National Quality Forum

Moderator: Nicole McElveen
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10:00 a.m. ET

Operator: Welcome to the conference. Please note, today's call is being recorded. Please stand by.

Nicole McElveen: Good morning, everyone. This is Nicole McElveen from NQF. Thank you for joining us on our Health Care Disparities Conference Call today. This is our post comment conference call. So, the purpose of the call today is to review some of the comments we received on our draft report focused on the Disparities-Sensitive Measures Assessment and also to get some feedback from the committee on how to respond to some of those comments that we received.

For those of you who are joining us on the webinar, we aren't displaying anything new. I thought it would be easy to just display the memo and then the Excel file as needed as we go through to discuss several of the comments. So, if you're on the webinar, great. But you can just as easily follow along using the materials that were sent out to you on Friday.

So, our comment period, to give you a quick overview, we received about 44 comments which we were very pleased with. Again, the distribution of the comments, we got one comment from the public and then 10 of our member organizations provided comments as well. And the memo outlines the number of comments that came from the different stakeholder groups. So, for example, we got 10 comments from health professionals. The health plan was another group that commented quite a bit and several comments from consumers as well.

So, the three specific comments that we wanted to bring to the group today was first, around defining "healthcare disparities" and we'll take that issue up first. The second, we got some comments around the statistical validity that's used when selecting specifically around the criteria of prevalence, which is part of our criteria. And also, looking at the lack of standardization for data collection of race and ethnicity. There was a comment around that.

So, those are the three main ones we're going to discuss on the call today. If there are any additional comments that any committee members have reviewed or looked through and feel that you want to discuss with the group, certainly feel free to bring that up at the end. We should have time to assess any additional comments that we see fit.

So, let's jump right in. And, Kevin, I know that you're on the line. So, I will kind of (veer) to you provide some context for this. But this was a discussion that the committee has had for quite a while around defining "healthcare disparities" and earlier on in the project when we were beginning to launch our quality measures, this came out.

At that time, we decided to go with the more generic definition which you can see on your screen. It's just very simple data. NQF defines disparity as a condition or fact that brings unequal as in age, rank or degree. And so, using that at the time, we never had a chance to really come back to this issue – excuse me – and specifically find that definition that the group agreed upon that would really reflect what we were trying to do with our work.

And Kevin very nicely laid out, you know, the IOM definition and what some of the issues with that current definition are as well as the suggestions for a revised definition. And all of that I've tried to summarize in this memo at the starting point to begin the conversation as well as some suggestions at the end.

So, Kevin, if you want to provide any kind of intro comment, I know you've given us a lot of information already but before the committee starts, I just want to give you a chance to say anything.

Kevin: Yes. I think – a couple of points. First, I think having a clear definition is absolutely critical to our task as well as future rounds of measures. I think it

also may be critical to the field in general because there is not a good definition out there.

I think two limitations, both in terms of the IOM definition and in terms of the definition that was just highlighted on the screen, is that it focuses only on racial and ethnic differences and not other factors related to social (disadvantage) – that's the main issue. And the second issue is it doesn't indicate the impact that the effect or difference may adversely affect them.

So, I'd sent out an earlier definition and got some comments back. Actually, I was hoping to spark alternative definition – that's really what I was trying to do. And as a result of those comments, I've submitted actually a simpler definition which states the differences in healthcare quality adversely affecting members of racial and ethnic minority groups and other socially disadvantaged populations.

So, I'm hoping that that addresses some of the comments from my fellow committee members in response to the earlier definition but tries to capture the broader context of healthcare disparities including the potential for adverse – that's linked to adverse effects, not simply a difference which could be favorable or adverse, particularly with related to overuse.

Elizabeth Jacobs: This is Liz. I have a quick question for Nicole and the draft folks and that is – I mean, I like the idea of changing the definition that Kevin has talked about, but I think I'm a little bit – like I'm a little bit kind of going confused as to how this definition will be used by the individuals that look at this report. Or what is the intent of providing this definition, so that when people go out and use these quality measures, we're defining for them what they should look at? Is that the intent? That would really help me really think about this.

