISHIMI: Yes.

21 CO-CHAIR CORA-BRAMBLE:
22 Acknowledged. Okay. Mara? It's you. It's

1 all you.

2 MS. YOUDELMAN: No, I know, but if
3 we parked the last issue, maybe I shouldn't be
4 talking about it.

5 CO-CHAIR CORA-BRAMBLE: Well, I
6 think it's a hot button issue.

7 MS. YOUDELMAN: Okay.

8 CO-CHAIR CORA-BRAMBLE: I don't
9 want to, you know, perseverate on that
10 particular issue, because --

11 MS. YOUDELMAN: Well, here -- I
12 guess I'll try to summarize it very succinctly
13 in saying I think we do want to be very clear
14 when we put out a report that we're not sort
15 of giving an out to doing quality improvement
16 because of difficulties in providing language
17 services.

18 We recognize it's difficult. I
19 agree wholeheartedly with everything that Liz
20 said. I've been working for years with a
21 national coalition in D.C. trying to get
22 better reimbursement, but we're not there yet.

1 Ideally, obviously, if everyone
2 could have a bicultural, bilingual healthcare
3 provider who needed it so we didn't need
4 interpreters and translators, that would be
5 great, but we're not going to get there any
6 time soon.

7 But I do want to be very cautious
8 of how this is framed and that this isn't
9 framed in a way that sort of identifies that
10 this is a way to say, "Well, I can't do it
11 because it's costly," or, "I can't do it
12 because I don't have the resources," because
13 Liz is right.

14 We've done a lot of work on the
15 cost-effectiveness. We've done a report on
16 malpractice and language barriers to show sort
17 of the other piece of the puzzle, and so I
18 think there is a lot of research and resources
19 out there to help providers do this the right
20 way.

21 I also think with the Affordable
22 Care Act there's a new non-discrimination

1 provision that's going to go beyond what Title
2 VI has typically done, which has applied to
3 federal fund recipients and said, "You should
4 be providing language services."

5 It's not tied to federal financial
6 assistance, so anything created under Title I
7 of the ACA, which is basically all of the
8 exchanges and therefore likely the plans
9 participating in the exchanges, are going to
10 not be able to discriminate on the basis of
11 race, color, national origin, disability
12 status, age, gender.

13 So I think that's also -- again,
14 it sort of reinforces what a lot of us have
15 been doing the work on, and it's just going to
16 continue to be that way.

17 CO-CHAIR CORA-BRAMBLE: Okay,
18 thank you. Can I ask you two to put your name
19 so that I know that we've covered you? Okay,
20 Norman and then Grace.

21 DR. OTSUKA: Two quick points.
22 I'm sorry to perseverate on the interpreter,

1 but I think we're all missing the point. You
2 can talk to a patient, but if you don't
3 understand them, there's no point having the
4 interpreter.

5 I've had interpreters mess up a
6 situation, mess up a consent. You have to
7 understand the patient and what their goals
8 are, and the interpreter sometimes just messes
9 up the situation.

10 The other thing is Romana's point
11 about team approach to culturally competent
12 care. If I recall correctly, the Joint
13 Commission sent out an announcement about two
14 years ago that it would be part of their --
15 what do they call it? -- accreditation
16 standards, so I think it's not innovative and
17 new. We should perhaps at least look into
18 what they wrote in their language of their
19 announcement.

20 CO-CHAIR CORA-BRAMBLE: Thank you,
21 Norman. Grace? This will be the final
22 comment before the break.

1 MS. TING: Right, so I think to
2 the point of the unfunded mandates, I think
3 there are two points I would like to make is
4 that, one, we need to be very cognizant that
5 just because there's a mandate or we make the
6 recommendation, if you don't change the
7 fundamental workflow or how patients like
8 Alameda County, how the patients perceive the
9 utilization of services, you can spend
10 millions and millions of dollars and have
11 severe under-utilization. You don't achieve
12 that goal, and that's just a wasted resource.

13 So I would say that, yes, you
14 know, having interpreter services available is
15 a really great first step, but if the attitude
16 surrounding it doesn't change on the patients
17 and there aren't infrastructural programs that
18 change that dynamic, it's still going to be a
19 waste of money. So from a health plan
20 perspective, we spend millions of dollars
21 setting up the infrastructure to deliver it,
22 but the utilization remains virtually

1 nonexistent.

2 Then the other thing with unfunded
3 mandates is that I think NQF and this
4 Committee is in a really great place to really
5 make some recommendations regarding policy
6 changes, of changing the funding structure.

7 They're seeing a huge payer move
8 towards paying for quality rather than just
9 incidents, CMS, and then on the private side
10 there's the patient-centered medical home and
11 NCOs, so there is this shift that I think we
12 can really leverage.

13 Two is that there is precedent for
14 compensating providers differently, and I
15 think my industry might dislike me for saying
16 so, because we don't want variation in claim
17 system. That really adds to administrative
18 costs, but we do have these exception payments
19 for centers of excellence, for physicians in
20 pay-for-performance programs that we've been
21 able to make work.

22 CO-CHAIR CORA-BRAMBLE: And when

1 you say "we," you're talking about Wellpoint.

2 MS. TING: Yes.

3 CO-CHAIR CORA-BRAMBLE: Okay.

4 MS. TING: And the hybrid
5 insurance industry in general, so, you know,
6 we have transplant centers of excellence,
7 bariatric centers of excellence, physicians in
8 pay-for-performance arrangements so that it
9 could be another model for hospitals, and
10 providers in under-represented areas might --
11 there could be some infrastructure that's set
12 up to compensate them differently.

13 So I'm just saying that it's not
14 without precedent, so I don't say, "Oh, we can
15 never do that," but I think right now when
16 there is a shift in paradigm about how we
17 compensate for physicians and medical
18 services. This is a great time to push some
19 of these policy advances.

20 CO-CHAIR CORA-BRAMBLE: Okay, rich
21 discussion. Joel, you're last.

22 DR. WEISSMAN: I know.

1 CO-CHAIR CORA-BRAMBLE: You're the
2 very last one. Go for it.

3 DR. WEISSMAN: I am, because I
4 have to go.

5 CO-CHAIR CORA-BRAMBLE: Okay.

6 DR. WEISSMAN: So I just wanted --

7 CO-CHAIR CORA-BRAMBLE: Fair
8 enough. Fair enough. Duly noted. The floor
9 is yours.

10 DR. WEISSMAN: I just wanted to
11 thank everybody for the opportunity to come
12 here and participate in this important
13 exercise, and I think, you know, you all are
14 doing great work.

15 I think it's going to be really
16 interesting to come out to see how this brief
17 is going to come out and kind of parse these
18 issues between, you know, quality improvement
19 and measurement and disparities at large.

20 I think, Denice, your point about,
21 you know, the Medicaid differential is so
22 important as a presumably color-blind policy

1 issue that disproportionately affects
2 minorities to, you know, a huge extent. You
3 know, you're really pushing the ball uphill
4 when you're trying to reduce disparities and
5 you've got this, you know, as my kids say,
6 ginormous difference in reimbursement.

7 There are other kinds of social
8 policies that are also presumably color-blind
9 that affect mostly health disparities, health
10 status disparities, not so much quality
11 improvement, that the context for that would
12 be great if you could include that in the
13 brief. In any event, thanks again, and good
14 luck with your report.

15 CO-CHAIR CORA-BRAMBLE: Let me
16 just say one -- I think I speak on behalf of
17 all of us. I think you did an outstanding job
18 writing the paper, so thank you so much for
19 that.

20 All right. We're going to take a
21 ten-minute break, so we'll convene back at
22 10:05.

1 (Whereupon, the above-entitled
2 matter went off the record at 9:54 a.m., and
3 resumed at 10:14 a.m.)

4 CO-CHAIR CORA-BRAMBLE: Okay,
5 everybody. I'm going to ask that we get
6 started again. We are close to the finish
7 line. This is the home stretch. I am going
8 to let Nicole frame the discussion regarding
9 priority and options for QI and public
10 reporting, because this one slide summarizes
11 the work that we still have to do. Okay, so
12 Nicole?

13 MS. MCELVEEN: So, our last
14 discussion over the past hour or so has
15 recapped in terms of disparities measurement
16 what we're looking to achieve. You all have
17 given some great additions on what to avoid.

18 The paper also then goes through
19 some design options, and we have touched on
20 some of these already, but we wanted to pull
21 this list up and just find out if there are
22 any gaps between what's presented and maybe

1 additional suggestions that the group has.

2 If you -- if I can quickly go
3 through these options that are listed, I don't
4 know if folks can see that.

5 DR. HAVRANEK: Could you explain
6 exception reporting?

7 DR. BURSTIN: So, there's often a
8 distinction made between exceptions and
9 exclusions. So exclusions to a measure are
10 ones you make where you carefully delineate
11 exactly what they are, and those patients are
12 removed from the denominator.

13 Exceptions is more the post hoc
14 analysis. As you're seeing the patient you'll
15 go, "You know, this patient doesn't really
16 fit," and you except them and give a reason
17 for it. So it's more of a post hoc versus
18 pre-exclusion.

19 DR. JACOBS: Quick question about
20 this. Can we use all of them? Are we
21 supposed to choose one? What are the -- what
22 is the choice?

1 MS. NISHIMI: No, these were drawn
2 from Joel's paper, and he just identified them
3 as any number of design options, so the
4 question is whether you feel some are totally
5 inappropriate or there are others.

6 DR. JACOBS: So we could endorse
7 all of them if we wanted. Okay. Thank you.

8 MS. NISHIMI: Yes, and they're not
9 mutually exclusive options.

10 DR. JACOBS: Thank you.

11 CO-CHAIR CORA-BRAMBLE: Correct.

12 DR. JACOBS: Thank you.

13 CO-CHAIR CORA-BRAMBLE: Romana?

14 DR. HASNAIN-WYNIA: So, I just
15 want to clarify the second one, which sounds
16 like it's an either/or as I'm reading it,
17 paying for performance based on lower racial
18 or ethnic disparities versus, and I think you
19 can do both, actually. You can show overall,
20 you know, quality reporting and disparities
21 reduction in reporting.

22 CO-CHAIR CORA-BRAMBLE: Noted.

1 Noted.

2 DR. HASNAIN-WYNIA: So I don't
3 think it should be a versus.

4 CO-CHAIR CORA-BRAMBLE: So that,
5 we need to change that. Okay. Other
6 comments? Marshall? That's okay. Just turn
7 on. Right.

8 DR. CHIN: Did anyone pick up what
9 was meant by the second-to-last bullet about
10 the structural characteristics? I mean, why
11 is he singling that out here?

12 CO-CHAIR CORA-BRAMBLE: And there
13 may be some question, since Joel is gone, that
14 we may have to circle back and ask him,
15 because I don't know that any of us are
16 prepared to answer that, unless you are,
17 Helen, or anyone else.

18 MS. TING: Actually, I was going
19 to say -- I was going to ask a question about
20 that, that second bullet with the versus. I
21 wonder whether it's -- and, Marshall, maybe,
22 or the researchers in the room can maybe

1 comment on this.

2 I wonder whether that point is
3 about how in the past paying for just higher
4 quality performance in general were not shown
5 to reduce health disparities. You know, it
6 was a case where, you know, the better
7 performing hospitals got better and got the
8 payment, but the lower performing hospital
9 never really got the researchers or were able
10 to improve, so I wonder.

11 It's not whether we should do one
12 or the other. It's just that what was
13 effective in reducing disparities and paying
14 for quality improvement didn't have as much
15 impact as maybe what you are proposing now,
16 which is paying for performance on lowering
17 the disparities specifically.

18 CO-CHAIR CORA-BRAMBLE: So I want
19 Helen to clarify, and then I'm going to go
20 around the table and let people comment.

21 DR. BURSTIN: I think he's
22 referring to the issue that they brought up

1 yesterday of their four criteria, as well,
2 that there's a preference for the outcome
3 measures over process measures ultimately, but
4 I think what he's saying here is that in terms
5 of public reporting, for where we are right
6 now in terms of disparities and cultural
7 competency, structural measures may be that
8 first step out the gate.

9 So proportion of patients who have
10 access to interpreter -- no, I take that back.
11 Does the hospital have interpreter services
12 available, as opposed to getting to more of
13 the process/outcome measures that get closer
14 to what we want? I assume that's what he
15 meant, but we can clarify with him.

16 CO-CHAIR CORA-BRAMBLE: Go ahead,
17 Romana. Oh, you know what? I actually
18 promised that we would start down there, and
19 then we'll come back up. Go ahead, Edward.

20 DR. HAVRANEK: So, you know, they
21 had presented some criteria regarding avoiding
22 -- I think they called it cherry-picking and

1 lemon-dropping.

2 CO-CHAIR CORA-BRAMBLE: Correct.

3 DR. HAVRANEK: I don't see
4 anything up there about that, so I'm wondering
5 if there needs to be some consideration to
6 access. So, in other words, does the -- does
7 the organization provide appropriate access to
8 their services to minority, racial, and ethnic
9 minority patients?

10 CO-CHAIR CORA-BRAMBLE: That's a
11 good point. I would actually prefer to keep
12 the terms. What is it, cherry-picking and
13 lemon-dropping? I thought that's great, great
14 term. Next person. Mara, you had a comment?

15 MS. YOUDELMAN: And I don't know
16 if it's appropriate for this piece or
17 somewhere else in the Call for Measures, but
18 we were talking a little bit about measures
19 that might specifically address use of
20 language services, use of health navigators,
21 et cetera.

22 Is there a way to sort of

1 reference that it might not be a typical QI
2 measure but that we also would be looking for
3 those types of measures, as well?

4 I know the Speaking Together
5 project did develop some measures for tracking
6 collection of language data and collection of
7 provision of language services. They didn't
8 take in discharge, and so those might be
9 useful as a way to expand the call for
10 proposals to get some of those if they're
11 relevant.

12 CO-CHAIR CORA-BRAMBLE: Okay.
13 Romana, you had a -- no? Okay. Anyone else?
14 Yes, Ernest?

15 DR. MOY: This just relates to the
16 framing of this design options, which is a
17 very generic kind of thing, and I think these
18 kind of look like discrete separate activities
19 that are independent from other kinds of
20 quality improvement and public reporting
21 activities.

22 I think, you know, another --

1 maybe that's implicit, but a better framing of
2 it is that looking at disparities and
3 measuring disparities should be an essential
4 component of all quality improvement and
5 public reporting activities --

6 CO-CHAIR CORA-BRAMBLE: Good
7 point. Good point.

8 DR. MOY: -- as opposed to
9 something separate, which some may say, "Oh,
10 well, we just won't do that part of it."

11 CO-CHAIR CORA-BRAMBLE: Very good
12 point. Very good point. I don't think that
13 was brought up in the past, but I do think
14 it's an incredibly important point that you
15 raise. Other comments around the table?

