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Cancer Spring 2021 Topical Web Meeting

Shalema Brooks, MS, MPH, Director
Matthew Pickering, PharmD, NQF Senior Director
Tamara Funk, MPH, NQF Manager
Karri Albanese, NQF Analyst
Monika Harvey, MBA, PMP, NQF Project Manager

July 30, 2021

Funded by the Centers for Medicare & Medicaid Services (CMS) under contract HHSM-500-2017-00060I Task Order HHSM-500-T0001.

Welcome

Housekeeping Reminders

- This is a Webex meeting with audio and video capabilities
  - Meeting number: 173 208 4610
  - Password: QMEvent (if needed)
- Optional: Dial **1-844-621-3956** Please place yourself on mute when you are not speaking
- We encourage you to use the following features
  - Chat box: to message NQF staff or the group
  - Raise hand: to be called upon to speak
- During the discussions, Committee members should: remain engaged in the discussion without distractions, attend the meeting at all times, keep comments concise and focused, allow others to contribute

If you are experiencing technical issues, please contact the NQF project team at **cancerem@qualityforum.org**

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Cancer Project Team

- Shalema Brooks, MS, MPH, Director
- Matthew Pickering, PharmD, Senior Director
- Tamara Funk, MPH, Manager
- Karri Albanese, Analyst
- Monika Harvey, MBA, PMP, Project Manager

Agenda

- Introductions
- Review and describe NQF's health equity work
  - Presenter: Kim Ibarra, NQF Senior Managing Director and Rebecca Payne, NQF Senior Analyst
- **Presentation:** *Leveraging Quality Measurement to Address Cancer Disparities*
  - Presenter: Meagan Khau, CMS Office of Minority Health
- **Presentation:** *Innovations from the Field: Actionable strategies to improve cancer measures for vulnerable populations*
  - Presenter: Jean Drummond, HCDI
- NQF Member and Public Comment
- Next Steps
- Adjourn

Introductions and Meeting Objectives

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Cancer Standing Committee

- Karen Fields, MD, (Co-Chair)
- Shelley Fuld Nasso, MPP (Co-Chair)
- Afsaneh Barzi, MD, PhD
- Gregary Bocsi, DO, FCAP
- Brent Braveman, PhD, OTR/L, FAOTA
- Steven Chen, MD, MBA, FACS
- David E. Cohn, MD, MBA
- Karen Collum, DNP, RN, OCN
- Matthew Facktor, MD, FACS
- Heidi Floyd
- Bradford Hirsch, MD
- Jette Hogenmiller, PhD, MN, APRN/ARNP, CDE, NTP, TNCC, CEE
- Wenora Johnson
- J. Leonard Lichtenfeld, MD, MACP
- Stephen Lovell, MS
- Jennifer Malin, MD, PhD
- Jodi Maranchie, MD, FACS
- Denise Morse, MBA
- Benjamin Movsas, MD
- Beverly Reigle, PhD, RN
- Robert Rosenberg, MD, FACR
- David J. Sher, MD, MPH
- Danielle Ziernicki, PharmD

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Improving Health Outcomes Requires Equitable Care

Kim Ibarra, NQF Senior Managing Director
Rebecca Payne, NQF Senior Analyst

July 30, 2021

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Overview

- Why Health Equity Matters
- Health Equity as a Strategic Goal
- NQF's Historic Work in Health Equity
- Current Work Underway

Why Health Equity Matters

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Defining our Terms

- **Health Equity:** The attainment of the highest level of health for all people.[1]
- **Social Determinants of Health (SDOH):** The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[2,3]
- **Health Disparity:** A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.[4]

1 Office of Disease Prevention and Health Promotion (ODPHP). Disparities. Office of Disease Prevention and Health Promotion. https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities. Last accessed July 2021.
2 Social Determinants of Health. Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health. Last accessed July 2021.
3 Social Determinants of Health | CDC. https://www.cdc.gov/socialdeterminants/index.htm. Published May 6, 2021. Last accessed July 2021.
4 U.S. Department of Health and Human Services. *The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I Report: Recommendations for the Framework and Format of Healthy People 2020*. http://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf.

Health Equity as a Strategic Goal

Advance Health Equity and Address Disparities

- **Goal:** Advance health equity by improving quality measurement and implementation
- NQF will use its unique convening power to collaboratively develop and promote policies and implementation practices advancing the use of data, measurement, and payment models to achieve health equity

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Five-Year Target

- Develop a shared national infrastructure to advance quality and payment innovation in health equity building on NQF's prior work such as the Roadmap to Health Equity and National Call to Action.
- Apply a health equity lens to all NQF work (internal and external) specifically identifying opportunities to address in measurement and implementation
- Objective for 2021
  - Set the foundation for and coordinate NQF's health equity activities

NQF's Historic Work in Health Equity

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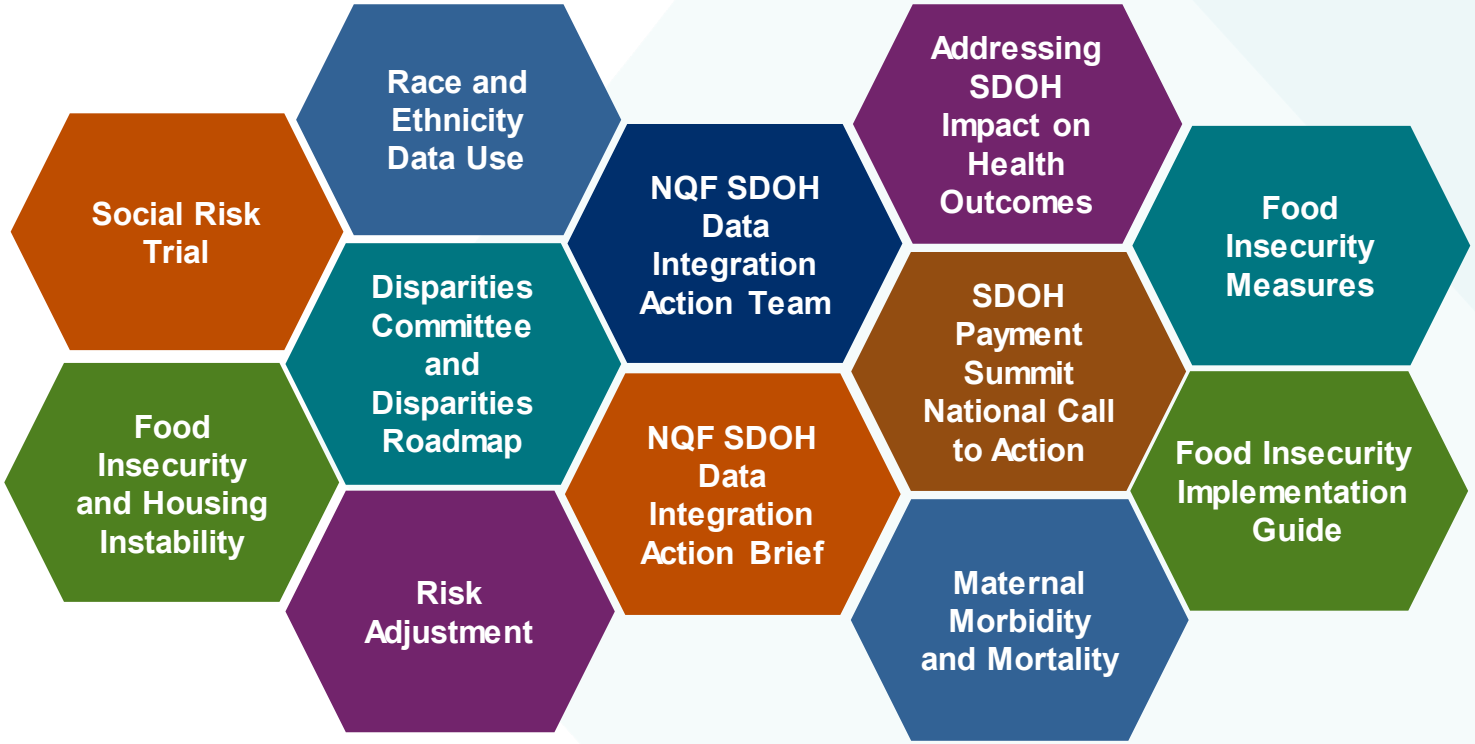
Overview of NQF's Health Equity Initiatives



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A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity

- **Purpose:** Develop a roadmap for how measurement and associated policy levers can be used to proactively eliminate disparities
- **Results:** NQF's Roadmap to Health Equity (PDF)