Nicole McElveen: Now, I think that the intent is to have a clear definition so as folks are reading not only this report but also our measures report, so they have an understanding of what definition the committee had in mind, as you were going through this process. And what is, I think, more – as Kevin said, it helps, I think, explain our work a little bit better, so we're not – yes, our report

was focused at this time on racial and ethnic disparities, but we recognize that disparities exist beyond that.

So, a definition that is – finally to fit our current work but that also is something that people can use in the future going forward.

Robyn, I don't know if you had any inputs to add to that?

Robyn Nishimi: No.

Nicole McElveen: OK. Thank you.

Female: I (didn't get) Kevin's definition.

Nicole McElveen: (So how do you)…

Female: Can you say that again? I missed that.

Nicole McElveen: Yes, on the screen – so essentially, Kevin put forward two definitions. There was, as he said, one that he put forward earlier. And what we did at NQF was we used that original, kind of generic definition, combining it with his suggestion so it would read that "NQF defines disparity as a condition or fact as being unequal (as in) in age, rank or degree specifically healthcare disparities that are (inaudible) possibly unavoidable and adversely affect socially disadvantaged groups."

So, that was the definition we were putting forward. Kevin then came back and based from the comments from the group, he revised it. So, we have a second one and it says, "differences in healthcare quality adversely affecting members or racial and ethnic minority groups and other socially disadvantaged population."

And you'll see both of those on the screen displayed. So, you know, it's up to the group in the sense of if you – which definition you like and if you have any further suggestions for making changes or…

Collette Edwards: This is Collette and I would prefer the second definition but I would want to extend it a little so it's "differences in healthcare quality access and/or outcomes."

Kevin Fiscella: I actually like that because I think some people – whereas I defined the healthcare quality to include access, some people don't. And I think that makes it explicit that access is included there. That makes good sense.

Marshall Chin: This is Marshall. But, you know, the NQF definition is much more (rough) and hard to understand. For example, "possibly unavoidable" – I don't know what that means. I like Kevin's edition. I would also suggest (firstly) deleting the word "socially" because there are going to be other (off the list) disparities, where it might not (necessarily) in the socially disadvantaged – gender (disparities) for examples. A little broader term.

Mara Youdelman: This is Mara and that sort of was my question, too, if what groups would be included in "socially disadvantaged." So if this is, you know, a definition that is also going to be going forward, would it include immigrants, limited English proficiency individuals, you know, gender disparities – LGBT disparities, sexual orientation, gender, identity disparities – are all of those encompassed in that term?

And either, if taking off "socially" takes care of it, that's great. But we might want to note or something that just explains what we mean by "disadvantaged population" if we want to be that comprehensive.

Jerry Johnson: This is Jerry. I like – Jerry Johnson – I like including the word "social" because it kind of speaks to the heart of social justice. So I would want to leave that in. And referring to "socially disadvantaged," I don't know that we need to try to define now every example of what "social disadvantaged" means. I don't think we could come up with an all-encompassing explanation what would serve all those purposes. And there is an understanding of what – a sufficient understanding of what "social disadvantaged" means so that there would be some leeway there.

Marshall Chin: (I just want to make a suggestion), just like there (inaudible) healthcare quality sort of adding "access and outcomes" because some people want some

(inaudible) quality. I think it's the same (inaudible) with "socially disadvantaged." For example, will it be a (fair) number of people that think that something like gender or age or LGBT doesn't fit socially.

And I would think that, you know, some people would say yes, some people will say – but (I think of that) it can be both socially, I think people are thinking about more like issues of socio-economic status we hear socially, but it does have a danger of being, in some people's minds, not inclusive.

Lourdes Cuellar: This is Lourdes Cuellar. I'm in favor of leaving it in because that one comment from the American Psychiatric Association, I think that also encompasses the whole aspect of mental health as well.