16 So I am hearing that we're not
17 going to necessarily select any of these and
18 that we actually think that they should all
19 stay on the list with a few additions or
20 contextualizing a few things, but other than
21 that the list is, we feel, comprehensive. Is
22 there anything we're missing? Colette?

1 DR. EDWARDS: I don't know how
2 this fits in, but certainly people are looking
3 more and more in terms of incenting the
4 patients, not just the providers.

5 CO-CHAIR CORA-BRAMBLE: I didn't
6 hear the verb.

7 DR. EDWARDS: Incenting the
8 patients --

9 CO-CHAIR CORA-BRAMBLE: Incent.

10 DR. EDWARDS: -- and not just the
11 providers.

12 CO-CHAIR CORA-BRAMBLE: Oh, I see.

13 DR. EDWARDS: I didn't know if
14 that would be a consideration.

15 CO-CHAIR CORA-BRAMBLE: So
16 providing incentives either not to just the
17 provider but also to the patient. Is that
18 what you're saying?

19 DR. EDWARDS: Yes.

20 CO-CHAIR CORA-BRAMBLE: Okay. Any
21 other comments, thoughts? Do you need, to the
22 staff is the question, anything from us in

1 terms of fleshing those out, or is it
2 sufficient for us to reach consensus that the
3 list is comprehensive?

4 MS. NISHIMI: I think right now
5 that's sufficient. You'll -- when there is a
6 final report, things come back --

7 CO-CHAIR CORA-BRAMBLE: We'll
8 circulate it.

9 MS. NISHIMI: -- around with
10 context provided, and you'll have the
11 opportunity then to wordsmith it.

12 CO-CHAIR CORA-BRAMBLE: Okay.
13 Donna, please.

14 DR. WASHINGTON: For the final
15 bullet, I would modify it to suggest risk
16 adjusting payments to providers, rather than
17 solely risk adjusting performance measures.
18 As currently worded, it looks like an
19 either/or.

20 CO-CHAIR CORA-BRAMBLE: I think
21 that's probably the word of caution on
22 several, the issue of excluding. You know,

1 it's either/or, as opposed to both.

2 DR. CHIN: Same with the first
3 bullet.

4 CO-CHAIR CORA-BRAMBLE: Right.
5 Right, and we talked about the versus, that we
6 have to eliminate that. Anything else, any
7 other comments?

8 MS. YOUDELMAN: I just have a
9 question --

10 CO-CHAIR CORA-BRAMBLE: Yes?

11 MS. YOUDELMAN: -- because I got
12 -- maybe I'm confused about the terminology in
13 the last bullet. Didn't we talk about not
14 risk adjusting performance measures? No, I
15 know, but I thought Donna said it's read as an
16 either/or, so the idea of risk adjusting
17 payments rather than risk adjusting
18 performance measures. When you were saying
19 either/or, did you mean to add in also risk
20 adjusting performance measures? Maybe I
21 misunderstood.

22 DR. WASHINGTON: No, actually, you

1 picked up on, I think, what might be a wording
2 problem. It shouldn't be risk adjusting
3 performance measures but risk adjusting
4 performance -- risk adjusting performance
5 achievement.

6 So currently providers, like pay-
7 for-performance, you're paid for achieving the
8 performance measures. They're suggesting also
9 considering risk adjusting the population
10 risk. So the word measures should be taken
11 out of the first sentence.

12 MS. YOUDELMAN: I thought -- maybe
13 I'm just confused, but I thought that what we
14 were talking about with Joel earlier is we
15 don't want to sort of risk adjust within your
16 population. You want to -- because that may
17 mask the disparities, or maybe I'm using --
18 maybe the terms I'm just confusing.

19 I thought what he was -- am I
20 confused as all get-out? I thought what Joel
21 was saying is you don't want to sort of risk
22 adjust for SES or something else. It may mask

1 disparities, and so is that what that's
2 talking about, which means we shouldn't be
3 doing it?

4 I'm fine with risk adjusting
5 payments that if you have a disparity
6 population and you need more resources to pay
7 for language services or because folks have
8 historically not had access and you need to
9 give them more care. I'm fine with that. I'm
10 just -- I don't understand the risk adjusting
11 performance measures.

12 DR. WASHINGTON: Maybe one way to
13 address it would be to substitute pay-for-
14 performance for risk adjusting performance
15 measures. So, in other words, I thought the
16 recommendation in the report was to consider
17 risk adjusting payments to providers in
18 addition to pay-for-performance.

19 CO-CHAIR CORA-BRAMBLE: I think
20 the confusion is around the term risk
21 adjusting performance measures. I don't think
22 it's the measures, at least the way I

1 understood it. I'm not sure that that's what
2 was intended, but we can go back and seek
3 clarity, but that to me is the question mark.
4 We're not really risk adjusting measures.

5 CO-CHAIR CORA-BRAMBLE: I see.
6 Okay. Norman, you had a comment?

7 DR. OTSUKA: William was first.

8 CO-CHAIR CORA-BRAMBLE: Oh,
9 William is first. Okay.

10 DR. MCCAIDE: What I thought this
11 meant was this kind of between within sort of
12 Norman when he was describing before, and this
13 would be like to compensate for a between
14 phenomenon where you might more generously
15 compensate a practitioner who cares for a
16 minority population with respect to not trying
17 to disadvantage people because of the measures
18 that you might otherwise have seen with them,
19 as opposed to risk adjusting the fact that
20 they may have lower numbers in the performance
21 measures that you actually see and then trying
22 to explain that away, which would be the

1 description of the, I guess, within
2 phenomenon. This is what I thought that
3 meant. Maybe I'm wrong.

4 CO-CHAIR CORA-BRAMBLE: Yes,
5 Norman?

6 DR. OTSUKA: Now that we talk
7 about money and pay-for-performance, we bring
8 this issue to a different level, and I'm
9 wondering. We're doing pay-for-performance
10 without giving the clinician more resources
11 or, like you were saying, I mean, I think the
12 first step might be to provide resources,
13 extra reimbursement for interpreting or, you
14 know, provide the hospital or the clinician
15 with the resources to be able to improve their
16 performance.

17 I mean, for me, in orthopedics, I
18 guess, pay-for-performance is if you give
19 prophylactic DVTs or if you give pre-operative
20 antibiotics, they're easy and cuts, you know,
21 straightforward and evidence-based and
22 relatively easy for the clinician to do. It's

1 basically funded.

2 You know, you can give the Ancef,
3 and it's paid for by the pharmacy, but this is
4 a tougher mandate to do and to expect them to
5 reach a certain level to get a one percent
6 increase in their pay-for-performance is
7 tough. You know, I'm on board. I'm on board
8 with it.

9 CO-CHAIR CORA-BRAMBLE: No, I
10 understand. I understand.

11 DR. OTSUKA: I love the principle.
12 I just want to make it easy for the grassroots
13 guy to be able to, so to speak, comply with
14 this and be able to -- frankly, it's not the
15 money, but it's being able to attain that
16 level or that performance level that may be
17 tough.

18 CO-CHAIR CORA-BRAMBLE: But I
19 think the issue that all of this brings to the
20 forefront is the fact that without the
21 financial discussion, all of these things are
22 great to have, but you have to have the

1 finances to be able to underwrite the work.

2 DR. OTSUKA: Right.

3 CO-CHAIR CORA-BRAMBLE: So, I hear
4 what you're saying.

5 DR. OTSUKA: You know, I was being
6 a little candid or maybe a little too -- about
7 the interpreter in my earlier statement, but,
8 yes, we do need them, and they're important
9 for the infrastructure. I don't think it --
10 to sound -- I mean, I don't think the one
11 percent I get for pay-for-performance would
12 underwrite the interpreters and --

13 CO-CHAIR CORA-BRAMBLE: But we --
14 but I think the discussion also goes to a more
15 direct payment for interpretive services.

16 DR. OTSUKA: Right. Right.

17 CO-CHAIR CORA-BRAMBLE: Not
18 necessarily linked to pay-for performance. In
19 other words, you know, you get the
20 interpreter. There is a reimbursement stream
21 that helps to underwrite that for whatever the
22 clinic -- you know, that --

1 DR. OTSUKA: And then if you
2 achieve that level, then you get your one
3 percent or two percent.

4 CO-CHAIR CORA-BRAMBLE: Right,
5 over and above, not necessarily instead of.
6 That's the way that I'm looking at it.

7 DR. OTSUKA: Okay. Well, then
8 that's -- I thank you for the clarification.

9 CO-CHAIR CORA-BRAMBLE: Okay. I
10 mean, that's me. I'm a clinician like you
11 are, so, you know, that's the way I'm looking
12 at it.

13 DR. OTSUKA: I'm just thinking of
14 all the physicians in America --

15 CO-CHAIR CORA-BRAMBLE: I hear
16 you. I understand.

17 DR. OTSUKA: -- just trying to
18 comply with this.

19 CO-CHAIR CORA-BRAMBLE: Mara?

20 MS. YOUDELMAN: I just, I mean, I
21 think that's what we've been talking about is
22 specific reimbursement for language services,

1 or like in an ACO model you could either have
2 an add-on or a risk adjustment if you have an
3 LEP population to pay either specific claims
4 for language services or if they just want to
5 risk adjust it and say, "You'll get X percent
6 more if it's an LEP person," or whatever
7 you're risk adjusting for. It hasn't been
8 adopted yet, but that's what we've, you know,
9 been trying to sort of talk about and think
10 through at the policy level.

11 CO-CHAIR CORA-BRAMBLE: Marshall?

12 DR. CHIN: It may have more to do
13 with the communication and the, I guess, the
14 writing. We talked about like, different from
15 a lot of prior NQF efforts, I mean, this is
16 measurement development but then also the
17 implementation issues.

18 They cannot be divorced, and right
19 now these are lists of things. You know,
20 there's a place for a list of things, but this
21 is going to be narrative that needs to be more
22 synthetic.

1 So, for example, the points that
2 Norman was raising about the payments for the
3 quality improvement infrastructure for the
4 under-resourced settings, right now that's
5 sort of listed as like one option up here, but
6 that's an example of one where that probably
7 needs to be sort of, you know, highlighted in
8 the general company narrative, whereas some
9 things like, you know, exclusive reporting,
10 you know, that a list, so it's the crafting.

11 CO-CHAIR CORA-BRAMBLE: No, I hear
12 you. I think there is some wordsmithing that
13 needs to happen. I just don't know if we need
14 to be involved in the wordsmithing, but I do
15 agree, and we need to -- you know, the, I
16 think, staff needs to decide where they're
17 going to put this, as opposed to a laundry
18 list, and that sort of -- that needs to
19 happen, but I don't know that we need to be
20 involved in that.

21 DR. OTSUKA: There are a lot of
22 other hidden costs, obviously, diet. I mean,

1 I shouldn't say this out loud, but I keep
2 patients extra time because of their religious
3 beliefs. They can't be discharged at a
4 certain time. You know, I mean, there are so
5 many, a multitude of hidden costs, you know.

6 CO-CHAIR CORA-BRAMBLE: Any other
7 comments from the group regarding this list?
8 See, we can reach consensus. Okay, go ahead.

9 MS. MCELVEEN: And so taking into
10 account what we've talked about just now and
11 then as well as in Section 4 with some of the
12 methodological issues, we just wanted to kind
13 of go through public reporting for disparities
14 and talking about how that should be used.

15 So, for example, should it be used
16 for payment and reimbursement purposes for
17 consumer choice? Should it be used to
18 motivate providers to improve performance?
19 Again, we may have touched on some of these
20 topics already, so if you have any additional
21 comments.

22 CO-CHAIR CORA-BRAMBLE: Romana, go

1 ahead.

2 DR. HASNAIN-WYNIA: So I'm curious
3 about or I'd like to hear thoughts about the
4 motivating providers to improve performance,
5 because, you know, when we talk about public
6 reports, I think the first thing that comes to
7 mind are public reports for the public, but,
8 again, I'm going to use my aligning forces for
9 quality experience to highlight what's taking
10 place in 17 markets throughout the United
11 States where there is a strong focus on public
12 reporting.

13 So the providers are not
14 necessarily publicly reporting all of their
15 measures publicly, especially the disparities
16 measures, mostly because they don't have the
17 race, ethnicity, and language data right now
18 to do that.

19 But even as they do go forward
20 with their kind of initial public reports,
21 they are reporting them internally within
22 their, you know, within their professions,

1 basically, which has a place in motivating
2 performance, kind of being accountable to your
3 profession.

4 So when we're talking about public
5 reports here, I think we do need to delineate
6 whether we're talking about public reports for
7 the public or whether we're talking about
8 public reports for, you know, practices or
9 medical groups, whether we're talking about
10 individual provider reports. Are we talking
11 about --

12 CO-CHAIR CORA-BRAMBLE: That's a
13 good point.

14 DR. HASNAIN-WYNIA: --
15 disaggregating them or not?

16 CO-CHAIR CORA-BRAMBLE: Very good
17 point. I don't know that we had addressed
18 that explicitly, but I agree with you that
19 it's a good point, and I do know that some of
20 those that are collecting data, oftentimes
21 it's shared internally, and it doesn't even
22 make it to their website, so I do understand

1 what you're saying.

2 Marshall, did you have a comment?
3 You have to turn your card around so I can see
4 it. Go ahead.

5 MS. WU: So, a couple things with
6 regards to Romana's point. I have actually
7 sat on a lot of quality data reporting
8 advisory committees that tried to get to the
9 consumer, and it's really hard, really super
10 hard.

11 People are bending over backwards
12 to make it consumer friendly and, you know,
13 how they can search and stars and happy faces
14 and all that kind of stuff, and it just
15 doesn't seem to quite work. It doesn't, so I
16 think there's still --

17 CO-CHAIR CORA-BRAMBLE: What is it
18 that's so hard about it, for those of us who
19 have not been involved in that process?

20 MS. WU: I'm not sure our
21 healthcare market is set up for being driven
22 by consumer choice. You know, the comparison

1 is like the coffee shop.

2 When you have three coffee shops
3 in a couple blocks and you can go, and there's
4 price and quality versus going to a website
5 and looking at all this medical data and
6 trying to make sense of it for yourself and
7 then making a choice with your provider in a
8 health plan, and even understanding that
9 difference I think is hard. Our healthcare
10 system is very complicated.

11 So I think there is -- that
12 transparency and public reporting are
13 absolutely critical. There are consumer
14 advocates, navigators, other kind of middle
15 people who can probably help with that
16 interpretation.

17 I just would caution doing the
18 public reporting for the consumer's sake just
19 because it's a lot of work. It's a lot of
20 effort, and I'm not sure how much it yields,
21 and I'm a consumer advocate, but I think it --

22 CO-CHAIR CORA-BRAMBLE: So

1 different levels of reporting, and I think the
2 observation that was made is that we really
3 haven't discussed that there are multiple
4 levels. That may be sort of the ultimate, but
5 there are still a few others that are interim
6 levels that I think, you know, their work --

7 MS. WU: That are really
8 important.

9 CO-CHAIR CORA-BRAMBLE: Right,
10 they're important in terms of, you know,
11 motivating providers to improve quality of
12 care. That's one of the things that we do in
13 our clinics, and it's very effective. It's
14 very powerful when you share the data.