The Four I's for Health Equity

» **Identify** and prioritize reducing health disparities

» **Implement** evidence-based interventions to reduce disparities

» **Invest** in the development and use of health equity performance measures

» **Incentivize** the reduction of health disparities and the achievement of health equity

Disparities Project page

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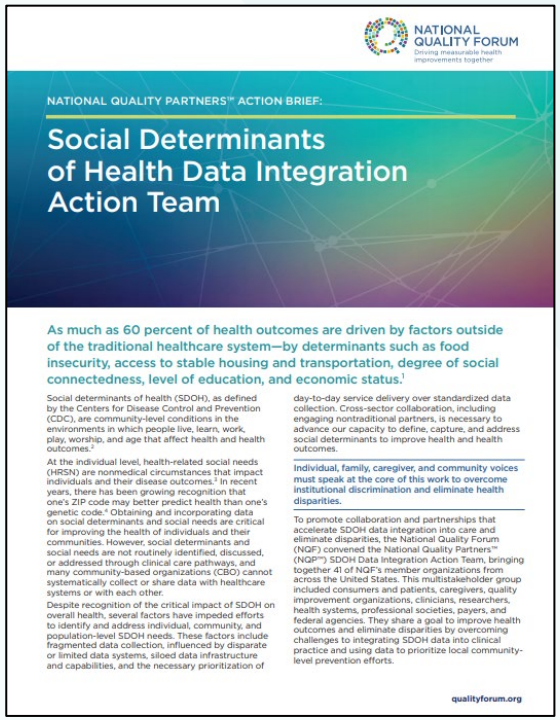
The Social Risk Trial

- **Purpose:** Test the inclusion of social risk factors in measure endorsement and implementation processes to answer this key question: Should quality measures adjust for social risk factors?
- **Results:** Final Report
  - **Key Recommendations**
    - » Declare the elimination of health and healthcare inequities a top national and performance measurement priority
    - » Consistently collect, report, and submit demographic and social risks data
    - » Each submitted measure should be individually assessed
    - » The measurement community should assess the effects and unintended consequences of social risks for marginalized populations
    - » Prioritize the identification of demographic risk alternatives to current social risk proxies

Project page

SDOH Data Integration Action Team

- **Purpose:** Accelerate the integration of SDOH data into clinical practice
- **Results:** SDOH Data Integration Action Brief (PDF) and Key Recommendations
  - **To improve person-centered care and health outcomes through SDOH data integration, healthcare and community organizations should:**
    - » Standardize and share data
    - » Demonstrate collaboration and partnership across sectors
    - » Evaluate effectiveness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NATIONAL QUALITY PARTNERS™ ACTION BRIEF:

Social Determinants of Health Data Integration Action Team

As much as 60 percent of health outcomes are driven by factors outside of the traditional healthcare system—by determinants such as food insecurity, access to stable housing and transportation, degree of social connectedness, level of education, and economic status.[1]

Social determinants of health (SDOH), as defined by the Centers for Disease Control and Prevention (CDC), are community-level conditions in the environments in which people live, learn, work, play, worship, and age that affect health and health outcomes.[2]

At the individual level, health-related social needs (HRSN) are nonmedical circumstances that impact individuals and their disease outcomes.[3] In recent years, there has been growing recognition that one's ZIP code may better predict health than one's genetic code.[4] Obtaining and incorporating data on social determinants and social needs are critical for improving the health of individuals and their communities. However, social determinants and social needs are not routinely identified, discussed, or addressed through clinical care pathways, and many community-based organizations (CBO) cannot systematically collect or share data with healthcare systems or with each other.

Despite recognition of the critical impact of SDOH on overall health, several factors have impeded efforts to identify and address individual, community, and population-level SDOH needs. These factors include fragmented data collection, influenced by disparate or limited data systems, siloed data infrastructure and capabilities, and the necessary prioritization of day-to-day service delivery over standardized data collection. Cross-sector collaboration, including engaging nontraditional partners, is necessary to advance our capacity to define, capture, and address social determinants to improve health and health outcomes.

Individual, family, caregiver, and community voices must speak at the core of this work to overcome institutional discrimination and eliminate health disparities.

To promote collaboration and partnerships that accelerate SDOH data integration into care and eliminate disparities, the National Quality Forum (NQF) convened the National Quality Partners™ (NQP™) SDOH Data Integration Action Team, bringing together 41 of NQF's member organizations from across the United States. This multistakeholder group included consumers and patients, caregivers, quality improvement organizations, clinicians, researchers, health systems, professional societies, payers, and federal agencies. They share a goal to improve health outcomes and eliminate disparities by overcoming challenges to integrating SDOH data into clinical practice and using data to prioritize local community-level prevention efforts.

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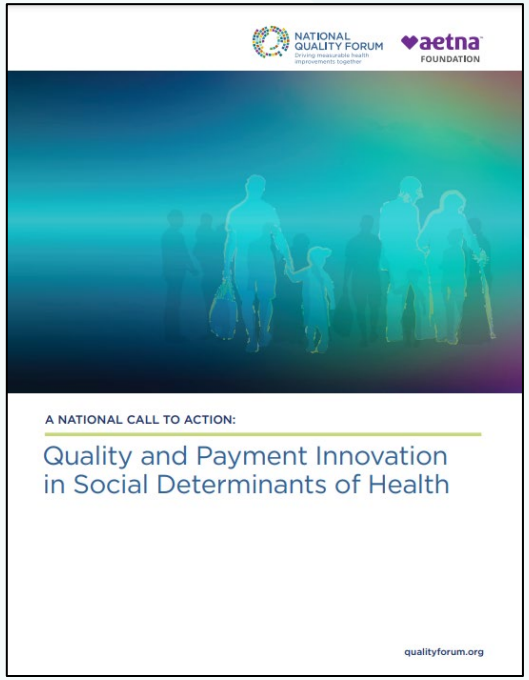
Project page

SDOH Payment Summit

- **Purpose:** Advance payment's role in supporting successful innovations in SDOH
- **Results:** National Call To Action (PDF) and Hill Briefing
  - **Key Recommendations**
    - » Align policies, funding, and reimbursement
    - » Develop key sets of measures
    - » Execute the recommendations from the NQF SDOH Data Integration Action Team
    - » Provide funding to test, collect data, assess, and measure
    - » Incentivize and reward

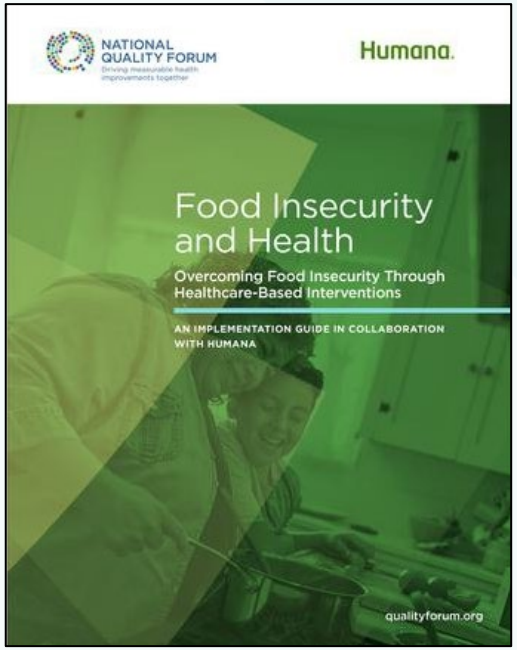
Press Release

healthcare organizations at multiple levels



Food Insecurity Implementation Guide

- **Purpose:** Enhance healthcare entities' capacity to drive improvement in food insecurity and health outcomes
- **Results:** Food Insecurity and Health Implementation Guide
  - **Fundamental Action Areas Identified:**
    - » Screening and assessment
    - » Clinical action
    - » Tracking and evaluation



NQF Store

Current Health Equity Initiatives Underway

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Best Practices for Developing and Testing Risk Adjustment Models

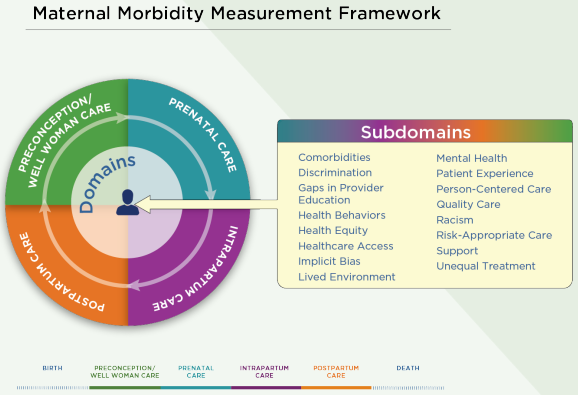
- **Purpose:** Identify best practices in developing and testing risk adjustment models
- **Project Milestones:**
  - Conduct an environmental scan
  - Develop technical guidance for measure developers
  - Host a public comment period
  - Upcoming Events:
    - » Web Meeting 5 – **July 30, 2021, from 1:00-3:00pm ET** Open to the Public
    - » Final Technical Guidance Report: **September 13, 2021**