Robyn Nishimi: This is Robyn. I just want to speak to the issue of – what Jerry mentioned – which is trying to lay out every single possibility. If one takes that approach, I do think that it has the potential to be somewhat limiting because should NQF go forward and decide that X constitutes social disadvantage and it wasn't in the list, people could push back on it and say, "Well, it wasn't in your list."

Whereas if it's undefined, theoretically going forward, then NQF would be free to say, "Well, of course, you know, it's included in that. You know, we left it open-ended to –
precisely to address the situation." That's just sort of a view from the NQF side of the table.

Collette Edwards: Does it help – this is Collette again – if – does it help – and I don't want to keep expanding and expanding – but does it help address some of the issues if we have "socially and/or economically disadvantages populations"?

Kevin Fiscella: This is Kevin. I want to say, I, you know, I implicitly adopted Paula Braveman and (Knowles') definition which they used in the American Journal of Public Health article. And they defined "social disadvantage" as unfavorable socio-economic and political conditions of some groups of people systematically experience based on their relative position and social hierarchies.

And I think that's broad enough to include factors such as LGBT, mental health, other disabilities, even gender. So I think it actually is broad enough to included a lot of the different groups that we're talking about.

Grace Ting: Right, so – this is Grace Ting – so if we're doing that then I just want to make sure that we reference it and say that that's sort of the source and then that way we can always claim back without having to make our definition here so long.

Male: I think it's…

Female: Yes, actually that's a good idea because also, some people raise the issue of how people are going to know what "plausibly" means and what "disadvantaged" mean and if you give people a reference, they can go to it. You don't have to include it in the report because you can go like, "I'm not exactly sure what they're talking about but here, let's go to the article."

Grace Ting: Right.

Female: Manuscript.

Grace Ting: I (want) reference citing or saying that this came from that.

Kerry Johnson: I think that definition of what "social disadvantaged" means is fine with me. I mean, I would favor doing that. It's about as clear as one can get without writing a whole essay on the topic and it is what persons will find if they go to the reference.

Nicole McElveen: So are we saying that we're going with the first definition or the second definition.

Female: Oh, we haven't decided yet.

Robyn Nishimi: Well, let me – this is Robyn – let me – what I've heard overall that needs to happen in (inaudible) is that "differences in healthcare quality access and outcome." There wasn't anyone who spoke against that. And "affecting members of racial and ethnic minority (groups and other socially disadvantaged population)." That second's slightly amended. And then

referencing the Braveman article as its source. That seems to be where folks (inaudible). Is anyone opposed to that approach?

Female: Robyn, can you repeat that?

Robyn Nishimi: So…

Female: (It's still) on the webinar.

Robyn Nishimi: Part one, if you want to look at it…

Female: Someone's modified it.

Nicole McElveen: It's on – I'm not (finding) it as we talk about it – this is Nicole.

Robyn Nishimi: So, number one, we will reference the article. The definition gets modified to be "differences in healthcare quality, access and outcome adversely affecting members of racial and ethnic minority groups and other socially disadvantaged population."

Denice Cora-Bramble: This is Denice. I'm in agreement with that definition.

Marshall Chin: I'd like to have a full definition from the Braveman article.

Robyn Nishimi: I didn't catch that.

Marshall Chin: We're going to reference Braveman's article that's why…

Robyn Nishimi: Yes.

Marshall Chin: …you know, if someone has the full definition so we can claim off on it.

Robyn Nishimi: We will reference the Braveman article.

Male: And for one thing…

Female: Can you just read it out now?

Robyn Nishimi: I don't have it in front of me. Kevin, do you have it?

Marshall Chin: I'd like to hear what the full definition is for the Braveman article.

Kevin Fiscella: Of "social disadvantaged"? I can read it.

Marshall Chin: Yes, that would be great.

Kevin Fiscella: "It refers to the unfavorable socio-economic or political conditions that some groups of people systematically experience based on their relative position and social hierarchies."

Marshall Chin: Great. Thank you, Kevin.

Nicole McElveen: OK, is there …

Female: OK.

Nicole McElveen: It sound like everyone is in agreement and what we could do is send that around after the call today to finalize the copy of that definition so everyone's clear.