15 MS. WU: So the second thing is I
16 think there's a really great opportunity here
17 where the ACAs and the exchanges are coming up
18 and running, because I know for each of the
19 state and federal, at the federal level, the
20 exchanges have to determine how health plans
21 are certified to qualify to play in the
22 exchange.

1 I think quality data and certainly
2 equity issues would be great to be added into
3 that, and we could work fast enough to get
4 ahead of that curve for when the exchanges
5 become operational in 2014.

6 CO-CHAIR CORA-BRAMBLE: Thank you.
7 Marshall?

8 DR. CHIN: Yes, in terms of that
9 last bullet, I think it's probably all of the
10 above. It's basically, you know, money, as
11 well as then for public reporting to different
12 audiences.

13 I remember very early on the first
14 day -- it may have been Ellen. I can't
15 remember -- someone made the point that even
16 the things that are designed for consumers,
17 the mechanism probably is not the consumer
18 comes the power.

19 It's really because providers
20 realize it's the public, and so they have to
21 act, and they're a large purchaser type of
22 consumer, so in some ways it doesn't matter,

1 probably, because once the data is out there,
2 it's out there, but it does apply to all of
3 those different mechanisms. I think it was
4 the report that said, "Well, here's the list
5 of potential mechanisms."

6 CO-CHAIR CORA-BRAMBLE: Thank you.
7 Luther?

8 DR. CLARK: I'm not sure this fits
9 in the first item there, but I was wondering
10 is there a role here for professional
11 societies and organizations, because they
12 develop guidelines and registries, and that
13 information is often reported, and if they can
14 be included in the loop, that would seem to be
15 a very helpful thing to do.

16 CO-CHAIR CORA-BRAMBLE: Dennis?

17 CO-CHAIR ANDRULIS: I just wanted
18 to add. Perhaps it kind of picks up a little
19 bit on what the troublemaker over here,
20 Elizabeth, raised.

21 CO-CHAIR CORA-BRAMBLE:
22 Troublemaker? Excuse me, Co-Chair. I don't

1 think that's language you use in this
2 Committee.

3 CO-CHAIR ANDRULIS: Oh, that's
4 right. I'm supposed to be --

5 CO-CHAIR CORA-BRAMBLE: Please
6 excuse him, Liz.

7 CO-CHAIR ANDRULIS: Politic. That
8 is the politic preference.

9 DR. JACOBS: When people stop
10 calling me a troublemaker, I'll be upset.

11 CO-CHAIR ANDRULIS: But it refers
12 back to a point, actually, Elizabeth and I
13 talked about, too, a little bit in the break,
14 and that is whether there is another purpose
15 that should be recognized here around
16 assisting providers who are caring for large
17 numbers of minority patients, safety net
18 providers in particular.

19 I don't know whether you want to
20 mention safety nets specifically but whether
21 there is an opportunity to use that
22 information or for that information to be

1 considered in the context of those
2 organizations that those providers that are
3 offering care to large numbers.

4 I don't see it specifically in
5 there. I see it for reimbursement purposes,
6 but I don't see it recognized in the context
7 of assistance, considering resource needs,
8 resource starved or those who need additional
9 resources.

10 CO-CHAIR CORA-BRAMBLE: Also, I
11 wanted to come back to what you were saying,
12 Luther. I actually think that's an excellent
13 point in terms of professional societies, and
14 I don't know that we addressed it at any point
15 before, so I think it's -- I just wanted to
16 highlight it that I think that's an excellent
17 suggestion.

18 Other comments? Francis?

19 DR. LU: Yes, I would just second
20 that in terms of the professional
21 organizations. I sit on the Executive
22 Committee of the Practice Guidelines for the

1 American Psychiatric Association, and I think
2 that it would be wonderful if we could include
3 some of these disparity measurements as part
4 of our practice guidelines, and perhaps there
5 are other organizations, as well.

6 CO-CHAIR CORA-BRAMBLE: Other
7 comments? Some of these societies and
8 associations are actually making steps. You
9 know, they're already going towards that, you
10 know, but this would help. I think this would
11 be very -- I sit on the Board of the Academic
12 Pediatric Association, and I think that would
13 be instrumental. Other comments?

14 MS. MCELVEEN: Great. So, this
15 really concludes our discussion about the
16 paper as a whole. I know we opened it up for
17 any additional comments, but, again, if you
18 have any additional comments, questions, now
19 is the time to talk about them. We're going
20 to now transition to framing our Call for
21 Measures around disparities, so are there any
22 -- Marshall?

1 DR. CHIN: I'll get back to what I
2 mentioned about Carolyn Chancy at a meeting
3 like this saying, "Well, don't forget the big
4 picture." We've mentioned maybe two or three
5 times, most recently, I guess, Francis, but I
6 think one of the big ones is this point about
7 equity measures aren't a separate thing, that
8 they really are something that all
9 organizations need to consider in all of their
10 quality efforts.

11 So we do have some disparity-
12 specific measures, but in some ways those are
13 the gross minority of the different things,
14 and so that frame in the overall document
15 needs to be a critical one so that it doesn't
16 become sort of a relatively small percentage
17 of what different organizations do.

18 CO-CHAIR CORA-BRAMBLE: Colette,
19 did you have a comment?

20 DR. EDWARDS: This goes back to
21 the conversation that we were having about the
22 language used with regard to cultural

1 competency, and I don't now, Robyn, that maybe
2 this has already been hashed out, as you said,
3 in some other committee in terms of do we want
4 to think about using minorities versus
5 something else.

6 CO-CHAIR CORA-BRAMBLE: I'll defer
7 to the NQF staff.

8 MS. NISHIMI: Yes, it really has.
9 That's a term that actually came out of the
10 first work. If there are -- I think there are
11 ways to craft why we use this term, you know,
12 "And by this we mean," and then if you had
13 other verbiage you'd like to suggest around
14 it, but to make this sort of a whole scale
15 reversal of terminology I think is really not
16 --

17 CO-CHAIR CORA-BRAMBLE: I think,
18 though, it is helpful to note that in some
19 places in the U.S. the minorities are really
20 not minorities anymore, so just so that the
21 reader understands --

22 MS. NISHIMI: Right.

1 CO-CHAIR CORA-BRAMBLE: -- that,
2 you know, we know that.

3 MS. NISHIMI: Right, and so that's
4 what I meant, yes, exactly, that kind of sort
5 of framing in explanatory language but to sort
6 of replace that construct for another
7 construct I think would be not really a good
8 idea at this time.

9 CO-CHAIR CORA-BRAMBLE: Okay.
10 Noted. Comments? Yes.

11 MS. WU: Actually, I wanted to add
12 on to that, and I'm glad Colette brought it
13 up, because I know mainly in California when
14 we talk about it, we talk about communities of
15 color, and we're 60 percent majority minority,
16 so it feels like it's hopefully starting to be
17 an outdated term that hopefully we can shift
18 to a better descriptive.

19 CO-CHAIR CORA-BRAMBLE: That's a
20 good point. I do. I think that it's a good
21 observation, and it's always tough to read
22 guidelines and recommendations that a

1 committee has reached consensus on that seem
2 devoid from reality, and I want to make sure
3 that to the degree that our name is going to
4 be on it that it's grounded.

5 Other comments from anyone else?
6 Yes? I'm sorry, I didn't see you.

7 DR. MOY: Again, a more generic
8 kind of comment, which is I don't know if
9 there's a need in this document somewhere to
10 try to make the case what are the social goods
11 of disparities. Why do we care about it other
12 than for the disparate populations and the
13 providers that take care of it?

14 So, you know, what are the
15 implications for society of dealing with these
16 issues of disparities? There are obviously
17 the issues of inequities and trying to achieve
18 a fair society and other arguments, I think,
19 that have been put forward, though, for why
20 people who are not members of disparate groups
21 or providers should care or that sometimes we
22 can look at disparities as the canary in the

1 mine, and that is a lot of the problems with
2 healthcare often are first detected through
3 issues of disparities.

4 So, for instance, we had the
5 conversation about language, and so, yes,
6 obviously, you can't counsel somebody if they
7 don't understand the language you speak. I
8 think that's led to the broader conversation
9 about health literacy for English speakers.
10 They can't understand you, either.

11 So that's, you know, a translation
12 from disparities to a general quality
13 improvement kind of benefit for all of
14 society. I don't know if we have to
15 articulate that or if NQF simply assumes
16 disparities reduction and measurement is good.

17 CO-CHAIR CORA-BRAMBLE: No, I
18 think your point is well taken. I do.

19 CO-CHAIR ANDRULIS: Again, I think
20 this comes back to context for the report,
21 that issues around employment, employer base,
22 the diverse workforce that is growing in our

1 society, the recognition that even though you
2 may think you're not going to be affected that
3 there are not only the canary in the coal
4 mine, but you've got conditions like panflu.

5 If you can just ground it a bit
6 more, I guess, is what we're talking about
7 here in a real live context, I think that will
8 add kind of a life and a resonance to other
9 audiences, broader audiences to pick up on
10 what you're saying.

11 CO-CHAIR CORA-BRAMBLE: Liz?

12 DR. JACOBS: Oh, just to follow up
13 on what Ernie said, I think people don't
14 realize that, actually, disparities cost us in
15 so many ways, right, because we're actually
16 dedicating resources to taking care of
17 patients who are sicker.

18 Ron Anderson makes this great
19 argument, you know, like if you look at trauma
20 centers, and if we're not doing things -- you
21 know, all of us are disadvantaged if we can't
22 get into a trauma center, and if minorities

1 are disproportionately there and we're not
2 doing things to prevent it, then we also miss
3 out on that resource. So if you want to speak
4 to people's self-interest, I think that's
5 another way to do it.

6 CO-CHAIR CORA-BRAMBLE: Good
7 point. Any other comments? Joel has his card
8 up, and so he's going to speak in absentia
9 over there. Any -- I hear you. I hear you.
10 Did you have a comment? Yours is up. No?
11 No. Anything else? Comments from any of the
12 participants on the phone? I don't know if
13 their lines are muted or not.

14 MS. MCELVEEN: Operator, can you
15 open the lines on the phone?

16 OPERATOR: All lines are open.

17 CO-CHAIR CORA-BRAMBLE: Any
18 comments from the phone participants? Okay.
19 I pass on a consensus baton to you.

20 MS. MCELVEEN: Okay. So, next
21 we're going to talk about framing our Call for
22 Measures, and so there are several documents

1 that we've provided to the group to help think
2 this through. Two are examples of previous
3 Call for Measures. One should be on care
4 coordination, and the other would be on child
5 health.

6 The third packet of information
7 that we've provided you with is a rather
8 lengthy document, which is our online measure
9 submission form, and so we're not going to go
10 through that entire form, but we really wanted
11 to just provide that example to you so you
12 have an idea of what we ask for in terms of
13 submitting standards for consideration.

14 So, first I'd like to go through
15 the examples provided to the group, the two
16 examples on the Call for Measures, and briefly
17 when we do a Call for Measures, obviously
18 there is some contextual information around
19 the background of the project, but the meat of
20 that call is really around specifically the
21 types of measures you're looking for and any
22 sub-topics.

1 So some just examples that I
2 pulled that we put in the past are, you know,
3 specifying that we're looking for measures on
4 patient-reported outcomes or we're looking for
5 measures that address healthcare utilization.
6 In addition, we do want to be specific around
7 the areas that should be addressed.

8 So some examples that I pulled
9 were measures to evaluate the capacity of
10 primary care and specialty care, measures to
11 address care coordination for patients with
12 comorbidities. So it leaves the room for the
13 Committee to come up with as much specificity
14 as you all think is appropriate.

15 One thing I also wanted to note,
16 if you're looking at the Call for Measures
17 around child health outcomes, that Committee
18 actually crafted that Call for Measures, and
19 one important point to note is they really
20 sort of pushed the envelope in terms of
21 requesting measures around public health.

22 You know, that's really a new area

1 for NQF, and we don't have very many measures
2 around there, so they really pushed the
3 envelope and put it out there. Not
4 surprisingly, we got some very, very good
5 measures that really addressed the key issues
6 that they highlighted.

7 So you all as a group have that
8 authority and really that capacity to ask for
9 the measures that you're looking for. It
10 doesn't mean we'll get them all in, but I
11 think putting it out there for measure
12 developers to be aware of what's important for
13 disparities and what we're ultimately looking
14 for is where we want to go.

15 I have also the cultural
16 competency framework. I think you all
17 highlighted some great suggestions for
18 addressing cultural competency for
19 measurement. I just wanted to pull up this
20 framework.

21 This is from the NQF project on
22 cultural competency. This is the framework

1 that we endorsed, and so I just wanted to
2 highlight the domains within that framework,
3 but I think, again, you all touched a lot on
4 some areas around cultural competency, so we
5 won't prolong on that.

6 Then, finally, just recapping some
7 of my notes from yesterday, we did get some
8 recommendations on measures thus far, and we
9 did get a few more today, as well. The ones
10 that I have noted are it's important that we
11 get measures around system and structural
12 measures for capturing disparities.

13 Again, we'll need some more
14 clarity to help flesh out that idea, but
15 that's something that came out at the meeting
16 yesterday, as well as cross-cutting measures
17 that are really applicable for all
18 populations. So those were the two that rose
19 to the top.

20 There were some more mentioned
21 today, and I can -- it was measures around,
22 again, language services, which was heard loud

1 and clear, and also patients' use of
2 navigation services. Those are the two that
3 I have in my notes today.

4 So now is the time to open up the
5 discussion again for being a little more
6 detailed about the ideas that I have up there
7 and providing some additional recommendations.

8 DR. CHIN: Can we use the white
9 boards?

10 MS. MCELVEEN: Yes.

11 CO-CHAIR CORA-BRAMBLE: Okay. The
12 floor is open. We'll start off with you at
13 the end.

14 DR. O'BRIEN: Can we have
15 something to start with in terms of the text
16 that was circulated with getting this
17 Committee together? Do we have basically a
18 title of what this is about with just some
19 language just to look at?

20 CO-CHAIR CORA-BRAMBLE: I think
21 this is all we have. I don't think there is
22 anything else other -- well, she did. She

1 gave examples of child health and care
2 coordination. I think that for those of us
3 who have never drafted measures, it may be we
4 may need a little bit more, so let's --
5 Francis, go ahead.

6 DR. LU: On the page 51 of the
7 report, I think there are some additional
8 suggestions in this area.

9 MS. MCELVEEN: Yes, that's a great
10 starting point, Francis. If we want to start
11 on page 51 from the report, they provide some
12 suggestions on what measures should be
13 selected. We can use that maybe as a starting
14 point with the group.