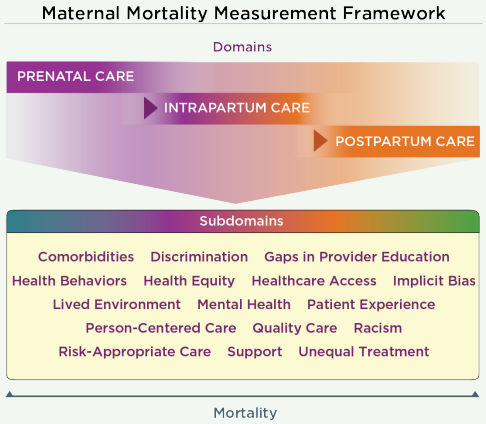
Project page

Maternal Morbidity and Mortality

- **Purpose:** Build a foundation of tangible recommendations for enhancing maternal morbidity and mortality measurement and achieve larger goals of improving health outcomes for maternity care

- **Project Milestones:**
  - Develop an environmental scan
  - Develop two measurement frameworks for maternal morbidity and maternal mortality
  - Final Report release: **August 13, 2021**





Project page

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Addressing SDOH and Impact on Overall Health Outcomes

- **Purpose:** To identify quality measures, strategies, and resources specific to addressing SDOH and their impact on overall health outcomes
- **Project Milestones:**
  - Conduct two environmental scans
  - Host two virtual strategy sessions to identify measure concepts
  - Identify two prioritized measure concepts for development and testing
  - Develop an implementation field guide

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Food Insecurity Measure Development

- **Purpose:** Enhance healthcare entities' capacity to drive improvement in food insecurity and health outcomes
- **Project Milestones:**
  - Open request for information (RFI)
  - Partner a with measure developer
  - Facilitate the development and testing of 3 measures in food insecurity
  - Summarize outcomes and provide recommendations

Project page

Opportunities for Engagement

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Collecting Stakeholder Input on Health Equity Opportunities in Measurement and Implementation

- **Purpose:** Identify strategies and initiatives being undertaken across the healthcare spectrum to improve health equity in quality measurement
- **We want to know:**
  - What are your organizations doing to drive health equity in quality measurement?
  - What needs would you like to see NQF address in this space?

Engaging in NQF's Health Equity Work

- Sign up for NQF Project Alerts and follow NQF on LinkedIn to learn about upcoming initiatives and opportunities to provide comments on current initiatives
- Contact Kim Ibarra at KIbarra@qualityforum.org with any thoughts or questions

THANK YOU.

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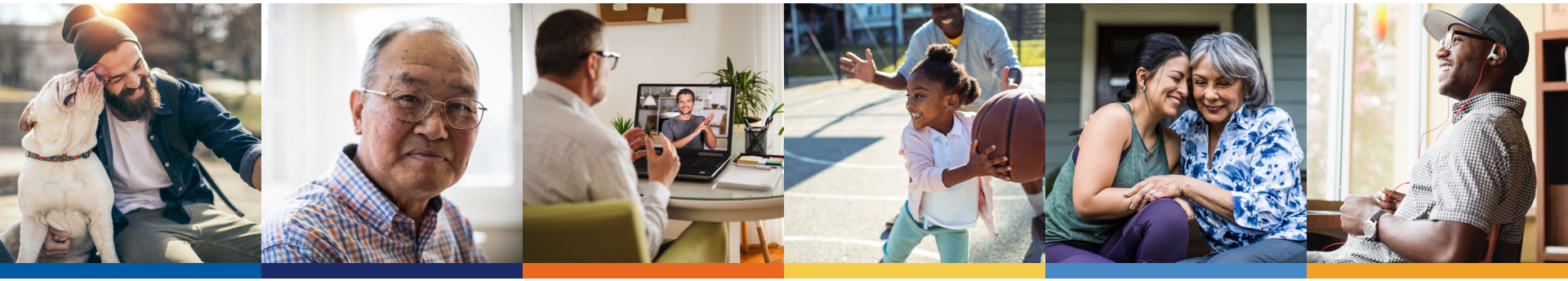
CMS' use of Quality Measures for Health Equity

W O R K I N G T O A C H I E V E H E A L T H E Q U I T Y



Leveraging Quality Measurement to Address Cancer Disparities

July 30, 2021

Meagan Khau
Data and Policy Analytics Group
CMS Office of Minority Health

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OFFICE OF MINORITY HEALTH

HHS Offices of Minority Health

When the Affordable Care Act was introduced, it called for the establishment of six offices of minority health within HHS agencies, including the CMS Office of Minority Health.

These offices joined forces with the HHS Office of Minority Health and the National Institute on Minority Health and Health Disparities to lead and coordinate activities that improve the health of minority populations.

Focus Populations

CMS OMH serves as the principal advisor to the agency on the needs of all minority populations, including:

- Racial and ethnic minorities
- People with disabilities
- Members of the lesbian, gay, bisexual, transgender, and queer community (LGBTQ+)
- Individuals with limited English proficiency
- Rural populations
- Persons otherwise adversely affected by persistent poverty or inequality

Executive Orders

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OFFICE OF MINORITY HEALTH

Executive Order 13985

Executive Order 13985: Advancing Racial Equity and Support for Underserved Communities Through the Federal Government

- Systematic approach to redress inequities in federal policies and programs that serve as barriers to equal opportunity.
- Embedding of fairness in the decision-making processes within executive departments and agencies of the federal government.
- Comprehensive approach to advancing equity for underserved communities such as:
  - —Those adversely affected by persistent poverty and inequality,
  - —The tribal community,
  - —People of color, and
  - —Otherwise historically marginalized populations.

Executive Order 13985: Highlights

EO 13985 Focuses on Data:

Section 4(a)

- Identify Methods to Assess Equity
  - *"Assist agencies in assessing equity with respect to race, ethnicity, religion, income, geography, gender identity, sexual orientation, and disability…"*
  - Emphasizes the need to take actions to collect demographic data in order to fully assess impact of health equity responses and extent of existing health disparities

Section 9(a)

- Establishes a workgroup to gather necessary data
  - *"Many Federal datasets are not disaggregated by race, ethnicity, gender, disability, income, veteran status, or other key demographic variables. This lack of data has cascading effects and impedes efforts to measure and advance equity."*
  - Emphasizes the need to gather data to promote equity

Executive Order 14031

- **Executive Order 14031:** Advancing Equity, Justice, and Opportunity for Asian Americans, Native Hawaiians, and Pacific Islanders
- Four sections:
  - Section 1: Policy
  - Section 2: President's Advisory Commission on Asian Americans, Native Hawaiians, and Pacific Islanders
  - Section 3: White House Initiative on Asian Americans, Native Hawaiians, and Pacific Islanders
  - Section 4: General Provisions

  - ***General goals:***
    - **Improve data collection and monitoring efforts on the AA/NHPI communities**
    - Address racism and xenophobia, including improving preventing and responding to anti-Asian hate crimes
    - Address barriers in healthcare and workforce
    - Promote inclusion and increase opportunities for the communities

Data Challenges

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Many Federal datasets are not disaggregated by race, ethnicity, gender, disability, income, veteran status, or other key demographic variables.

- What Federal datasets are available with this information?
- What standards the Federal datasets are using?
  - —Race and ethnicity data:
    - 1997 OMB Standards
    - 2011 HHS Data Standards*
    - Other Standards
- It is important that for us to be able to collect race and ethnicity data at the disaggregated level for more targeted interventions.

OMB 1997 Standards*	2011 HHS Data Standards*
Race	**Race**
• White	• White
• Black	• Black
• American Indian or Alaska Native	• American Indian or Alaska Native
• Asian	• Asian Indian
• Native Hawaiian or Other Pacific Islander	• Chinese
	• Filipino
	• Japanese
	• Korean
	• Vietnamese
	• Other Asian
	• Native Hawaiian
	• Guamanian or Chamorro
	• Samoan
	• Other Pacific Islander
Ethnicity	**Ethnicity**
• Not Hispanic or Latino	• Not Hispanic or Latino
• Hispanic or Latino	• Mexican
	• Puerto Rican
	• Cuban
	• Another Hispanic Origin

*https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

**OMB recommends that when self-identification is used, a method for reporting more than one race should be adopted, and that when a list of races is provided to respondents, the list should not contain a "multiracial" category.