Female: And thank you, Kevin, for (that).

Kevin Fiscella: You're welcome.

Nicole McElveen: The next comment to discuss is displayed on the screen and there is a commenter that mentioned a – she talked about a correlation with the preparedness of the healthcare delivery system on how to deal with disparities and the prevalence of a condition among a certain group. And she – the commenter gave a hypothetical example of what she was referring to and laid out some examples and observations from that example. (And that I'll just put on the screen).

So we wanted to get the committee's view on this and to find out if based on this comment, if the report should be revised in some way to reflect the opinion of this commenter.

Jerry Johnson: This is Jerry. The comment is true. I just don't know that it's relevant to what we're asking persons to do. We're not asking them to – in their practices or

their health plans – to conduct research which will show differences. If so then that sample (file) issue is relevant.

What we're saying is based on known research and evidence that practices should make these changes. So I'm not – it read as true but not relevant to me.

Elizabeth Jacobs: Yes, I mean, I'm – this is Liz – I second Jerry's comment. I mean, I feel what she's saying but – or he – but it's like – well, that's true in any setting that if you don't have enough members of one group to say something statistically valid. But it doesn't mean that for those that you can do the measures on and accurately and undoubtedly do it but you should do it.

I mean I guess – maybe this person's asking, do you have a comment in the report about how – I mean this is one way to address this – about how there may be important disparities existing that cannot be detected through these measures because of the lack of enough people in different groups. But it doesn't mean that those disparities don't exist. I mean, maybe that's what this person's concerned about, that certain groups will be ignored or not looked at or different changes will not be made to address their unique needs because they're so small.

Male: I agree with that suggestion to just make that comment – I don't know what else we can do.

Nicole McElveen: Any more comments? And again we can – that was a good suggestion, thank you. We can now add that note to the report.

OK, the next comment is interesting. This is a comment around – it comments about the standardization of data collection on race and ethnicity, particularly how does it relate to the information collected on the quality gap.

So the commenter noted that because the data is collected differently, that a quality gap for measure A, for example, may not be equivalent to a quality gap for another measure. And so then, our – which then would impact the scoring system that we have outlined based on the quality gap percentages that were collected.

You know, the – and also the comments are also – mentioned about the one-question versus two-question formats for collecting race and ethnicity. And the committee did discuss that specific comment on our last call a few months back. And at the time, we cited the IOM recommendation to address that.

This though, is a little different because what they're saying is that lack of standardization reflects on the data that we've collected and that we're using to determine these measures as disparities-sensitive.

So we wanted to, you know, again, bring this to the group and find out if you have any additional thoughts that we can add in our response to this comment. And I just also wanted to quickly say that one – that we – obviously, we recognize that that lack of standardization, but what we've tried to emphasized on several comments is that this is a starting point in our initial step that identify these measures as disparities-sensitive.

And so we understand that as, you know, more data is collected and things evolve, so to speak, that our work will evolve as well. So we try to emphasize that a few times in many responses to several different comments. But, anyway – but we must hear what you guys think if you have any further thoughts on it.

Marshall Chin: This is Marshall. You know, this comment as well as the prior one, has been to get at the issue of what is use or purpose of the measures. You know, if we assess the quality improvement purpose, then you know, things like this (well,) charity or, you know, whether or not race and ethnicity (inaudible) as important.

You know, what people are probably concerned about are, you know, being (shelved into both finance and reimbursement of penalties) on data or measures that cannot be, you know, pristine. And so I think besides the general language about, well, you know, this evolution language about – if it has a, you know, for quality improvement purposes would be an important issue.

Elizabeth Jacobs: This is Liz. I think one – I mean, this is opening a whole other can of worms but it might be helpful to, like, direct people to some measures that are good

measures of race and ethnicity. Or I mean, maybe not something – I mean – I think, that's the only way to address this comment.

Because again, it's like – as Marshall was saying, it's like the previous comment. It's like, we can't necessarily go around and tell health plans or groups everything that they're going to do. Like, you have to measure it this way and, you know, because we want them to use the measures.