15 DR. O'BRIEN: Yes, I just think
16 that delineating the scope is a really
17 important part of it and trying to figure out
18 how broad to be, but in order to get this
19 group together, we received an email saying,
20 "Hey, we're getting a group together to do
21 something." What was it that the NQF staff
22 wrote to us and invited us to or had a call to

1 have a Steering Committee for?

2 CO-CHAIR CORA-BRAMBLE: I mean, we
3 did the task, which is basically the consensus
4 regarding, you know, the work that we did. I
5 don't understand what you're asking for. Help
6 me understand it. Yes, Romana?

7 DR. HASNAIN-WYNIA: So, if I'm
8 understanding what Sean is saying, when the
9 call went out, for example, when the call went
10 out from NQF to nominate and to convene this
11 Committee, there were certain specifications
12 in that.

13 You know, there were certain
14 objectives of what the role of this Committee
15 would be, what we were charged to do, so
16 drawing from that as a starting point, as
17 well, to kind of frame the overall objective
18 that may potentially, you know, make its way
19 into the introductory language here, but it
20 gives us somewhat of kind of an umbrella or a
21 conceptual framing of why we're all here, and
22 then we can start, you know, delving into the

1 weeds.

2 MS. WU: Well, what about the --
3 what about the slides that were used for the
4 conference call, some of those?

5 CO-CHAIR CORA-BRAMBLE: They're
6 looking. Just give them a few minutes.
7 They're trying to retrieve that. Other
8 comments? Edward, did you have a comment
9 while we're waiting?

10 DR. HAVRANEK: Oh, yes. I'm
11 sorry. I just wanted to add to the list that
12 whole idea of access. Is there a way to
13 include as a quality measure a measure of
14 whether or not the organization adequately
15 cares for minorities that are in its catchment
16 area or in its local population?

17 Again, the idea is that, you know,
18 one way to make your disparities go away is to
19 not let a certain number of people in the door
20 or a certain type of person in the door, and
21 so I just want to be really sure that we don't
22 promote that by asking for a performance

1 measure that looks at access.

2 CO-CHAIR CORA-BRAMBLE: Ellen?

3 MS. WU: Can I -- I'm going over
4 some measures, and I just --

5 CO-CHAIR CORA-BRAMBLE: Sure, go
6 ahead.

7 MS. WU: So I really -- I have my
8 notes on page 51 -- really like the health-
9 related quality of life measures idea. I know
10 that there are some developed for pediatrics,
11 and I'm not sure if there are for general, but
12 it would be great to get some of those.

13 Then what was the slide that was
14 up before in terms of systems measures, I
15 think there are a lot of different elements
16 that could be under that. Certainly, one is
17 IT system and the ability to collect the
18 information but also what to do with it and
19 all the IT.

20 There's probably national work,
21 but there is also a statewide in California an
22 IT consumer collaborative where we've outlined

1 some principles which probably we could draw
2 upon to fill that in, and then I know there's
3 other --

4 I don't know. Mara would probably
5 have to help me out. I forget the different
6 groups that have talked, kind of tried to
7 define what cultural competency is and how to
8 operationalize it within an internal system
9 like diversity of staff within the healthcare
10 system, the leadership team, the training that
11 happens from kind of member orientation within
12 the system. So think those are already
13 outlined somewhere.

14 MS. YOUDELMAN: Well, the Joint --

15 CO-CHAIR CORA-BRAMBLE: Go ahead
16 and make your comment.

17 MS. YOUDELMAN: I was going to say
18 the Joint Commission, when it developed its
19 new hospital accreditation standards for
20 cultural competence in patient-centered care
21 and effective communication, which a number of
22 us were involved in the development of that,

1 we put out a roadmap that has a lot of
2 recommendations and additional resources for
3 hospitals but really for anyone on sort of
4 implementing all of these different pieces of
5 the puzzle.

6 CO-CHAIR ANDRULIS: Yes, this is -
7 - this is, I think, a good place to talk about
8 cross-referencing to other resources. Again,
9 I think Mara's point is really well taken if
10 you look at what Tawara Goode has done in this
11 area.

12 Some of the areas you're talking
13 about are echoed in our cultural competence
14 assessment protocol, where you look at
15 leadership and workforce diversity and
16 community outreach and IT and business
17 strategies.

18 There are fields that are -- that
19 were prioritized by and looked at by
20 organizations as areas that they should be
21 concentrating on, at least structurally, but
22 then you could use and match with and

1 encourage the matching of effectiveness
2 measures, patient satisfaction with some of
3 the structural measures, as well.

4 [Off-mic comment]

5 CO-CHAIR CORA-BRAMBLE: I wanted
6 to go back to something that -- oh, Ellen, did
7 you have another comment? I wanted to go back
8 to something that Ed had said regarding access
9 and to take it to another level.

10 For some of the community
11 providers, particularly subspecialists, that
12 simply say, "We don't accept Medicaid
13 patients," that's sort of a way of cherry-
14 picking and lemon-dropping so that, you know,
15 their outcomes would probably be good because
16 of the fact that they're not accepting those
17 that are most at risk.

18 I don't know how we can craft
19 something in terms of measures that
20 specifically alludes to that. I don't know if
21 it's a social responsibility to accept those
22 sorts of -- I don't know how we -- the

1 language we would use, but I think that
2 excluding Medicaid populations from, you know,
3 different providers' panel is an easy way to
4 reach a certain level of quality of care.

5 Other comments? I don't see cards
6 up. Y'all are getting quiet on me in the last
7 hours. Come on. Marshall?

8 DR. CHIN: Just a process question
9 to make sure we understand the task. So the
10 past day and a half we've gone through a
11 number of measures, existing measures that
12 Joel and Joe have these three categories.

13 There were like these 700 measures
14 with a subset related to disparities. They
15 had a second category where maybe disparities
16 weren't evident, but they still are possible,
17 and they're part of the existing 700.

18 So this is now the third
19 component, where we're asked to come up with
20 what are the different potential domains which
21 don't exist in any of the 700 existing NQF
22 measures that we then have this RFA to ask

1 developers to submit actual questions or
2 measures that then have been validated.

3 So this is to fill in that
4 particular gap, and these measures are for
5 what purpose, then? These are for like public
6 reporting and --

7 CO-CHAIR CORA-BRAMBLE: Helen?

8 DR. BURSTIN: The full range of
9 accountability functions, whether that's
10 public reporting, pay-for-performance,
11 whatever that case may be.

12 DR. CHIN: So the audience is
13 going to be largely big players in terms of
14 health insurers and --

15 DR. BURSTIN: Yes, I mean, these
16 should be measures that he'll feel comfortable
17 are validated, could be used for comparison
18 across providers, things like that, yes, not
19 necessarily just the internal QI ones but
20 really ones that rise to the level of feeling
21 like they've met a threshold, and you'd feel
22 comfortable comparing Provider A to Provider

1 B.

2 DR. CHIN: And the assumption is
3 that these are areas where basically they
4 don't -- well, it may be a good assumption. I
5 was going to say the assumption is that these
6 measures don't exist, so people are going to
7 be developing them or else they already exist,
8 and now people are proposing them.

9 DR. BURSTIN: I think our hope is
10 -- we've given a time line for this. It's the
11 latter, but, then again, there may be that --
12 part of what we also do as part of these
13 efforts is we signal to the field where
14 measure development is needed.

15 We recognize that's not going to
16 happen in the next few months before this Call
17 for Measures goes out, so in this case we're
18 really saying, "Those of you out there who
19 have got a measure that you've worked with
20 that you think could be brought in, please
21 bring it forward to NQF."

22 DR. CHIN: This issue that either

1 Sean or Ed brought up earlier that some
2 measures may be validated for majority
3 populations but may not have been tested in
4 minority populations, and so what qualifies
5 for that in terms of being a measure that is
6 able to be submitted, then? In other words,
7 it has to be validated upon a minority
8 population or just validated in some
9 population?

10 DR. BURSTIN: It's really a
11 question, Marshall, if anybody else wants to
12 jump in. I think that, in general, if it's a
13 measure that includes the patient voice, like
14 a survey, we would very much expect that the
15 populations who would be completing it would
16 be tested.

17 I think for a measure that looks
18 at outcomes of heart disease or whatever the
19 case may be, we don't have an expectation
20 necessarily that you would provide that data,
21 although, again, if it's a measure already in
22 our portfolio that's up for maintenance and a

1 full review again, we would expect to see
2 those stratified results back to us.

3 MS. NISHIMI: And if I could just
4 add, at the end of the day, when NQF receives
5 that information, you know, at some level I
6 think, and Helen can correct me if I'm wrong,
7 but if the Committee feels that, you know,
8 it's otherwise a very good and solid measure,
9 has some testing data in populations that
10 you're not entirely satisfied with, you know,
11 that's something that you could think about
12 whether or not it meets the threshold to at
13 least move over and be further considered.

14 CO-CHAIR CORA-BRAMBLE: Norman and
15 then Liz.

16 DR. OTSUKA: I mentioned it
17 earlier, but there should be some measure
18 about education for academic centers and their
19 adherence to some of the ACGME guidelines or
20 core competencies or their commitment to
21 teaching culturally competent care to their
22 residents and medical students.

1 The other -- another point, you
2 asked about providers, how much of their
3 profile would be private pay versus non-
4 private pay. I guess it's all geographic. I
5 mean, if a physician is in a place where it's
6 90 percent non-private and their profile is 90
7 percent private insurers, I mean, there is
8 some disparity there.

9 CO-CHAIR CORA-BRAMBLE: But right
10 now that's not kept in check. In other words,
11 in the District of Columbia, which is still,
12 you know, predominantly African-American --
13 well, let me put it this -- it's a transition,
14 but there is still a sizeable African-American
15 population.

16 There are providers in the
17 District who refuse to see Medicaid patients,
18 and I'm not talking about just a few. I'm
19 talking about the majority of providers in
20 certain subspecialty areas --

21 DR. OTSUKA: So that --

22 CO-CHAIR CORA-BRAMBLE: -- refuse

1 to see Medicaid patients.

2 DR. OTSUKA: So that physician's
3 profile would not be in keeping with the
4 geographic area.

5 CO-CHAIR CORA-BRAMBLE: Correct,
6 but right now it doesn't matter. It's up to
7 the provider to make that choice.

8 DR. OTSUKA: Right, so I guess
9 there's no real way to compare.

10 CO-CHAIR CORA-BRAMBLE: Correct.
11 Exactly, but then they may be eligible for,
12 you know, added payments for X. If they don't
13 have that sort of at-risk population that
14 requires additional resources, yes, they're
15 likely to reach that benchmark much quicker.

16 DR. OTSUKA: My measure fails
17 then.

18 CO-CHAIR CORA-BRAMBLE: Yes.

19 DR. OTSUKA: Okay.

20 DR. JACOBS: Oh, just to follow up
21 on what Norman said, and this goes under
22 systems, is actually looking at whether

1 organizations do training around how to care
2 for patients from different backgrounds,
3 cultural competency or however you want to
4 call it.

5 I know the Joint Commission has
6 some actual language around it. I mean, we
7 should -- we can look at some of their
8 standards that they proposed, I think, as
9 things that we could develop measures around,
10 actually.

11 CO-CHAIR CORA-BRAMBLE: You know,
12 my suggest is that we also look at use as much
13 as has been developed that is relevant to this
14 work, you know, the class standards. There
15 are other -- people have spent hours and
16 hours, and some of these Committee members may
17 have been a part of those Committees, so let's
18 not reinvent the wheel would be my suggestion.

19 DR. OTSUKA: So, I'm sorry, I
20 guess the infrastructure, a measure of the
21 infrastructure that exists, I mean,
22 interpreters --

1 CO-CHAIR CORA-BRAMBLE: Yes.

2 DR. JACOBS: Also the training
3 that they give.

4 DR. OTSUKA: And the training to
5 nurses, et cetera.

6 DR. JACOBS: Right. Right, so in
7 addition to residents.

8 CO-CHAIR CORA-BRAMBLE: I'm going
9 to go to this side of the table now for a
10 minute. Okay, Romana, you speak, and then
11 we'll take all of these other folks on the
12 right side.

13 DR. HASNAIN-WYNIA: Just in terms
14 of resources, and this is for the NQF staff,
15 but the Ethical Force Program for the American
16 Medical Association put out a report on
17 communication with multiple patient
18 populations.

19 They actually developed a number
20 of domains, but most importantly, under those
21 domains such as engaging the community
22 workforce, collecting data, evaluating

1 performance, health literacy, many of the
2 things that we've talked about today, at the
3 end of each chapter there are a list of
4 suggested performance measures for
5 organizations. So that might be a starting
6 point. I just pulled it up.

7 CO-CHAIR CORA-BRAMBLE: Give me
8 the name again.

9 DR. HASNAIN-WYNIA: Yes, the name
10 of the report, and it's available online, and
11 you guys --

12 CO-CHAIR CORA-BRAMBLE: Okay, just
13 for the rest of us, because we don't --

14 DR. HASNAIN-WYNIA: It's
15 "Improving Communication, Improving Care: How
16 Healthcare Organizations Can Ensure Effective
17 Patient-Centered Communication With People
18 from Diverse Populations."

19 CO-CHAIR CORA-BRAMBLE: And the
20 organization that published it is?

21 DR. HASNAIN-WYNIA: It's the
22 American Medical Association.

1 CO-CHAIR CORA-BRAMBLE: Oh, AMA.

2 Okay.

3 DR. HASNAIN-WYNIA: Yes, Ethical
4 Force Program, but --

5 CO-CHAIR CORA-BRAMBLE: Got it.
6 That's the disclosure, right? There you go.

7 DR. HASNAIN-WYNIA: But it's the -
8 - the piece that's important in that is that
9 at the end of each chapter it has the
10 performance evaluation.

11 CO-CHAIR CORA-BRAMBLE: Their
12 performance measures. Got it.

13 DR. HASNAIN-WYNIA: Performance
14 measures, right.

15 CO-CHAIR CORA-BRAMBLE: Okay. All
16 right. We'll start right here with Ernest,
17 and then we'll work out way down. Go ahead.

18 DR. MOY: Okay, so I think this is
19 kind of topical areas related to this reducing
20 disparities that we haven't kind of covered so
21 far, right. One area that we could include
22 specifically are patient perceptions and

1 experiences of bias in healthcare settings,
2 something I don't think we've talked about so
3 far, and there is some science there.

4 CO-CHAIR CORA-BRAMBLE: Okay.
5 Thank you, and there has been -- yes, there's
6 published literature as it relates to that.
7 Francis?

8 DR. LU: In terms of the wording
9 of the call, I think it might be helpful to,
10 if we all agree with this, number 5 on page 51
11 if we would agree to endorse the 35 ambulatory
12 disparity-sensitive measures. That could be
13 referenced as like examples for people to look
14 at in terms of, you know, in terms of how --
15 to help people with the process of submission.