Assessing equity with respect to race, ethnicity, religion, income, geography, gender identity, sexual orientation, and disability

- Currently not all of these data elements are being collected across the different HHS and/or CMS's programs
  - —New data collection
  - —What standards to use to collect for each data element – it's important for us to have data standardizations
- What result will we get from the data collection?
  - —Analyze data and assess quality and comprehensiveness
  - —What do the data say about race and ethnicity – the importance of collecting disaggregated data
  - —What questions can we ask from the data and understanding the impact of structural racism and health inequities
- How can we use the data to impact programs and policies to assess and address health inequities?
  - —Data interpretation
  - —Data stratification
  - —Measure health inequities and advance equity
  - —Applying an equity lens to all data analyses

Our Work Towards Quality and Equity

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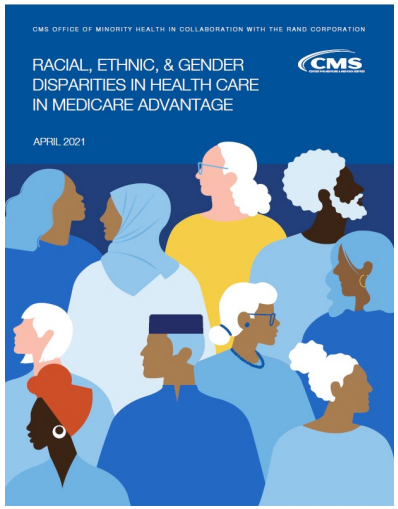
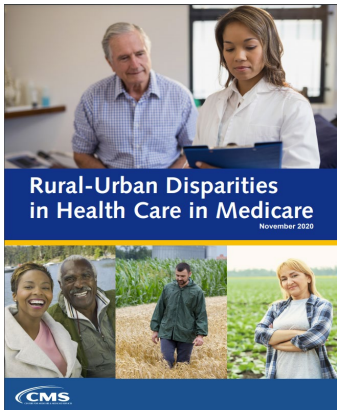
Data Analysis

The Data and Policy Analytics Group (DPAG) within CMS OMH conducts special studies regarding CMS and HHS programs, policies, or regulations that impact underserved populations to help inform CMS policy and decisions. Responsibilities include:

- Planning the development/implementation of new initiatives and data analyses to monitor and improve aspects of care
- Working with agency partners to improve data collection, analysis, and reporting by demographics and other characteristics associated with health disparities





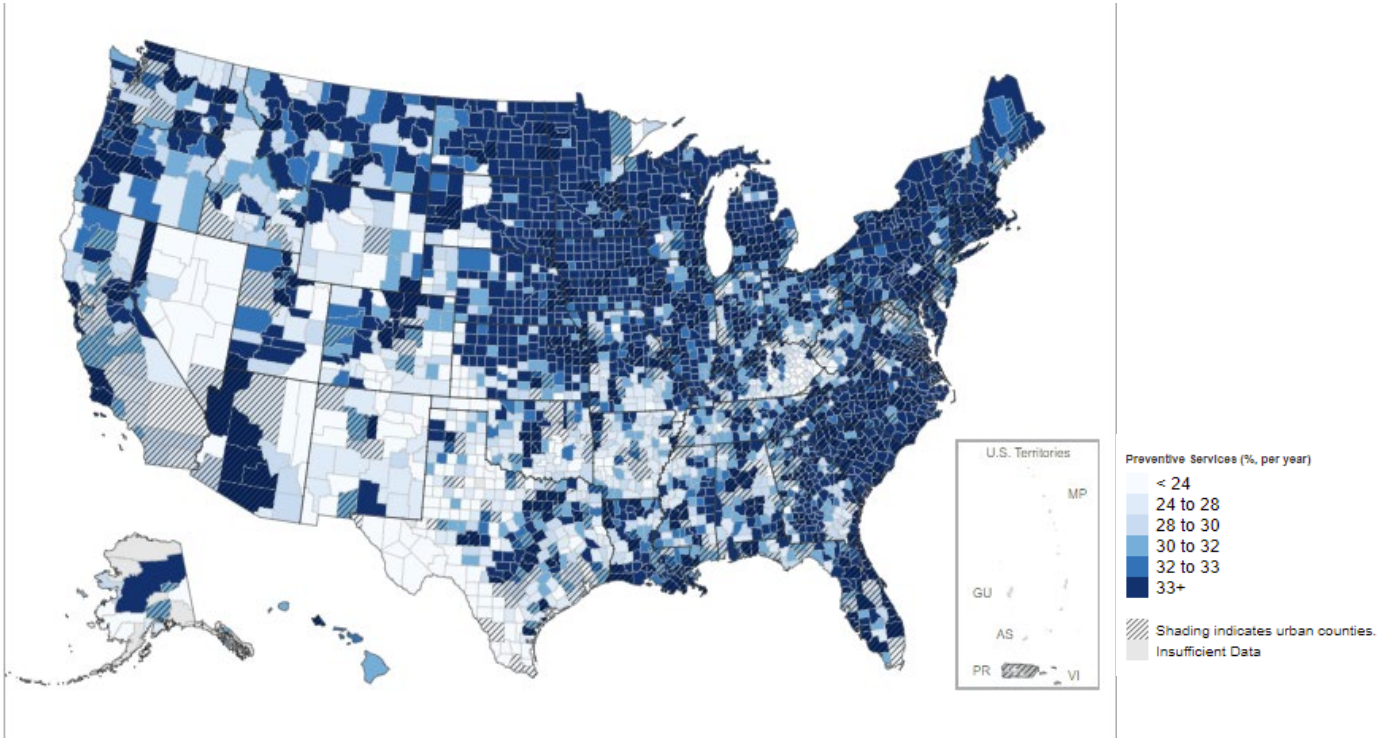
Available at: https://www.cms.gov/About-CMS/Agency-Information/OMH/research-and-data

Data Analysis: Mapping Medicare Disparities (MMD) Tool

- Launched in March 2016 by CMS OMH
- Interactive map that allows users to identify areas of disparities between subgroups of Medicare beneficiaries (e.g., racial and ethnic groups), chronic disease prevalence, health outcomes, spending, and utilization.
- User friendly and visually appealing
- Medicare Fee-for-Service (FFS) data, recently updated with 2019 data
- Downloadable data and maps
- Available in Spanish
- Population View and Hospital View

Available at: https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH-Mapping-Medicare-Disparities

Mammography Screening Rate Among Medicare Fee-For-Service (FFS) Beneficiaries, 2019

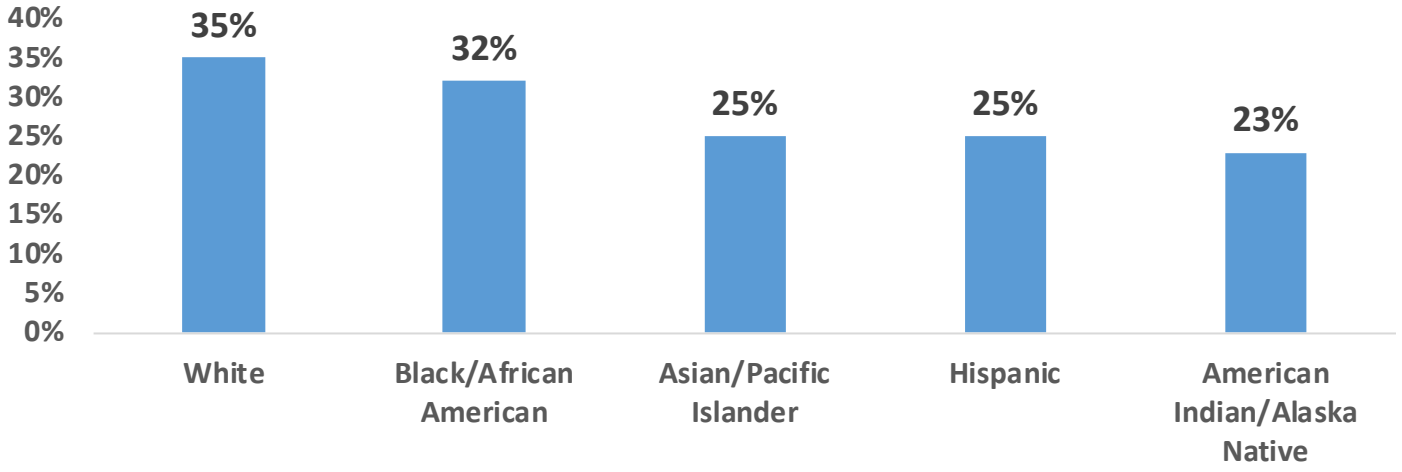


SOURCE: *Mapping Medicare Disparities Tool*, Centers for Medicare & Medicaid Services https://data.cms.gov/mapping-medicare-disparities, July 14, 2021.