Nicole McElveen: So, Liz, are you suggesting out of the list of measures that we selected to specifically highlight some that would be more appropriate for adjusting race and ethnicity? I'm not…

Elizabeth Jacobs: (I think) what this person's saying is depending on how you measure race and ethnicity – like, right. Am I reading that wrong? They ask how do groups – if a healthcare organization measure – you know, collect race and ethnicity in one way that's different than another one, how are they going to be comparable?

Nicole McElveen: Right.

Elizabeth Jacobs: Right?

Nicole McElveen: Yes.

Elizabeth Jacobs: So I'm saying, is there a way we could recommend, you know, a particular measure of race and ethnicity that have shown to be good. I mean, Romana's developed some of these, other groups have developed these. As I remember as our endorsed – we don't have anything like that in the endorsed measures.

Nicole McElveen: Right.

Female: You don't have it…

Nicole McElveen: (You know, we have a) collection.

Female: Don't we have it from the first NQF project?

Nicole McElveen: Yes, we – in our cultural competency project. What we recommend was to use the HRC toolkit for data collection – the guidelines outlined in that toolkit.

OK.

Male: So, we can refer them back to that?

Nicole McElveen: Right. Yes, we can. And – yes, definitely. Were there any further comments from the group on this last issue?

OK. So overall, many of the other comments we received – many were fairly common – fairly redundant, which is common, you know, if one group or a large council wants to kind of drive home a point, several people will kind of talk about the same comment. But overall, people were very pleased with the report and happy that we have decided to sort of embark on this – on this process and to think about addressing disparities, more specifically in our work.

Going forward, the plans are to bring this information to our CSAC – the Consensus Standards Approval Committee – just as an informational piece. They wont, you know, be endorsing the measure or the work or anything but really to get their input on our work as well.

The other thing that we've been doing is trying to take this process of selecting disparities-sensitive measures and figure out how we can do this perspectively within each of our committees moving forward.

So, as many of you know, our projects are outlined as endorsement maintenance projects. So, we review measures that are up for maintenance alongside new measures – new submitted measures.

And we had a chance to start that with our infectious disease committee that met probably about a month ago. And one of the things we figured out which the committee has already told us, is that – is that we do definitely need to look into revising some of the questions on our measured submission form to really figure out better ways to pool the right data we're looking for from the measure developers.

So just, I think really providing more clarity, being more specific about what we're looking for from them to – and help inform the disparities of the measure that exists. And so, we're looking to do that. And then as well, during this meeting, what we tried to do was to incorporate the discussion of disparities into the other elements that are discussed as you talk about evaluating and reviewing a measure in the whole.

And that worked for most – for some of the measures and for some, it didn't. You know, you all have been through an evaluation process. You know there's so many other things to talk about but we really try to focus the discussion around disparities particularly for infectious diseases because disparities exist so broadly in that group.

And there's still a lot of work on the backside being done once a committee does identify what measures they want to recommend going forward. And so, a little bit of work on our end to help fill in the holes for the quality gap as that it something that's missing.

So, that is all. I want to make sure the committee is aware of that. And once we have both of these publications kind of finalized and read for distribution, I'll make sure that we obviously send a copy to the committee as well. But from here and out, there may be some small e-mails we might be distributing to follow up if we have any questions or need further input. But there won't be any more conference calls that we will be scheduling with the group.

So, I just want to thank you guys again for your time and hard work on all of this – on this project. I know that NQF is really proud of the work that we're moving forward with. And that we're really happy to have worked with you all on it. So, thank you.

Female: Thank you.

Male: Yes, thank you for excellent, excellent staff work here.

Female: Really, annotation every time.

Female: I'm really glad to see this is happening.

Nicole McElveen: Great. Thank you, guys.

Male: Thank you. Bye-bye.

Male: Yes. Bye-bye.

Female: Bye-bye.

Female: Amy, you can go ahead and conclude the conference.

Operator: This concludes today's conference. You may now disconnect.

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