16 CO-CHAIR CORA-BRAMBLE: Okay.
17 Thank you. Colette?

18 DR. EDWARDS: My comment had to do
19 with the comment that you made in terms of
20 let's not reinvent the wheel for things that
21 are already specifically disparities-related,
22 but do we want to also think about things that

1 aren't specific to disparities but are high
2 priority like readmission that Medicare is
3 focusing on where we know that disparities do
4 exist?

5 CO-CHAIR CORA-BRAMBLE: I see.
6 Okay. Good point. Mary?

7 DR. MARYLAND: I'd ask two things,
8 that we think about education in terms of
9 training the next generations, that we would
10 look at these issues in relationship to health
11 professions and hospital administration and
12 all the folks who will be making these
13 decisions in the future.

14 How do we include this? And, as
15 we move forward, are there ways to reference
16 what's important in the ACA that this might
17 directly impact as we have full
18 implementation?

19 CO-CHAIR CORA-BRAMBLE: Go ahead,
20 Dennis. That actually was a comment to what
21 Mary is saying, because otherwise you're going
22 to have to wait until everybody else talks.

1 I promised -- I promised my
2 esteemed colleagues on the right side of the
3 table that we would go in line, and then we
4 come back, unless it's a comment. Not a
5 comment?

6 All right. There you go. It is a
7 comment. I'd better let him talk. Let me let
8 him talk, okay, and then, you know, there you
9 go. Go ahead.

10 CO-CHAIR ANDRULIS: I want to
11 build on, I think, previous comments about
12 looking at what the actual calling form has
13 put on in terms of priority areas. There is
14 a care coordination piece that I think might
15 serve as a piece for, I think, us and NQF to
16 reflect on, because care coordination is such
17 a huge, huge issue with regard to the priority
18 populations we're talking about.

19 So I think this piece in
20 particular may be worthwhile looking at as a
21 priority area, building on what you were
22 saying, Colette, about what you would select

1 out as kind of greater than in some ways.

2 CO-CHAIR CORA-BRAMBLE: Okay.

3 DR. CHIN: So I think a big
4 umbrella category to include specifically is
5 medical home concepts for multiple
6 populations, because within that there's going
7 to be like a set of like six to eight
8 different domains that cut across a lot of
9 things we're talking about, across to
10 communication, care coordination,
11 communication with external providers,
12 tracking and monitoring of patients, quality
13 improvement, shared decision-making, et
14 cetera.

15 This would be medical home
16 concepts both patient measures, so, for
17 example, NCQA how has a medical home CAPS
18 that's going to enter the field very soon, as
19 well as an organizational measure. It's going
20 to be organizational structure measures.

21 But if you start getting into that
22 literature and you have a writeup, that's

1 going to cover a lot of things we've talked
2 about, and then it should resonate, because
3 these things are being done more broadly, but
4 for vulnerable populations, then there's less
5 out there in terms of instruments which have
6 the tailoring for a lot of the populations
7 we're talking about.

8 CO-CHAIR ANDRULIS: I agree with
9 the importance of medical home. I think I
10 wouldn't want it to be an umbrella piece,
11 because by the nature of the way services are
12 going to be rendered, I mean, medical home is
13 maybe a goal, not the nature of the way
14 services are going to evolve.

15 DR. CHIN: Maybe I misspoke.
16 Maybe the thing is to -- maybe medical home is
17 listed but then specifically going back and
18 then pulling out like the eight different
19 traditional domains that are used. Like if
20 you look at the current NCQA domains for
21 medical home, they've got six to eight or so
22 that are the ones we're talking about.

1 MS. CUELLAR: -- care
2 coordination. I was also thinking about the
3 diversity of particularly systems of
4 leadership and of the actual staff providing
5 the care and also the development and use of
6 community advisory groups that come directly
7 from the population.

8 CO-CHAIR CORA-BRAMBLE: Thank you.
9 Next?

10 MS. WU: I'm just -- she mentioned
11 the community input, the process to get
12 community engagement and input.

13 CO-CHAIR CORA-BRAMBLE: Thanks.
14 For those who already spoke, Francis and
15 Lourdes, just put your name tags down so that
16 I know you're done. Sean?

17 DR. O'BRIEN: Well, I hope I'm not
18 changing focus or derailing, and just let me
19 know if I'm going in a direction that you
20 don't want to go, but I've been just thinking
21 about what are the components that I think
22 need to be in a Call for Measures and that

1 maybe would be discussed.

2 There's some just basic issues of
3 scope, and I don't know if anything requires
4 discussion or not, but it's basically there's
5 lots of groups you could focus on, but it
6 sounds like this group is focusing
7 specifically on race, ethnicity, and low
8 English proficiency, and that's it. Would
9 that go in the Call for Measures? Basically,
10 that's the scope of this particular activity.

11 CO-CHAIR CORA-BRAMBLE: You know,
12 it's a point well taken, because, I mean, as
13 I go around the country speaking about
14 cultural competence, you know, that's one
15 issue that is oftentimes raised. It's like,
16 "Well, what about the physically disabled or
17 challenged, or what about the gay and
18 lesbian?"

19 You know, so I think it's a point
20 of discussion. We may get that pushback from
21 the field once this goes out as to what -- and
22 if it is exclusively focused on language or

1 race or ethnicity, then it needs to be so
2 stated. She says yes.

3 DR. O'BRIEN: Another one is that
4 --

5 CO-CHAIR CORA-BRAMBLE: Before you
6 continue, perhaps it would be helpful to at
7 least, whatever report we submit, that it
8 states that we acknowledge that diversity
9 includes other things beyond race and
10 ethnicity, but the task of this group was
11 focused exclusively in that area. Okay.

12 DR. O'BRIEN: Another big one with
13 NQF, all the measures are required to be
14 suitable for public reporting, and that is
15 something that some measures may or may be
16 less amenable with the public reporting versus
17 internal quality improvement, but if that's a
18 requirement from the NQF, that probably should
19 be highlighted in the Call for Measures,
20 because it probably would make a difference in
21 terms of which measures would be approved or
22 not.

1 DR. BURSTIN: All of our Calls for
2 Measures make it explicit what the purpose of
3 NQF addressed measures are, and it is really
4 broadly accountability, not just public
5 reporting, so pay-for-performance, whatever
6 the case may be.

7 DR. O'BRIEN: And -

8 CO-CHAIR CORA-BRAMBLE: Go ahead.
9 Finish.

10 DR. O'BRIEN: And then some
11 statement about the level, the unit, the level
12 of reporting, and I'm sure that would be in
13 there, too, but are there any so, you know,
14 individual practitioners, community hospitals,
15 plans, national --

16 CO-CHAIR CORA-BRAMBLE: Right, and
17 we touched on that.

18 DR. O'BRIEN: Is it all of the
19 above, including kind of the national
20 population level reporting, as well? That's
21 the kind of thing includes the AHRQ, National
22 Disparities Report. Is there anything you'd

1 like take off the table?

2 DR. BURSTIN: Yes, it's another
3 really good point. We are happy to accept
4 population health level measures, as long as
5 there's a comparison group, so a national
6 would be kind of hard unless you're looking at
7 international.

8 But certainly we've taken it in as
9 part of the Child Health Project, for example,
10 Medicaid state program measures compared to
11 each other, things along those lines, but I
12 think it will be important in the project in
13 particular to elucidate what levels of
14 analysis we're referring to.

15 CO-CHAIR CORA-BRAMBLE: Thank you.
16 Good observations, Sean, good questions. I
17 know you were trying to probe, you know, but
18 it raised some important issues that we needed
19 to clarify. Any other comments? Nicole?

20 MS. MCELVEEN: Okay. Okay. Thank
21 you. We got several recommendations from the
22 group on that, so that was very helpful, and

1 so the next piece that I wanted to touch on,
2 again, we reviewed this a little bit
3 yesterday, and that's NQF's approach moving
4 forward for addressing disparities.

5 Before we kind of dive into that,
6 I wanted to highlight to the group within our
7 measure submission form, which is that thicker
8 document that you all have, where we request
9 information around disparities, and maybe use
10 that as a starting point and see if, you know,
11 the group agrees with that approach. Certainly
12 feel free to provide some additional
13 suggestions.

14 So that's kind of a thick packet,
15 and I'll also pull it up on -- so the pages
16 aren't numbered, but, you know, I'll let you
17 know which pages I'm referring to.

18 So, to provide some background and
19 context, the first kind of two pages really
20 talk about the conditions that must be met for
21 the measure to even be considered by NQF.
22 Again, you know, this is with all of our

1 measures. The measure has to be in the public
2 domain or measure steward agreement has to be
3 signed.

4 Again, as we just mentioned, it
5 has to be intended for both public reporting
6 and quality improvement. The measure does
7 have to be fully specified and tested, and
8 also we do request that the measure developer
9 address harmonization and issues around
10 related measures, related or competing
11 measures.

12 So, moving on, if you go to page
13 four of that packet, that section then focuses
14 on the specifications of the measure, so we
15 get into the meat of the measure, the
16 description, the numerator, denominator.

17 So, on page four, it's Section DE-
18 5. You'll see there's -- and this is just a
19 check box area for them to first identify if
20 they choose to do so that the measure is
21 addressing disparities, as well as some
22 additional cross-cutting areas that are

1 highlighted in that section.

2 Then, moving on to page five, that
3 section 2a1-5, you'll see the target
4 population category. We do also then provide
5 an opportunity for the measure developer to
6 specify whether or not that target population
7 is disparity-sensitive or not.

8 DR. JACOBS: So would the form
9 change for this process, or it would be the
10 standard form that people would use, and you
11 would ask them to check these boxes?

12 MS. MCELVEEN: It would be the
13 standard form.

14 DR. JACOBS: Okay.

15 DR. BURSTIN: But I think part of
16 the bigger picture for us is as we look
17 forward towards updating these forms, which
18 you'd do probably annually, the idea being
19 what else based on our discussions would you
20 ask about disparities to ask the submitters to
21 submit the information you think would be
22 valuable.

1 DR. JACOBS: Okay. Thank you.

2 DR. BURSTIN: We could also do
3 supplemental requests for these specific
4 measures as you need to.

5 MS. MCELVEEN: Moving on through
6 the form, if you all go to page eight -- yes?
7 Sorry. Question? Sorry.

8 DR. O'BRIEN: Well, I mean, we can
9 come back to it. I was just going to ask. I
10 mean, I'm looking at the numerator and
11 denominator as the form is laid out for the
12 specifications. My question is does that
13 work? Does that format work for all the types
14 of measures that may be on the table?

15 For example, if you identify a
16 disparity population and the goal is to
17 basically measure improvement for some
18 particular end point or process in that
19 population, sure, a numerator and denominator
20 works.

21 Are there any measures where the
22 actual focus of the measure is measuring the

1 quantifying disparity, which implies a
2 comparison between two populations? In that
3 case, you have -- you don't just have a simple
4 numerator and denominator anymore, but I don't
5 know to what extent those are the types of
6 measures that will be submitted.

7 DR. BURSTIN: Accept attachments
8 or whatever we need if it doesn't quite fit in
9 the box. We actually even revised the
10 submission form for the recent project we just
11 did on research use measures, because they
12 don't fit this box at all, so if we need to do
13 that, we can do that for this project, as
14 well.

15 CO-CHAIR CORA-BRAMBLE: Any other
16 comments? Francis? Francis first and then
17 Ernest.

18 DR. LU: Yes, this is for --
19 there's no page numbers, but it says, "Subject
20 Topic Areas," and, again, this might be the
21 standard NQF --

22 CO-CHAIR CORA-BRAMBLE: Towards

1 the beginning or the end of the document?

2 DR. LU: This is -- this is the
3 fourth page in.

4 CO-CHAIR CORA-BRAMBLE: Okay.

5 DR. LU: It says, "Subject Topic
6 Areas," and, again, this might be standardized
7 and there's no changing it, but I'm just
8 wondering about having mental health be like
9 mental health/substance abuse to include that.

10 CO-CHAIR CORA-BRAMBLE: We want to
11 make it two different ones.

12 DR. LU: Slash.

13 CO-CHAIR CORA-BRAMBLE: We've got
14 it. Okay. Ernest?

15 DR. MOY: I think this group has
16 created a more formal definition of disparity-
17 sensitive than previously existed, so I was
18 wondering if you wanted to include that
19 definition in the form someplace and also
20 possibly have a check-off box about what
21 qualifies as disparity-sensitive. Is it
22 because it has a much higher prevalence in a

1 particular group --

2 CO-CHAIR CORA-BRAMBLE: Yes, good
3 point. Excellent point.

4 DR. MOY: -- in any group or a
5 particular --

6 CO-CHAIR CORA-BRAMBLE: Very, very
7 good point. Liz? Oh, I'm sorry, then Sean.
8 Go ahead. Go ahead, Liz.

9 DR. JACOBS: Just to follow up on
10 that, disparities means a lot of things to
11 different people, and I notice it just says
12 disparities. For instance, I don't think a
13 lot of people think of language groups as a
14 disparities population. They think, "Oh,
15 black, white, Latino, white," so I think that
16 maybe adding some definition or some more
17 detail around that would be helpful.

18 DR. BURSTIN: There actually are
19 definitions.

20 DR. JACOBS: Oh, there are? Okay.
21 We just don't see it.

22 CO-CHAIR CORA-BRAMBLE: Was it

1 Sean? Okay. Other comments? Excellent
2 suggestions and comments, really. Anyone
3 else? Yes, William, please?

4 DR. MCCAIDE: Looking at that same
5 group of topics or subject areas, some things
6 kind of can't really be broken down in the
7 organ systems, I guess. So, for instance,
8 pain, for instance, is a disparity. It isn't
9 listed as an organ system. It's not there,
10 and that might be something that one might
11 want to look at.

12 CO-CHAIR CORA-BRAMBLE: Excellent
13 point. Yes?

14 DR. OTSUKA: Under subjects I see
15 musculoskeletal. Thank you, but what about
16 children or pediatrics? I don't see them.

17 DR. BURSTIN: It's below it.

18 DR. OTSUKA: Is it?

19 DR. BURSTIN: It allows you to
20 choose by condition, cross-cutting area, and
21 then population, so we can capture both, yes.

22 DR. OTSUKA: All right. Thank

1 you.

2 CO-CHAIR CORA-BRAMBLE: Come on,
3 give us some credit for the musculoskeletal.
4 I mean, come on. We messed up the first time.
5 We got it this time.

6 DR. OTSUKA: Children's important,
7 too.

8 CO-CHAIR CORA-BRAMBLE: Donna?
9 Did you -- okay. All right, so Donna and then
10 Liz.

11 DR. WASHINGTON: Yes, there are
12 some categories on the form that we want to
13 discourage. So, for example, it asks about
14 risk adjustment type, and I wonder if people
15 developing or submitting performance measures
16 might take that to mean that they should risk
17 adjust when, in fact, we would like to
18 discourage that.