Breast Cancer Screening

In 2019, 33% of female Medicare FFS beneficiaries had breast cancer screening (i.e. mammography).

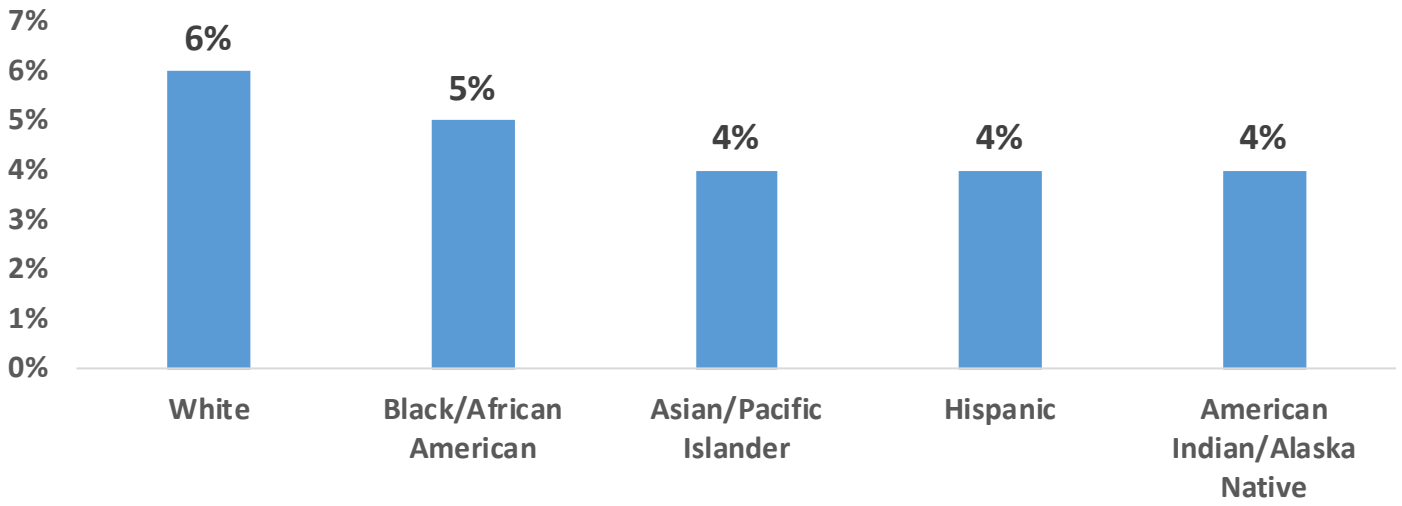
Breast Cancer Screening Rate among Female Medicare FFS Beneficiaries by Race and Ethnicity, 2019



SOURCE: Mapping Medicare Disparities Tool. https://data.cms.gov/mapping-medicare-disparities

Breast Cancer Prevalence

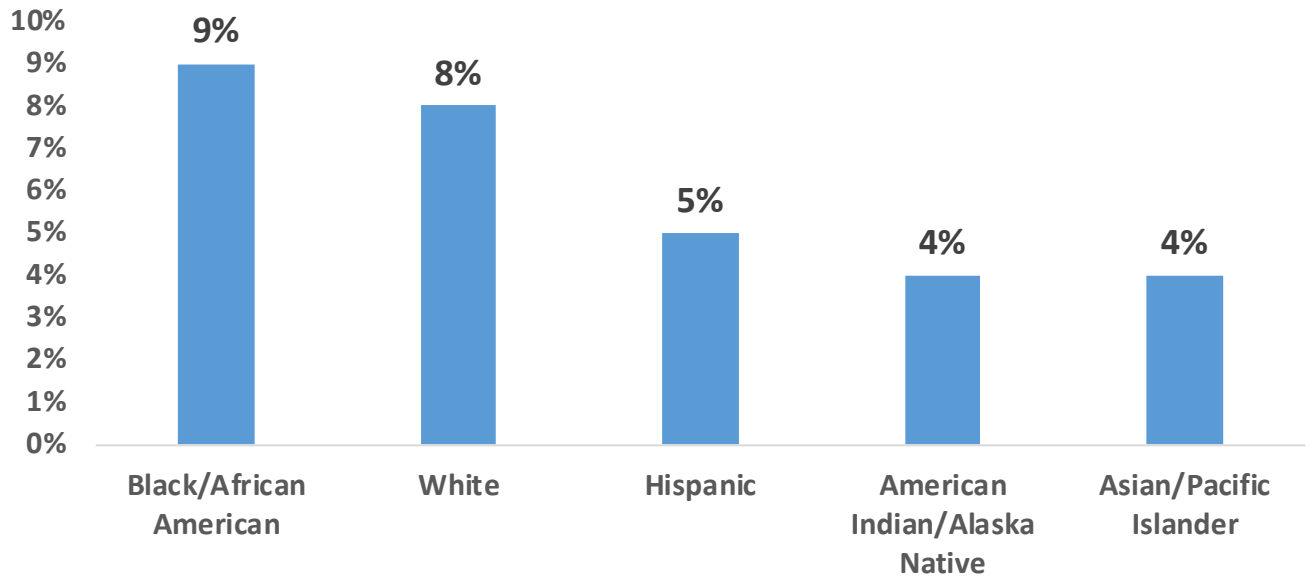
Prevalence of Breast Cancer among Female Medicare FFS Beneficiaries by Race and Ethnicity, 2019



SOURCE: Mapping Medicare Disparities Tool. https://data.cms.gov/mapping-medicare-disparities

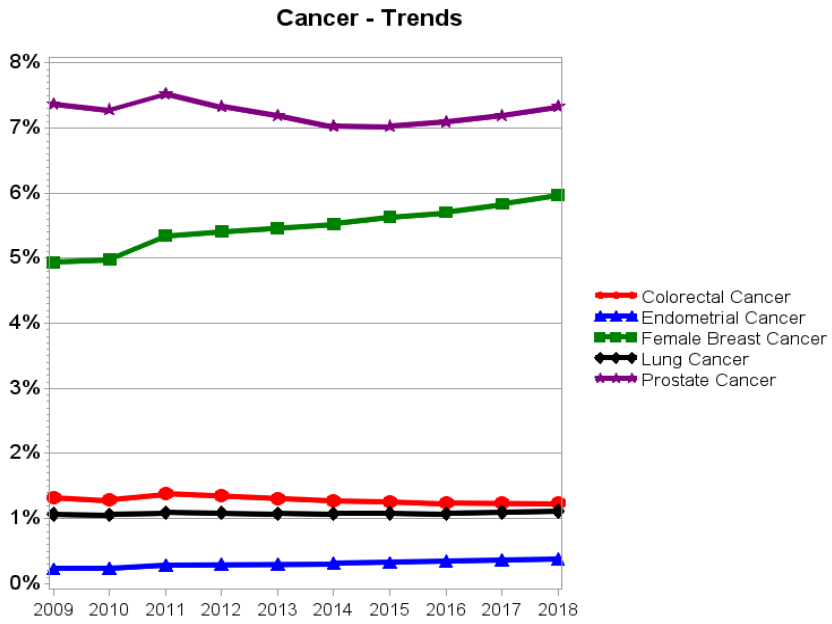
Prostate Cancer Prevalence

Prevalence of Prostate Cancer among Male Medicare FFS Beneficiaries by Race and Ethnicity, 2019



SOURCE: Mapping Medicare Disparities Tool. https://data.cms.gov/mapping-medicare-disparities

Cancer Trends among Medicare Fee-for-Service (FFS) Beneficiaries



- The rate for female **breast cancer** has risen slightly over time – from 4.9% in 2009 to 6.0% in 2018.
- The rate for **prostate cancer** fluctuated somewhat – from a high of 7.5% in 2011, to a low of 7.0% in 2014, then to 7.3% in 2018.
- **Endometrial cancer** showed a small gradual increase over time from 0.4% in 2009 to 0.7% in 2018.
- The rates of lung and colorectal cancer were stable over time.

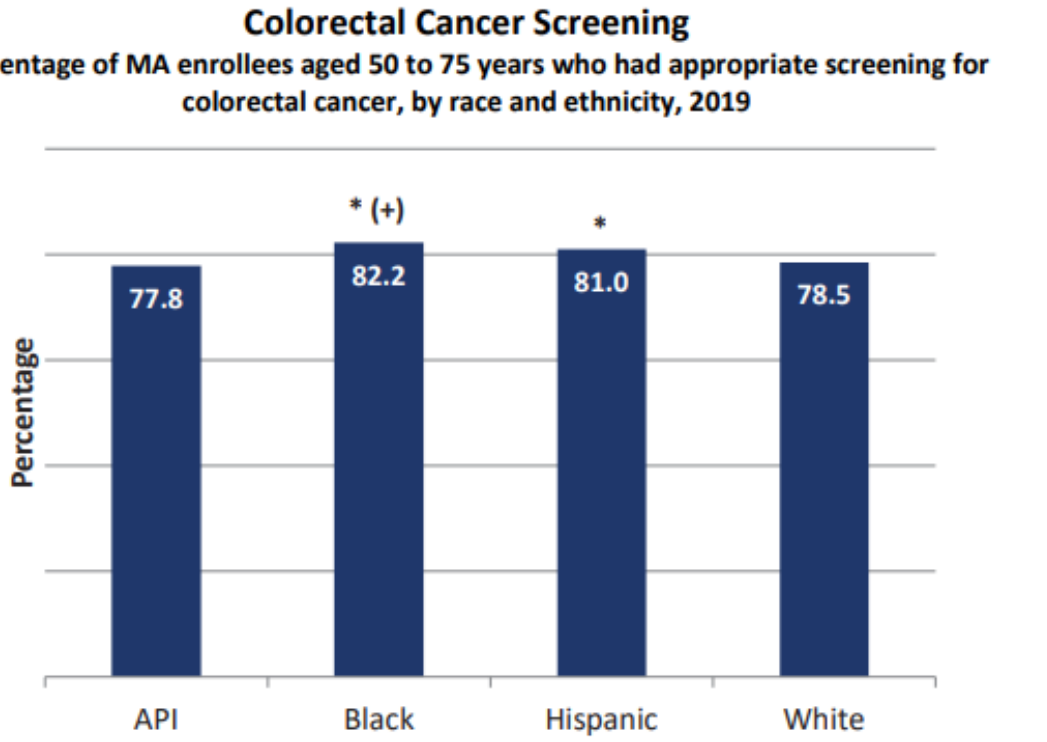
SOURCE: Chronic Condition Data Warehouse (CCW). Medicare Beneficiary Summary Files.

Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage (2021 Annual Report)

- Report highlights (1) racial and ethnic differences in health care experiences and clinical care, (2) gender differences in health care experiences and clinical care, and (3) how racial and ethnic differences in quality of care vary between women and men for Medicare Advantage beneficiaries in 2019.
- With just one exception, racial and ethnic minority beneficiaries reported experiences with care that were either worse than or similar to the experiences reported by White beneficiaries.
- Asian/Pacific Islander (API) beneficiaries reported worse health care experiences than White beneficiaries on the majority (6/7) of measures.
- Black, Hispanic, and API beneficiaries received worse clinical care than White beneficiaries on 14, 16, and 5 (of 39 total) clinical care measures examined, respectively.
- The key clinical care result was that Black and Hispanic beneficiaries had worse clinical care than Whites on a large proportion of measures.
- Women and men reported similar health care experiences with care for all measures of patient experience.
- Clinical care received by women and men was of similar quality for most of the measures.

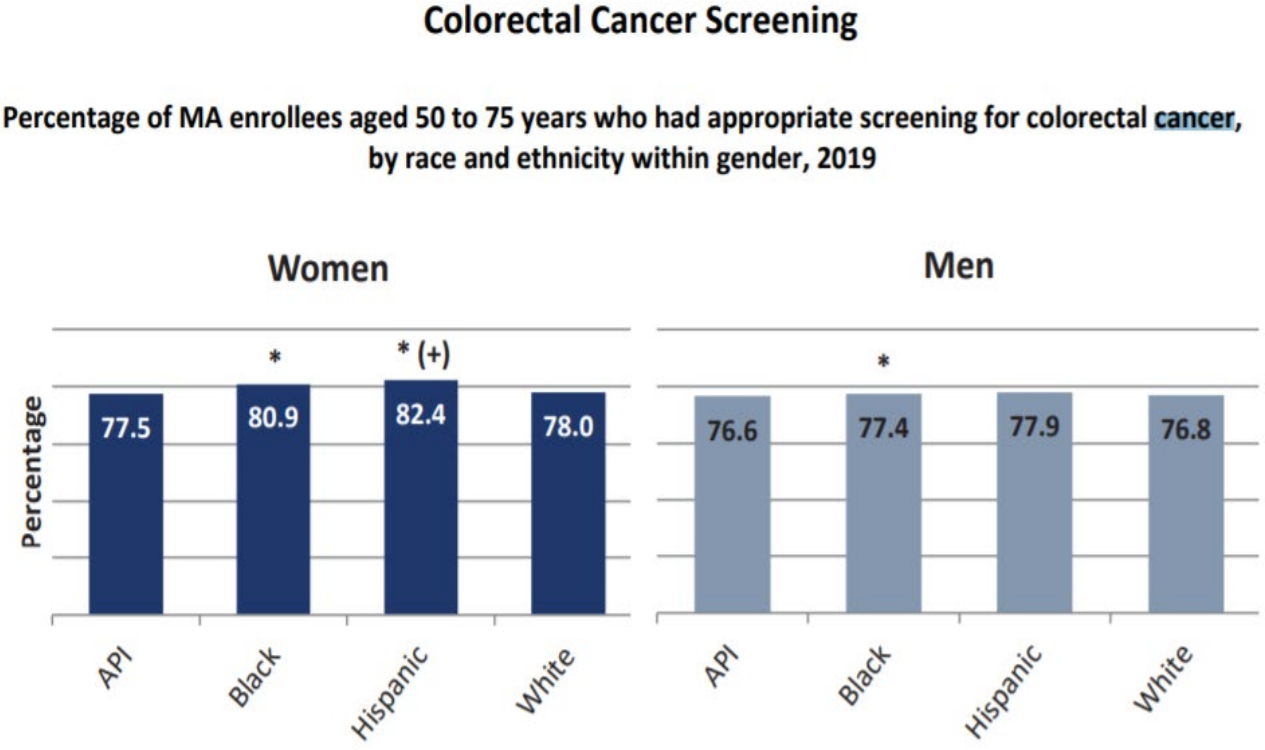
Source: https://www.cms.gov/About-CMS/Agency-Information/OMH/research-and-data/statistics-and-data/stratified-reporting

Colorectal Cancer Screening



SOURCE: Clinical quality data were collected in 2019 from MA plans nationwide.
NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

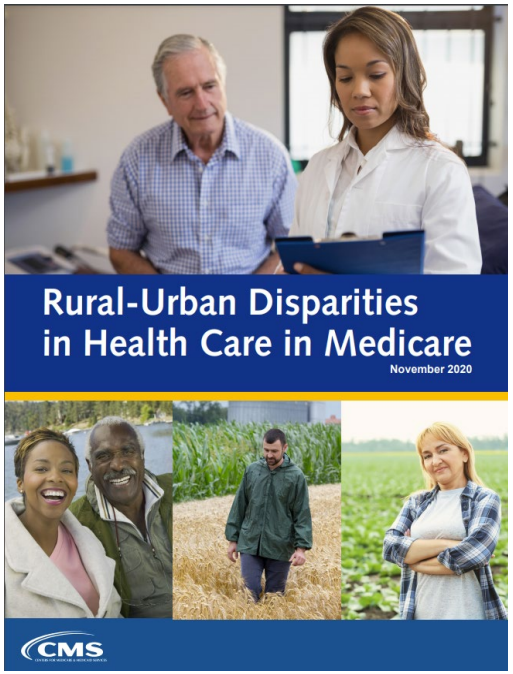
Colorectal Cancer Screening (Cont.)



SOURCE: Clinical quality data were collected in 2019 from MA plans nationwide.
NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic. Hispanic ethnicity includes all races.