19 CO-CHAIR CORA-BRAMBLE: Okay.
20 Liz?

21 DR. JACOBS: Yes, I notice there's
22 a section called "Importance," and it says,

1 "Demonstrate a high-impact aspect of
2 healthcare," and I wonder if we want to say
3 reducing disparities. Oh, I'm sorry. I don't
4 know the page number.

5 CO-CHAIR CORA-BRAMBLE: Towards
6 the beginning, towards the end?

7 DR. JACOBS: One, two, three,
8 four, five, six, seven, eight. It's right
9 after care setting, level of analysis,
10 importance, 1(a)1.

11 CO-CHAIR CORA-BRAMBLE: Okay.

12 DR. JACOBS: I wonder if reducing
13 disparities --

14 CO-CHAIR CORA-BRAMBLE: Oh, the
15 reason, yes.

16 DR. JACOBS: -- or something along
17 those lines.

18 MS. MCELVEEN: That's actually the
19 next section I was going to mention where we
20 talk about disparities, so thank you, Liz.
21 It's a little bit further down under
22 importance.

1 We do ask for a summary of the
2 data on disparities by the population group
3 and also citations to support that, so if
4 there are some more suggestions on how we can
5 capture that information or if you all think
6 that's sufficient, and this is under
7 importance.

8 The other thing I should mention
9 is importance is a threshold criterion. It's
10 important that they demonstrate, you know, the
11 opportunity for quality improvement and really
12 provide the evidence to support that. So this
13 is a section that when these measures come in
14 the group will weigh very heavily on, so we
15 want to make sure we're asking the appropriate
16 questions.

17 CO-CHAIR CORA-BRAMBLE: Go ahead,
18 William.

19 DR. MCCAIDE: I just flipped to the
20 next page. I'm looking at the quantity of
21 studies, the body of evidence. This is 1(c)5,
22 and it asks for total number of studies, not

1 articles, and the question in that regard is
2 since this is still an evolving and relatively
3 new field and disparities are just being
4 identified and different new technologies, is
5 that really a valid sort of question that you
6 still want to put in for this particular
7 analysis of development of metrics?

8 DR. BURSTIN: Most of this form is
9 for our standard, all of the measures that
10 come forward to us, and the Evidence Task
11 Force recently did some work identifying, at
12 least for now, the approaches to look at the
13 quality of the -- too much cold medicine --
14 quality, quantity, and consistency of the
15 evidence, so they'll weigh all three of those.

16 So at times there will be one very
17 good high-quality study but not a whole lot of
18 volume of studies, and that's okay as long as
19 it's consistent. So I don't know that we need
20 to get into the weeds of all the specifics.
21 We would be here for days, as our committees
22 often are, but it's a good point about

1 disparities, and we can --

2 CO-CHAIR CORA-BRAMBLE: I have two
3 that are eager to go, Marshall and Dennis.
4 You all decide.

5 MS. NISHIMI: Just to interject
6 more to Helen's point, too, the Committee will
7 see the submission form that comes in, and
8 they may see only one study, so I think it's
9 a valid thing to ask, because then you will
10 assess the input and decide for yourselves
11 whether that's important, being consistent or
12 not.

13 CO-CHAIR CORA-BRAMBLE: Okay.

14 DR. CHIN: Following up on Bill's
15 point that, you know, you look at something
16 like, well, diabetes measures. There's tons
17 and tons of studies, so it's easy to fill out
18 the form.

19 I think a disparities measurement
20 person looking at this form would say, there's
21 no way in hell I'm going to get it approved.
22 There's going to be a lot of blanks or no

1 evidence.

2 So I'm wondering does there need
3 to be -- well, first, you know, is it an
4 absolute, because if it is, then we're going
5 to get no measures that we're going to be
6 approving, but if there is a lower bar, in a
7 sense, in some ways we have to send that
8 message out that you don't necessarily have
9 to, you know.

10 CO-CHAIR CORA-BRAMBLE: Yes.

11 DR. CHIN: Otherwise, people are
12 going to say you're not ready for primetime.

13 CO-CHAIR ANDRULIS: Yes, I want to
14 build on both these comments, too, that this
15 is an opportunity to push the field a bit. My
16 sense is it's push and refine the field.

17 You know, I think the field could
18 benefit from this level of specificity, seeing
19 it, seeing what is required, but at the same
20 time to exclude or to so limit because
21 literature may not be available or some folks
22 will just throw up their hands, they've got

1 some good ideas.

2 So, whether it be part of this
3 process or in addition to this process, it
4 seems it may be worthwhile for us to consider
5 is there a way to advise NQF in terms of still
6 encouraging some submissions that may not
7 qualify or meet minimum, at least the minimum
8 set of criteria, but will at the same time, be
9 setting a course, you know, as a collective
10 body of information for where the field needs
11 to go. I think that's where you'll get into
12 some of these other areas that have not been
13 touched on.

14 DR. BURSTIN: Remember, this is
15 the Steering Committee that's going to review
16 those measures, so it's you guys. It's not
17 like you're passing this information on to
18 somebody else.

19 It's actually these measures in
20 the next phase come to you, so you'll have a
21 chance to reflect on all this, and maybe that
22 -- we have had discussion about in these sort

1 of emerging measurement areas can we have
2 some discretion, and we can indicate that
3 that's possible.

4 I think the concern has been in
5 some areas that are more clinical, sometimes
6 they may see emerging in terms of quality
7 measurement. There's a whole lot of evidence
8 there. This is really emerging in terms of
9 what the evidence base is, which I think is a
10 little different.

11 CO-CHAIR CORA-BRAMBLE: Francis
12 and then William.

13 DR. LU: Yes, just reiterating
14 what Dennis and Helen just said, I think this
15 touches into that area of the emerging
16 measures, and I think that needs to be kind of
17 highlighted in the up-front call in order to
18 encourage more of these emerging measures. I
19 think this may be a little different than some
20 of the other NQF calls.

21 CO-CHAIR CORA-BRAMBLE: Agreed,
22 yes. William?

1 DR. McCADE: So I don't know
2 whether each one of the Calls for Measures
3 comes with an FAQ, but I know they're very
4 useful for program directors in ACGME to have
5 FAQs about most every statement that we put
6 into a program requirement.

7 So I'm thinking that if there
8 isn't such a vehicle, maybe we should think
9 about doing that so that we enable people who
10 are going to write these things to have
11 additional information and explanation and
12 maybe also to allow us to justify ourselves in
13 the use of certain language that we talked
14 about already such as minority or other sorts
15 of phrases and the types of nature of
16 disparities that we're talking about.

17 CO-CHAIR CORA-BRAMBLE: Okay. Any
18 other comments?

19 MS. MCELVEEN: So, just to quickly
20 recap, it seems like the group is okay with
21 how disparities is mentioned underneath our
22 importance section. Is that right? Okay.

1 DR. JACOBS: I would say, I mean,
2 I don't know how this is going to be written,
3 but it says demonstrate a high impact of
4 healthcare. Shouldn't there be a box on
5 disparities? I mean, am I --

6 DR. BURSTIN: Again, you're only
7 seeing this form. There's actually a lot of
8 underlying definitions that go with it that
9 specifically tie high impact to the National
10 Quality Strategy, of which disparities is
11 front and center.

12 DR. JACOBS: Oh, okay.

13 DR. BURSTIN: So they're
14 automatically in --

15 DR. JACOBS: Okay, thank you.

16 DR. BURSTIN: -- in some ways on
17 impact.

18 DR. JACOBS: Thank you. Thank
19 you. Thank you.

20 CO-CHAIR CORA-BRAMBLE: This
21 actually makes it a bit hard to give you
22 comments when there are so many other layers

1 that we don't see.

2 DR. BURSTIN: I thought we were
3 just going to focus on just the elements
4 regarding the comparison.

5 CO-CHAIR CORA-BRAMBLE: I believe
6 -- that's what I'm saying. We don't want to
7 give you superficial comments, and you all are
8 already in the weeks.

9 DR. JACOBS: I just want to follow
10 up on what Marshall said, because I put my
11 card down, but he said exactly what I wanted
12 to say. Are we going to add some modification
13 of language around the evidence part?

14 DR. BURSTIN: We'll try to write
15 something up, and we'll share it with you.

16 DR. JACOBS: Thank you.

17 MS. MCELVEEN: And, lastly, the
18 third section in which we mention disparities
19 is under scientific acceptability, so let me
20 give you that page. That section starts on
21 page 11, and it's page 14, Section 2c-1, and
22 the scientific acceptability is essentially

1 the section that talks about reliability,
2 validity, and provides a lot of the
3 information around testing for the measure.

4 So you see disparities in care.
5 There's two basic questions, if the measure is
6 stratified for disparities and to provide the
7 results for that, and also if disparities have
8 been reported or identified but the measure is
9 not specified to detect those disparities.

10 So are there any comments first
11 around those two specific questions?

12 DR. JACOBS: What does that mean,
13 2c-2? It's not specified? I mean, if you
14 look and they're there, so I'm a little bit
15 unclear on that.

16 DR. BURSTIN: Will actually come
17 forward to us with strata, for example,
18 saying, "This is the measure. These are the
19 strata you should examine," and not many do,
20 so this is really just a point to them like,
21 "Okay, you haven't said it should be
22 stratified."

1 Early on, I believe there's also a
2 question about evidence. We may have skipped
3 over that. If there's evidence there are
4 known disparities in this area, okay, you said
5 there is known evidence of disparities. You
6 haven't presented a measure with strata.

7 DR. JACOBS: I see. Got it.

8 DR. BURSTIN: We struggle with
9 these questions, and we find we don't get very
10 good answers back, which is why we actually
11 want to get better advice from you guys.

12 Based on the discussion you've had
13 for the last two days, what are the right
14 questions to ask measure developers as they
15 submit measures to us, whether they're the
16 cross-cutting deposition measures or just any
17 measures that you want to be able to get at
18 the issues you guys talked about yesterday?

19 DR. O'BRIEN: Can there be -- can
20 this form be customized for each Steering
21 Committee and each activity, or is it you need
22 to stick with one?

1 DR. BURSTIN: It's possible.
2 We've done it for resource use when the entire
3 thing just didn't fit into this box at all.
4 We could always add an addendum or whatever we
5 need to do or specify, but, yes.

6 The problem is you're just looking
7 at the paper form. It's actually an online
8 submission tool, so it's not as easy to just
9 kind of delete, change, whatever, but we can
10 make it work.

11 MS. NISHIMI: I think the other
12 thing to keep in mind is that some of what's
13 being identified here can also be fit into the
14 call, so it's both a give and take. People
15 see the call, and then they call and say, "Yo,
16 we can't figure out where this fits in your
17 form," and the staff, you know --

18 CO-CHAIR CORA-BRAMBLE: I have two
19 comments, one from William and one from Liz.
20 Who else? Oh, I'm sorry. Donna? Oh, my
21 goodness. Wait a minute. Hold on. Hold on.
22 Let's start with Donna. We'll go all the way

1 around the table. Why don't we do that?

2 Donna?

3 DR. WASHINGTON: Sure, just to
4 raise the risk adjustment issue again, then in
5 this section 2b-4.4, then it asks the
6 submitters to justify lack of adjustment, so
7 it seems as if this section, if the form can't
8 be modified, then some instruction should be
9 included.

10 CO-CHAIR CORA-BRAMBLE: Liz, then
11 Grace. Oh, let me see. Romana, you're next
12 and then Liz.

13 DR. HASNAIN-WYNIA: I'm not sure
14 whether this is a concern, but when I first
15 saw the heading here on scientific
16 acceptability, and I might be wearing my
17 researcher hat right now, but I'm worried that
18 as, you know, as the people who look at this
19 for submitting measures see that section, what
20 I'm wondering is whether we need to have
21 language, because, you know, I saw that, and
22 the first thing that jumps to mind, and maybe

1 it's because it's just because I've been
2 having these conversations, is I think about
3 scientific acceptability.

4 I start thinking about randomized
5 control trials. There aren't very many.
6 There's a lot of pre-post. There are a lot of
7 comparison groups. There's, you know, seeing
8 improvement within the same group.

9 So I don't know whether we need
10 to, you know, again, in terms of our language
11 and what our expectations are in this
12 particular section, because soon as I saw
13 that, I started to think, "Oh, would somebody
14 see this and think, 'We don't fall into that
15 bucket, because'" --

16 DR. BURSTIN: And, just to be
17 clear, it's actually scientific acceptability
18 of the measurement properties. It's not the
19 whole thing.

20 DR. HASNAIN-WYNIA: Right, so
21 maybe we should -- right. No, that's what I
22 mean, though. I'm just talking about kind of

1 what jumped out at me initially, so if that's
2 the kind of intent, then I think we need to
3 make sure that that is right there.

4 CO-CHAIR CORA-BRAMBLE: Liz and
5 then Grace.

6 DR. JACOBS: So, I'm wondering if
7 2c-1 should be present stratified results
8 based on our conversation, and then, instead
9 of if measured to stratify, then say, "If not
10 stratified, justify why." I mean, sometimes
11 people may not stratify, because the groups
12 are too small.

13 CO-CHAIR CORA-BRAMBLE: Good
14 suggestion.

15 DR. JACOBS: So maybe the gold
16 standard should be is it stratified, and then
17 they have to justify why they're not.

18 CO-CHAIR CORA-BRAMBLE: Yes. Good
19 suggestion. William and then, Sean, didn't
20 you have yours up? You changed your mind?
21 Trying to confuse me. William, go ahead.

22 DR. MCCAIDE: I don't understand

1 the actual value of 2c-2, and I would just
2 eliminate it from our particular call just
3 because the measures that we're trying to call
4 for are ones that are specifically designed to
5 detect disparities. Is that not correct?

6 CO-CHAIR CORA-BRAMBLE: Good
7 point. Other comments?

8 MS. TING: This is more of a
9 question, and I may have seen this, but after
10 the NQF reviews all of the 700, and let's say
11 you come up with hopefully just 30 or 40,
12 who's going to be filling out the form for
13 those measures and submitting them?

14 MS. NISHIMI: They've already been
15 endorsed.

16 MS. TING: Oh, okay, I see that.
17 Okay.

18 MS. NISHIMI: You guys know this.
19 They split them up.

20 MS. TING: I'm sorry, more
21 questions. So how is that going to be
22 expressed so that people won't submit

1 duplicate to those? Is that going to be
2 shared when you release the call of, "Here's
3 what we're thinking of already"?

4 MS. NISHIMI: Yes, I think that as
5 part of the call we ask people to review
6 what's already endorsed in NQF's portfolio, so
7 that's sort of SOP, I think, and then staff
8 would understand, which is not to stop someone
9 from --

10 CO-CHAIR CORA-BRAMBLE:
11 Resubmitting.

12 MS. NISHIMI: -- resubmitting, but
13 --

14 MS. TING: But, wait, so like I
15 would not want to go through 700 standards to
16 figure out which ones I should, so if you
17 already now down a list, you can say, "Here
18 are the ones that we" --

19 CO-CHAIR CORA-BRAMBLE: Right,
20 that relate to disparities, right, to make it
21 easier.

22 MS. NISHIMI: I think that, at the

1 end of the day, folks make their decision to
2 submit or not submit based on sort of the face
3 value of the call, because the fact of the
4 matter is we're not going to be able to winnow
5 down the 700 and release that list. First you
6 all have to review that in time for the call
7 to occur.

8 CO-CHAIR CORA-BRAMBLE: Any other
9 comments?

10 MS. FITZGERALD: This is Dawn on
11 the telephone.

12 CO-CHAIR CORA-BRAMBLE: Okay.
13 Sure.

14 MS. FITZGERALD: Actually, I'm a
15 little bit confused on that last statement
16 about the requirements for resubmission of
17 measures. So if I have, let's say, any one of
18 the HEDIS measures, for example, could
19 resubmit for disparity sensitivity. Is then
20 the change in that measure the sense that
21 there would be then required to have
22 stratification of that measure?

1 DR. BURSTIN: No, there would be
2 no requirement to resubmit a measure for
3 disparity sensitivity, although I think it
4 does bring up the question -- I think Ernie
5 raised this yesterday -- of whether we need to
6 actually as part of the submission indicate
7 those criteria we're actually listing out for
8 disparity sensitivity as one consideration.

9 MS. FITZGERALD: I get the sense
10 that if we don't put the parameters around it,
11 everybody would simply resubmit measures.

12 MS. NISHIMI: I mean, I think what
13 the call would indicate is that measures that
14 have already been endorsed are already being
15 reviewed, so it's not that they have to
16 resubmit it. If there is a HEDIS measure that
17 didn't get endorsed and has never been
18 submitted, then, yes, that would have to be
19 submitted.

20 CO-CHAIR CORA-BRAMBLE: Yes.
21 Okay. Other questions, comments?

22 DR. BURSTIN: One more

1 consideration for you. I mean, you guys are
2 all so steeped in disparities. You think
3 about this a lot.

4 Think about measures and, you
5 know, this kind of forum going to the renal
6 committee that's meeting in a couple of weeks
7 at NQF. What would you want to make sure they
8 have that they're going to want to get the
9 information from that will kind of raise some
10 flags for them?

11 Part of the issue is it's not
12 always going to be folks who are pretty
13 steeped in disparities. They'll oftentimes be
14 clinicians, evidence-based medicine folks,
15 statisticians -- no offense, Sean -- who have
16 this sort of bigger picture of the
17 measurements side that may not bring the
18 disparities lens to the table.

19 That's kind of what we were hoping
20 to get, to see if there's something else we
21 should ask here that would be useful. I
22 thought there was a question on evidence base,

1 as well, isn't there?

2 DR. CHIN: What's an example of
3 what you're thinking about?

4 DR. BURSTIN: So the question
5 would be we just had a committee that reviewed
6 all the ESRD measures, so a whole slew of the
7 ESRD measures they reviewed. Some they took.
8 Some they didn't like, but there was not a
9 whole lot of discussion through the course of
10 the Steering Committee that said, "Boy, we
11 know these are areas where there are known
12 disparities. Which of these measures should
13 be stratified?"

14 So part of this is to sort of get
15 into their thinking as they're prospectively
16 reviewing measures. How do they think about
17 the disparities piece?

18 So, you know, we've had minimal
19 questions here to date. They haven't been
20 terribly useful except when a measure is now
21 up for maintenance, where we have been making
22 it very clear you can't resubmit a measure to

1 us for additional endorsement without that
2 stratified data at your three-year point, but
3 particularly for new measures that are coming
4 to us, what would you want the Committee to
5 know about that measure or consider about the
6 populations for whom the measure is important?

7 CO-CHAIR CORA-BRAMBLE: Do you
8 want to respond to that, Sean?

9 DR. O'BRIEN: No, I wasn't
10 responding, and maybe I --

11 CO-CHAIR CORA-BRAMBLE: You had
12 your name tag up.

13 DR. O'BRIEN: I did.

14 CO-CHAIR CORA-BRAMBLE: Okay, go
15 ahead.

16 DR. O'BRIEN: Well, I mean, yes, I
17 really -- I guess I would agree, and my past
18 experience is what you put on the form
19 probably has a lot to do with what you get in
20 the submission, and you can -- I don't know.
21 I would maybe think about taking this form and
22 having somebody take a really go at going

1 through it and coming up with a customized
2 version of it.

3 I mean, there's some that's in
4 there has to be in here, because there's
5 basically previous NQF work that's established
6 a framework, and things need to fit into that
7 framework, but in my experience helping people
8 fill out these forms and actually looking at
9 them as a reviewer is you can make -- you can
10 try to make things fit into an existing form
11 if you have to, but that leads to people who
12 are confused about, "Well, how does this
13 sentence here really fit in this context?"

14 The more you have that's confusing
15 to the people who are submitting the measures,
16 it's not going to do us any good, and so it
17 may seem like too much detail to spend more
18 time on this, but this up-front work of trying
19 to really figure out what needs to be asked
20 and revising this I think would pay off.

21 CO-CHAIR CORA-BRAMBLE: I have
22 Francis and then Romana.

1 DR. LU: Since this area may be
2 quite new to many people, because disparities
3 reduction, you know, is such an emerging
4 concept by itself, and as we've been talking
5 about the last couple of days and as all we
6 know, I'm just wondering, for example could
7 the Harvard-commissioned paper, if that's --

8 At some point within the public
9 domain, could that be linked to this call so
10 that people can kind of read the background
11 about what this is all about and understand
12 where we're coming from and what the
13 priorities are being here, racial, ethnic,
14 minorities, and language?

15 That's kind of the -- I mean, even
16 -- because I think the better -- the more we
17 can specify this in a reasoned way and provide
18 the background rationales and all of this, it
19 will reduce, hopefully -- it will help the
20 submitters, because they'll know more
21 precisely what we're looking for and are
22 thinking, and also it will help us, the

1 reviewers, because we'll have better
2 submissions with more information and someone
3 to help us to figure things out, because
4 otherwise it will be kind of garbage in-
5 garbage out, I'm afraid.

6 CO-CHAIR CORA-BRAMBLE: Romana and
7 then Mary.

8 DR. HASNAIN-WYNIA: Helen, I
9 actually wanted to --

10 CO-CHAIR CORA-BRAMBLE: I mean
11 Donna. I'm sorry.

12 DR. HASNAIN-WYNIA: I wanted to
13 ask you about kind of so you used the end
14 state renal disease folks as the example. So
15 basically what I'm trying to understand is
16 what are, you know, what are they going to
17 get?

18 Let's just take that example
19 through. So will that Committee, for example,
20 provide measures for us? I'm trying to
21 understand where in the process we are trying
22 to inform them, because that is very hazy to

1 me.

2 DR. BURSTIN: Okay. That's good.
3 I think I'm just too inside a baseball.

4 DR. CHIN: As opposed to having
5 people like us on that Committee or people
6 like them on this Committee.

7 DR. BURSTIN: Right, exactly, and
8 they are a blend of all of you, and we
9 actually do try to make sure there's
10 disparities expertise around the table. I
11 think the idea would be that it wouldn't come
12 back to you, per se.

13 The idea would be what do you want
14 every single committee at NQF to look at,
15 regardless of the topic area, whether it's
16 cross-cutting care coordination, whether it's
17 ESRD or heart disease or palliative care or
18 prenatal care in the coming year. What do you
19 want every single one of those committees as
20 they're reviewing these measures to think
21 about, to want to know from the measure
22 developers about is there evidence of

1 disparities in this given area, you know,
2 provide stratified data?

3 It's just really kind of high-
4 level thinking that you want to make sure they
5 all at least go through that process. As much
6 as they look at reliability, they look at
7 validity.

8 Again, it's the point we tried to
9 make with the NHQR and the DR, that we put the
10 same quality measures on the DR intentionally
11 to make the case that we weren't marginalizing
12 disparities. I think the question is how do
13 you make it front and center in what they're
14 doing in a way that makes sense.

15 DR. HASNAIN-WYNIA: So, can I
16 follow up?

17 CO-CHAIR CORA-BRAMBLE: Follow up,
18 and then we have Mary and then Donna.

19 DR. HASNAIN-WYNIA: Okay, so the -
20 - so I guess my question then is is this the
21 document, what those committees are? The
22 document that they get is this one.

1 DR. BURSTIN: Yes, is this form,
2 and they evaluate the measures based on this
3 form and our criteria.

4 DR. HASNAIN-WYNIA: Okay, so I
5 like the idea of attaching the report, but
6 that, you know, is a 100-plus page report.

7 CO-CHAIR CORA-BRAMBLE: Maybe the
8 Executive Summary.

9 DR. HASNAIN-WYNIA: The Executive
10 Summary might, but I also think how we frame
11 this up front is going to be -- is really
12 going to drive that, I mean, really setting
13 that stage in that up front, you know, the
14 front end piece of this document. So we are -
15 - I think you said we are going to all get a
16 chance to review that and comment on that,
17 right?

18 CO-CHAIR CORA-BRAMBLE: I do
19 believe.

20 DR. HASNAIN-WYNIA: Okay.

21 CO-CHAIR CORA-BRAMBLE: So, Mary,
22 Donna, then Liz.

1 DR. MARYLAND: So part of the
2 answer, I think, in relationship to ESRD and
3 any other disease process is the question, "Is
4 there a differential that should be considered
5 that may be attributed to race, ethnicity, et
6 cetera?"

7 So, when you look at ESRD, is
8 there something in this packet that says,
9 "Have we considered whether the person should
10 be a transplant candidate? Yes/No. Have we
11 considered whether or not they have a
12 satisfactory English proficiency to be a
13 satisfactory candidate for transplant?
14 Yes/No."

15 So what is it that guides us to
16 believe that no matter the area, we have asked
17 that critical question that there has not been
18 automatic reflects of exclusion based on race-
19 ethnicity.

20 CO-CHAIR CORA-BRAMBLE: Okay, so
21 Donna, Liz, Ernest, and Colette.

22 DR. WASHINGTON: So, along those

1 lines, to address Helen's question on the
2 importance, the demonstrated high-impact
3 aspect of healthcare, maybe that's a place to
4 specifically clarify that it could affect
5 large numbers of minorities.

6 So, for example, if you had a very
7 small, numerically small minority population
8 that was disproportionately affected by a
9 certain condition that did not affect the
10 overall population, that may not necessarily
11 qualify the way the form is currently written.

12 CO-CHAIR CORA-BRAMBLE: Liz?

13 DR. JACOBS: My comment is really
14 brief. Following up on what Romana said about
15 the Executive Summary, I actually found the
16 Executive Summary -- I didn't understand it
17 until I read the report, so it would just have
18 to be a little bit more fleshed out, actually.
19 I think it would be extremely useful. It just
20 needs a little work, and we can give them
21 feedback on that if that would be helpful.

22 DR. MOY: Okay. It seems to me

1 that this is actually a moderate change in the
2 NQF processes to introduce this new
3 disparities concept, and I think I'm concerned
4 that the way disparities are currently spread
5 out all across the form it's not going to get
6 a lot of focus.

7 If you're -- if this is important
8 enough that you're going to give them this
9 Executive Summary for a new review methodology
10 that you might want to pull the disparities
11 piece out as a separate section that someone
12 is going to formally review it for
13 consideration for disparities.

14 CO-CHAIR ANDRULIS: Colette?

15 DR. EDWARDS: I guess my question
16 is do we feel as if this area is important
17 enough that -- I don't know what the language
18 would be that would be used, but if it
19 actually fell into the NQF conditions section
20 that sends the message loud and clear of the
21 importance of that and it goes across the
22 board for the committees who are reviewing

1 measures and for the people filling out the
2 form that you have to have thought about this
3 before you do any type of submission. It may
4 be that whatever you're submitting may or may
5 not have something that's disparities-related,
6 but you have to have done some analysis to
7 answer that question.

8 CO-CHAIR CORA-BRAMBLE: Luther?

9 DR. CLARK: I actually have a
10 question. Maybe it's for the group, but it's
11 in response to Helen's question in terms of
12 what would we like to be present in all of
13 these documents or on these metrics.

14 My question, can anyone think of a
15 surrogate marker for a disparity that would
16 allow you to detect it, you know, a measure of
17 all the things that we're doing that if you
18 see it there, then this is a marker that there
19 is a disparity?

20 It's a pretty complicated field
21 with a lot of different parts, but if there
22 was some signal or clue that it's there that

1 we could measure easily, then that would be
2 very, very helpful. I don't know. We have a
3 lot of thinkers around the table, so it's just
4 something you've thought about.

5 CO-CHAIR CORA-BRAMBLE: It's
6 notable that I don't see a whole lot of cards
7 going up. Your question just -- there was
8 just not -- there you go. Sean.

9 DR. O'BRIEN: No, I'm not giving
10 the answer, just a follow-up question. Do we
11 have a definition of disparity that we're
12 using?

13 CO-CHAIR CORA-BRAMBLE: I assume
14 that we do.

15 CO-CHAIR ANDRULIS: IOM.

16 DR. O'BRIEN: So IOM has that part
17 in it that are not related to access. I mean,
18 one of the things it excludes is access-
19 related factors. Is that really consistent
20 with what everyone here is thinking?

21 CO-CHAIR CORA-BRAMBLE: Oh, I see
22 what you're saying. Liz? Oh, Liz and then

1 Mary. Go ahead.

2 DR. JACOBS: I actually noted
3 that, too, the access, and I was wondering why
4 that was, because maybe everyone has access to
5 healthcare, but there are other forms of
6 access within the healthcare system, so I'm
7 wondering if we want to think about how we
8 want to define that.

9 CO-CHAIR CORA-BRAMBLE: That's a
10 good point. Mary, and then I want to see if
11 anybody has an answer for Luther.

12 DR. MARYLAND: And so I'm going to
13 take a stab at it. Is it that the answer is
14 always retrospective and in the unequal
15 outcome?

16 CO-CHAIR CORA-BRAMBLE: He's not
17 moved.

18 DR. CLARK: I think that would be
19 in retrospect, so I think that, you know,
20 something that would allow us to detect it
21 prospectively, because once it's there, I
22 think that this group will be clear that it's

1 there, but it's a thought. It may not exist,
2 but if it did, it could simplify a lot of what
3 we're trying to do.

4 CO-CHAIR CORA-BRAMBLE: I agree.
5 If it did exist, it would simplify. Romana?

6 DR. HASNAIN-WYNIA: I'm sorry. I
7 just don't understand the question. Maybe I'm
8 --

9 CO-CHAIR CORA-BRAMBLE: Is there a
10 hemoglobin Alc for diabetes? Is there
11 something comparable, if I understand you
12 correctly? It's oversimplistic, but that's
13 sort of the gist of it. Is there a marker?