Rural-Urban Disparities in Health Care in Medicare (2020 Annual Report)

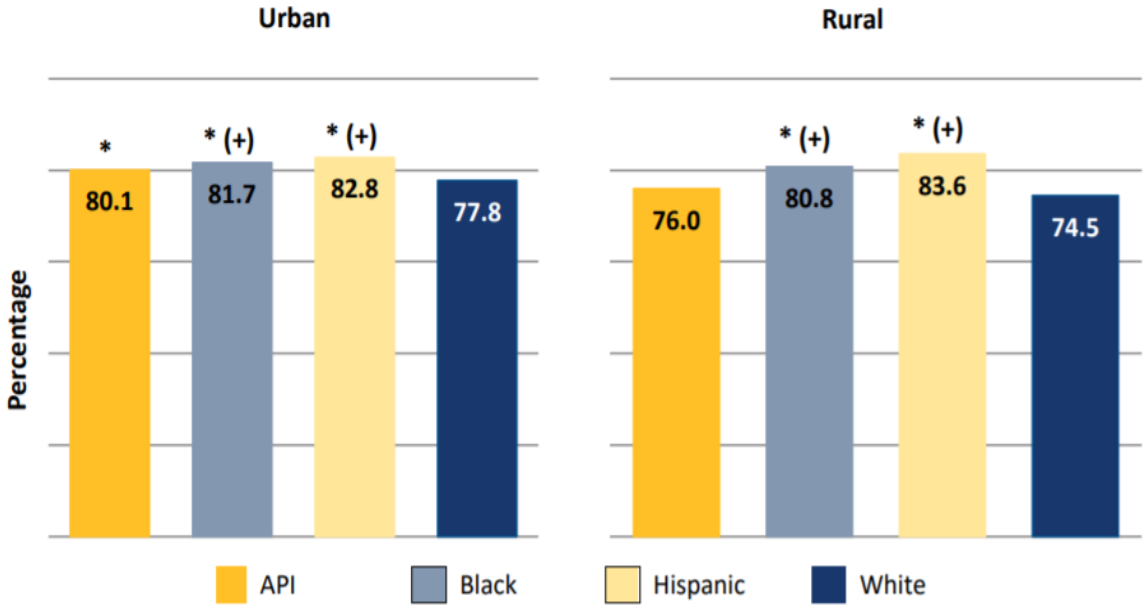
- Report highlights (a) rural-urban differences in health care experiences and clinical care, (b) how rural-urban differences vary by race and ethnicity, and (c) how racial and ethnic differences vary between rural and urban areas for Medicare beneficiaries in 2019.
- Rural residents reported experiences with care were similar to the experiences reported by urban residents but often had worse results for clinical care than urban residents.
- Patterns of racial and ethnic differences (compared with White beneficiaries) in patient experience were similar in urban and rural areas for Asian Pacific Islander and Black beneficiaries but not for American Indian/Alaska Native and Hispanic beneficiaries.
- Urban American Indian/Alaska Native beneficiaries typically reported experiences with care that were similar to the experiences of care reported by urban White beneficiaries, while rural American Indian/Alaska Native beneficiaries typically reported experiences with care that were worse than the experiences reported by rural White beneficiaries.
- Hispanic beneficiaries generally had worse results than White beneficiaries, the difference between these groups was evident far more often in rural areas than in urban areas.



Source: https://www.cms.gov/About-CMS/Agency-Information/OMH/research-and-data/statistics-and-data/stratified-reporting and https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/reports-and-publications

Breast Cancer Screening

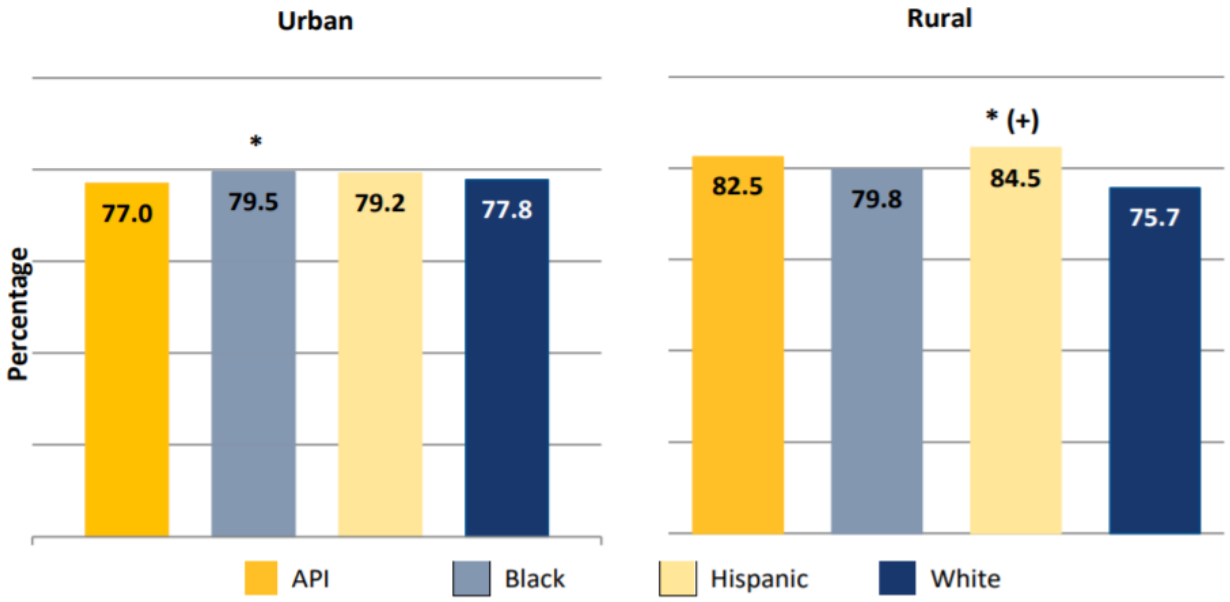
Percentage of MA enrollees (women) aged 50 to 74 years who had appropriate screening for breast cancer, by race and ethnicity within urban and rural areas, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.
NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Colorectal Cancer Screening

Percentage of MA enrollees aged 50 to 75 years who had appropriate screening for colorectal cancer, by race and ethnicity within urban and rural areas, 2019



SOURCE: Clinical quality data collected in 2019 from Medicare health plans nationwide.
NOTES: API = Asian or Pacific Islander. Racial groups such as Black and White are non-Hispanic; Hispanic ethnicity includes all races. Clinical quality data are not available for Medicare FFS beneficiaries.

Health Equity Summary Score

- Fundamental, upstream causes of health (i.e. causes of causes)[1,2] affect a multitude of health and health-related outcomes and health disparities.
  - —**e.g.** exposure to disease; underlying health conditions and comorbidities; access to and engagement in quality health care[3-5]
  - —**e.g.** disparate patterns across sociodemographic strata or groups (e.g. race and ethnicity groups; gender groups; income level groups)[6,7]
- The Health Equity Summary Score (**HESS**)[8] is a stratification/group differences **summary measure** that was developed to:
  - —increase visibility of health care quality disparities for quality improvement (QI) and for disparity reduction.
  - —provide a mechanism for targeting incentives to achieve equity in quality of care across groups (e.g. racial and ethnic groups, those who are and are not dually eligible for Medicare and Medicaid/eligible for Low Income Subsidy [LIS]).

Proof-of-concept Exercise

- The HESS methodology, a summary measure of health care quality equity, was developed by CMS OMH and then applied to data from Medicare Advantage (MA) contracts (i.e. health plans) as a proof-of-concept exercise.
- While other potential grouping (i.e. stratification) variables were considered, ultimately the exercise was performed with the following grouping variables**: race and ethnicity** (i.e. Asian or Pacific Islander, Black or African American, Hispanic or Latino, and white) and **dual eligible/LIS status**.
  - —Any number of grouping or stratification variables with any number of strata can be used.
  - —Health quality indicators can span any domains of quality; the proof-of-concept exercise used indicators spanning patient experience and clinical quality domains.
- OMH's a priori requirements for the methodology included (a) allowing for multiple grouping variables, not all of which will be measurable for all plans, (b) allowing for disaggregation by grouping variable for nuanced insights and QI, and (c) allowing for additional and different grouping variables to be used in the future.

Data Sources and Requirements

- Analysis was restricted to plans with enrollment of 500 or more (~90% of plans), with at least one publicly reported MA summary rating, and at least one CAHPS or HEDIS star rating.
- Each plan's score was based only on combinations of health care quality measures (e.g. getting needed care) and grouping variable unit (e.g. Black/AA group for which it met measurability requirements to ensure accurate measurement: sufficient sample size (n=100) and reliability (≥0.70).