14 DR. JACOBS: Mortality, but that
15 you can't measure, I mean.

16 CO-CHAIR CORA-BRAMBLE: Right. I
17 mean, it's -- we have a lot of thinkers around
18 this table, and I don't see -- as I said, it's
19 --

20 DR. HASNAIN-WYNIA: I definitely
21 don't think there is one, just because, I
22 mean, I think one of the conversations that

1 we're having shows, I mean, is evident of that
2 and also the fact that it's so multi-
3 factorial.

4 CO-CHAIR CORA-BRAMBLE: Correct.

5 DR. HASNAIN-WYNIA: You know, the
6 underlying causes of disparities are so multi-
7 factorial.

8 CO-CHAIR CORA-BRAMBLE: Agreed.

9 Agreed. Any other comments?

10 DR. CHIN: It took me a while to
11 sort of put this thing in my head, but now I
12 see why Helen keeps on getting -- she's been
13 subtly bringing this up across the meeting
14 about this point about how can we influence
15 the other committees.

16 So I wonder if we can spend a
17 little bit more time talking about it. Maybe
18 give a little more context, Helen, in terms of
19 our brainstorming, because this is actually
20 probably as important if not more than what
21 we're doing in terms of how it's going to
22 actually disseminate across, I guess, the

1 overall measures.

2 DR. BURSTIN: Right, so maybe I'll
3 give an example which actually might help. So
4 cardiovascular disease, a long history of
5 known disparities.

6 God knows half of us in the room
7 have written about the disparities in
8 cardiovascular disease, I think, and yet, you
9 know, these measures all come to the
10 Committee. They reviewed 65 measures, all the
11 current cardiovascular measures in inpatient,
12 outpatient, nursing homes, everywhere all
13 together in one bucket.

14 You know, if you look at what
15 comes in, nothing was really heavily
16 stratified, or there wasn't a strong
17 orientation to disparities, and it really came
18 down to the Chair of the Committee, Ray
19 Gibbons, who is the Chair of cardiology at
20 Mayo, who just said, "Stop. Half these forms
21 that are measures that have been endorsed for
22 three years have no data on disparities.

1 Disparities is a well known area in
2 cardiovascular disease. I will not review
3 these measures until somebody gets me some
4 stratified data."

5 I'm like in the back of the room,
6 and, you know, the question is how do we kind
7 of put it front and center? Really, I think
8 Ernie is absolutely right. If this is a sea
9 change and we are trying to make people think
10 about this for all measures prospectively
11 going forward, what do you want them to think
12 about?

13 What do you want to make sure they
14 put front and center as they review any
15 quality measure as it relates to disparity
16 populations so that you can -- and I think the
17 point here would be if these measures didn't
18 get picked up by CMS or others, as they
19 frequently do for all these various
20 accountability functions, do we ultimately
21 start pushing to making sure that they're
22 stratified, that that stratified information

1 becomes part of that public reporting?

2 I just -- I think it's a path
3 towards, I think, where many of us would like
4 to go, and I just want to -- I'm trying to
5 think about what steps we take on our end to
6 help push that.

7 CO-CHAIR CORA-BRAMBLE: So Norman.

8 DR. OTSUKA: I mean, briefly, if I
9 could provide you with the model of the
10 American Academy of Orthopedic Surgeons,
11 various committees have business plans where
12 they ask the Board for money, but all those
13 plans have to go through our Diversity
14 Advisory Board, and they have a checklist of
15 three questions.

16 Is there an effect on diversity or
17 healthcare? I mean, does it involve
18 healthcare disparities, and if it does, how
19 does it? If it doesn't, no.

20 So my point to you is all of our
21 business plans go through our committee, so
22 maybe sort of a form or a way to sort of

1 review all these measures, and I don't know
2 how many measures go through the NQF, but
3 there's probably a few dozen, three dozen
4 business plans that go through the American
5 Academy that our committee reviews, so just a
6 thought, just a different model.

7 CO-CHAIR CORA-BRAMBLE: Thank you.
8 Edward?

9 DR. HAVRANEK: I was just going to
10 say, just to echo what you've already said,
11 which is that when other disease-specific
12 groups look at measures that they have -- that
13 they are requiring themselves that they look
14 at data on whether or not disparities exist,
15 that would be the one thing.

16 The second thing that I would add
17 is, and this is a theme that has come up again
18 and again, is will this measure have a
19 disproportionate effect on institutions that
20 disproportionately care for disparity
21 populations?

22 So, you know, I think that that is

1 -- that there are frequently unintended
2 consequences on disparities via effects on
3 disparity serving -- institutions that serve
4 disparate populations or populations with
5 disparities. So those are the two questions,
6 or that would be the two hurdles I would ask
7 them to jump over.

8 CO-CHAIR CORA-BRAMBLE: William
9 and the Mary.

10 DR. MCCAIDE: I was actually
11 thinking that's where Norm was headed when he
12 was getting ready to speak, before he spoke.
13 I only add to Edward's comment that not just
14 institutions but providers of information of
15 all types who would be adversely impacted by
16 this particular standard when you're invoking
17 a new metric.

18 CO-CHAIR CORA-BRAMBLE: Mary then
19 Marshall then Liz. I got it down now.

20 DR. MARYLAND: One consideration
21 is to make it a non-optional opt-out, rather
22 an opt-in, so that could solve the problem and

1 very stringent criteria to meet in opting out.

2 CO-CHAIR CORA-BRAMBLE: Marshall
3 then Liz.

4 DR. CHIN: Some of this is
5 brainstorming, but, I mean, just bringing
6 together some of the things people have
7 already said, so if there is a separate
8 section called disparities, maybe just a
9 preamble, you know, disparities, equity is a
10 critical component of all the quality efforts.
11 Do your -- the stratification of the measures,
12 the existing measures.

13 This is also an issue in terms of
14 the documentation, but then there is also
15 thinking about are there measures which help
16 you elucidate mechanism, I guess, and so
17 potentially asking about, "Well, do you have
18 measures that -- I think most of them will be
19 measures that document disparities, per se, in
20 terms of the process or the outcome, but
21 something about which of your measures help us
22 understand the underlying causes of the

1 disparities or somehow sort of getting at that
2 angle. That's a little bit different here.

3 CO-CHAIR CORA-BRAMBLE: Okay. Liz
4 and then --

5 DR. JACOBS: Yes, so to follow up
6 on this conversation that Helen and Edward are
7 having, I think it depends on how we're
8 talking about using these measures, because,
9 again, we talked about how should these
10 measures be used if we're actually going to
11 use them to actually provide more resources to
12 people to see if they can reduce disparities.

13 It's not penalizing them. It's
14 actually identifying the problem that we're
15 going to help solve, so I think it all also
16 lies in --

17 Following up on what Marshall
18 said, I mean, it's good to see can we look at
19 what are some of the root causes, but also is
20 there a way to actually, you know, not see
21 this as penalizing people or punitive --
22 excuse me. That's the word I'm looking for.

1 CO-CHAIR CORA-BRAMBLE: Romana?

2 DR. HASNAIN-WYNIA: So, Marshall,
3 are you basically saying that we should really
4 focus on asking for not just the documentation
5 of, you know, there's a disparity in this
6 process measure or disparities in this outcome
7 but asking for kind of what the underlying,
8 potential underlying cause of the disparity,
9 the reason for the disparity, not just the
10 documentation of the disparity?

11 DR. CHIN: No, I misspoke. It's
12 probably mostly like a process measure that
13 helps you understand etiology. So a sample
14 like -- this is not a good example, but like
15 just a care coordination process measure that
16 helps understand why follow-up is poor at ESRD
17 listed or something like that, so trying to
18 get them to think beyond the usual suspects in
19 terms of the measures.

20 Again, this is all sort of -- I
21 can't articulate it well, but I think it just
22 gets at a different angle than probably like

1 most of the measures that are already there.

2 CO-CHAIR CORA-BRAMBLE: Liz, did
3 you still have something to say? No? Okay.
4 Anyone else, any other comments? Marcella?

5 DR. NUNEZ-SMITH: Oh, okay, so I
6 just had one follow-up to -- Sean and Liz were
7 both talking about the IOM definition, so we
8 might just need language around specifying
9 when we talk about access, it's sort of, you
10 know, the IOM I think is referring sort of
11 access to a healthcare system, and maybe we're
12 thinking about access within the healthcare
13 system around some of the measures or the
14 stats such as language access.

15 So it's probably important,
16 because I think there are many people who
17 might see if we're using the IOM definition
18 and automatically, again, step away, and so
19 just maybe a proposition definition to say
20 access within healthcare and give an example
21 might be helpful.

22 CO-CHAIR CORA-BRAMBLE: Okay. I

1 think that was a point well taken in terms of
2 the access part of the IOM definition.

3 Nicole, next steps?

4 MS. MCELVEEN: Yes.

5 CO-CHAIR CORA-BRAMBLE: She didn't
6 think we could do it, by the way. Let the
7 record show.

8 MS. MCELVEEN: I had confidence.
9 I thought we would go until 2:00. I thought
10 we would go until 2:00, though, but it's
11 12:05, so kudos to the group and our Co-Chair
12 here.

13 Yes, so we are on next steps. So
14 there are several documents, as you can
15 imagine, that we are going to pass by the
16 Committee, so I wanted to first review that,
17 and these specific pieces we will be
18 circulating to you in the very near future.

19 First is the summary of the
20 meeting, so minutes from our meeting here.
21 The NQF staff will produce a document that
22 describes the protocol that the Committee has

1 suggested we use for reviewing the 700-plus
2 measures in our current portfolio.

3 We will also provide a document
4 that has some conclusions and recommendations
5 around the methodological issues. There were
6 several recommendations the Committee made
7 around that, suggestions around changing terms
8 and some word smithing, so that will be a
9 document we will send you.

10 The draft Call for Measures, you
11 will receive that, as well as our approach for
12 how we're handling disparities moving forward.
13 There is some thinking that we have to do on
14 our side in terms of the changes that we'll be
15 able to make to the form for our current Call
16 for Measures that will happen pretty soon,
17 versus changes that may be a little bit longer
18 term moving forward. So we will discuss that
19 a little bit internally but certainly bring
20 that back to the group for review.

21 So, just to recap for the time
22 line purposes, the next time we meet in person

1 as a group will be when we review measures for
2 consideration. Between now and that time,
3 there will be a few conference calls that will
4 obviously take place. We certainly want to
5 get your review on several of these documents,
6 and we'll assess if it's needed, maybe, to
7 have a conference call to discuss any topics
8 in particular.

9 One thing that did come out that
10 might be helpful for the group is including a
11 very brief webinar, maybe 30 minutes to an
12 hour, around the work that's happening with
13 MAP and the National Priorities Partnership,
14 and MAP is the Measure Applications
15 Partnership.

16 I know there's definitely a lot of
17 crossover between their work and what we're
18 doing here, so I thought maybe a short webinar
19 to capture where those goals and efforts align
20 and overlap might be helpful as a contextual
21 information for the group.

22 I will, obviously, be in contact,

1 as well as the other staff will be in contact
2 with the group for setting up the additional
3 conference calls that may follow. Anything
4 else?

5 Oh, and with reviewing the
6 documents, I did want to mention that I know
7 you guys are very busy, but I just wanted to
8 emphasize the importance of reviewing these
9 documents. All of our materials and our work
10 is public.

11 So we definitely want to make sure
12 that we are really capturing the Committee's
13 intent, what you have mentioned, so it is
14 important that you review these documents and
15 really make sure that we're on the right path,
16 because it will be public, and we will get
17 comments, good and bad comment, but, you know,
18 I just want to emphasize that to the group.

19 Finally, I want to thank our Co-
20 Chairs, Denice and Dennis, who have steered us
21 on the past few days to accomplish our goals
22 and to end early, which is always a plus, so

1 thank you to the Co-Chairs, and if there are
2 any additional questions -- sure.

3 DR. JACOBS: I just have one last
4 question. I'm curious as to who submits these
5 measures. Who does it, and what are their
6 motivations? I'm just curious.

7 DR. BURSTIN: It's pretty
8 complicated. We're masochists. It's a very
9 complicated process. We tend to -- there are
10 a large set of large measure developers, the
11 Joint Commissions, NCQAs of the world, CMSs,
12 contractors, but then you'd be surprised.

13 There's a lot of leading health
14 systems, for example, Minnesota Community
15 Measurement, Health Partners. Partners
16 increasingly in Boston are submitting
17 measures, so that's why I think we don't
18 realizes you may have measures that you've
19 been using in your internal systems, which is
20 actually some pretty good data that oftentimes
21 those are great ones to submit.

22 They don't have to come out of the

1 AHRQ. Sorry, didn't mean to leave off ARHQ,
2 of course not. You know, again, the points
3 both Luther and Norman raised about specialty
4 societies are also very involved in submitting
5 measures to us.

6 DR. JACOBS: Can we propose
7 measures as members of the Committee?

8 DR. BURSTIN: You can. You'd have
9 to recuse yourself from that review,
10 obviously, but, yes, you can.

11 MS. MCELVEEN: No, but that also
12 brings up an important point that if you are
13 aware of measures that are out there or
14 developers who are working on measures,
15 certainly mention to them, obviously, this
16 work, or feel free to provide us with that
17 information so that we can follow up
18 accordingly.

19 Yes?

20 DR. MARYLAND: And I believe
21 you've had many requests for contact
22 information, so that will be coming?

1 MS. MCELVEEN: Yes, thank you for
2 reminding me. There was a request made to
3 circulate contact information to the group, so
4 if folks are comfortable with that, we can
5 circulate that information. Okay.

6 CO-CHAIR CORA-BRAMBLE: And I
7 really would like to see the work that you
8 talked about earlier about the --

9 DR. JACOBS: I sent it to you, the
10 language barriers. Yes, Carliner, did you get
11 it? I don't think it went to the whole
12 Committee for some reason.

13 CO-CHAIR CORA-BRAMBLE: Okay. All
14 right.

15 DR. JACOBS: So you did get it?

16 CO-CHAIR CORA-BRAMBLE: If
17 somebody could forward it to me, that would be
18 great.

19 DR. JACOBS: Okay.

20 CO-CHAIR CORA-BRAMBLE: Thank you.

21 MS. MCELVEEN: You do have -- the
22 travel expense form I think was recirculated

1 to the group, so you have that, and, finally,
2 lunch is available out in the hall, so feel
3 free to grab and go or stay and chat.

4 CO-CHAIR CORA-BRAMBLE: Okay,
5 thanks to all.

6 MS. MCELVEEN: Thank you, guys.

7 CO-CHAIR CORA-BRAMBLE: Thank you
8 very much.

9 (Whereupon, the foregoing matter
10 was adjourned at 12:10 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript


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Before: NQF

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Place: Washington, DC

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