PATIENT EXPERIENCE (MCAHPS)

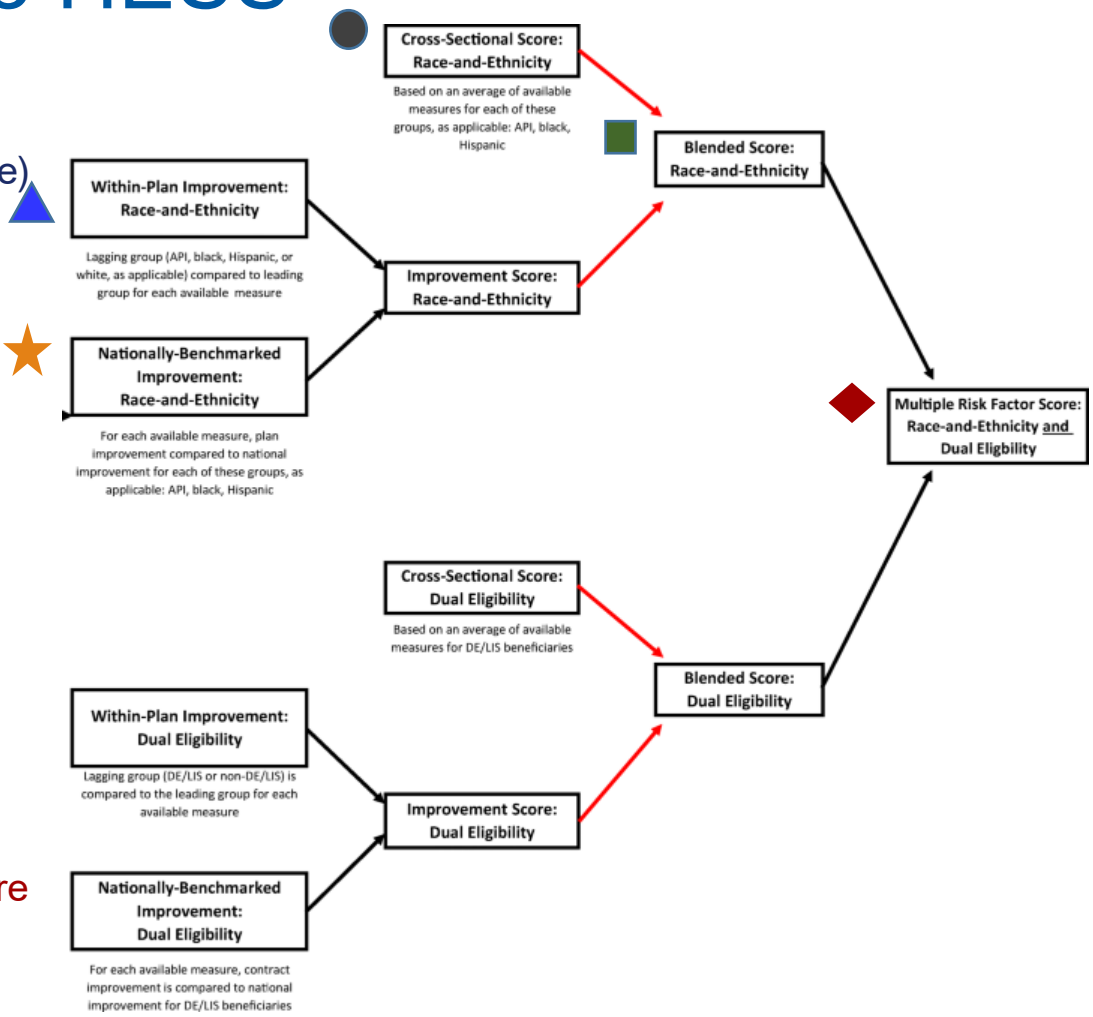
- Getting needed care
- Getting appointments and care quickly
- Customer service
- Doctors who communicate well
- Care coordination
- Getting needed prescription drugs
- Annual flu vaccine

CLINICAL QUALITY (HEDIS)

- Adult BMI assessment
- Breast cancer screening
- Colorectal cancer screening
- Diabetes: blood sugar controlled
- Diabetes: kidney disease monitoring
- Diabetes: retinal eye exam
- Controlling high blood pressure

Construction of the HESS

- Within-plan improvement: examining standardized (i.e. z-score) differences between leading (group with highest score) and lagging groups during each time period
- Nationally benchmarked improvement: absolute improvement over time
- Cross-sectional score: average across underserved groups
- Each grouping variable's blended score combines cross-sectional and improvement scores (and gives more weight to improvement when cross-sectional performance is low).
- The final, overall, multifactoral HESS score combines blended results (and allows analysis of multiple grouping variables simultaneously).



Agniel D, Martino SC, Burkhart Q, Hambarsoomian K, Orr N, Beckett MK, James C, Scholle SH, Wilson-Frederick S, Ng J, Elliott MN. Incentivizing excellent care to at-risk groups with a health equity summary score. Journal of General Internal Medicine. 2019 Nov 11:1-1.

Key Takeaways for HESS

- CMS OMH has developed a succinct, summary measure of health care quality equity that can be used to encourage high-quality, equitable care delivery for all individuals.
- Our proof of concept exercise was performed using race and ethnicity groups and dual eligible/LIS status groups with HEDIS and CAHPS measures of health care quality (patient experience and clinical quality domains) from MA plans.
- The approach was feasible for almost all plans (~90%) and moderately correlated with MA plans' summary ratings.
- The HESS can identify plans that do well at providing equitable health care across groups, as well as plans that may possibly require equity-focused technical assistance and other related supports.
- The HESS was designed such that it can easily be extended to additional settings (e.g. hospital setting, which we are in early stages of exploring) as well as to different measures (either grouping [e.g. gender] or health quality variables [e.g. other clinical quality variables, such as STI screenings]).
- ASPE rated the HESS highly in their recent "Developing Health Equity Measures" report, released May 2021.

CMS Health Equity Technical Assistance Program

HealthEquityTA@cms.hhs.gov

CMS Health Equity TA program supports quality improvement partners, providers, and other CMS stakeholders by offering:

- Personalized coaching and resources
- Guidance on data collection and analysis
- Assistance to develop a language access plan and disparities impact statement
- Resources on culturally and linguistically tailored care and communication
- Training and resources to help embed health equity in stakeholder's strategic planning

Connect with CMS OMH

Contact Us

OMH@cms.hhs.gov

Visit Our Website

go.cms.gov/omh

Listserv Signup

bit.ly/CMSOMH

From Coverage to Care

CoverageToCare@cms.hhs.gov

Health Equity Technical Assistance Program

HealthEquityTA@cms.hhs.gov

Rural Health

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OFFICE OF MINORITY HEALTH

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Innovations from the Field: Actionable strategies to improve cancer measures for vulnerable populations

Presented by: Jean Drummond, President and CEO HCD International

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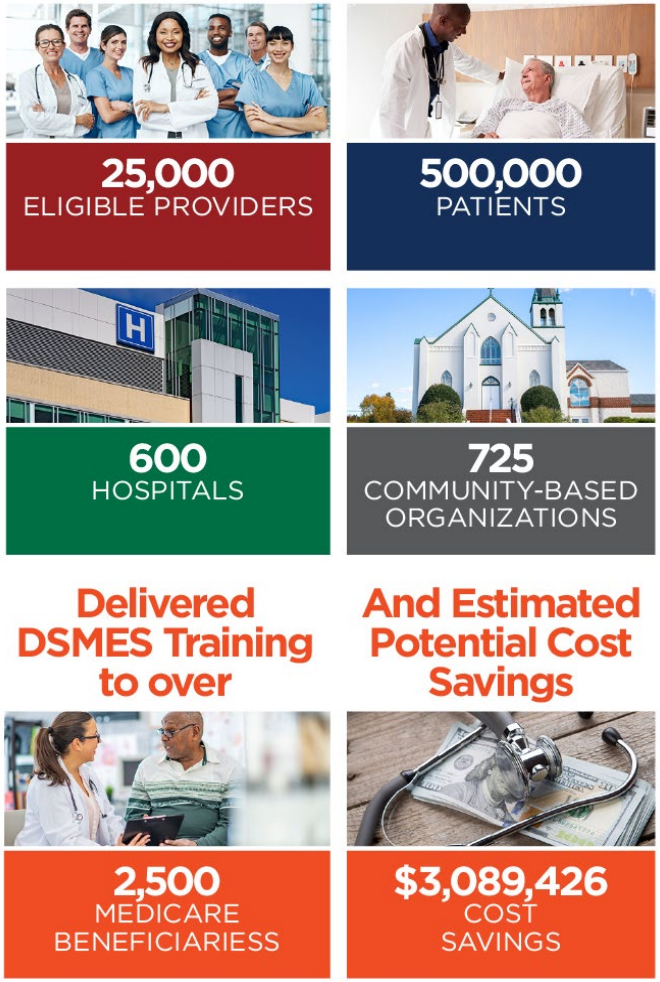
NATIONAL QUALITY FORUM
qualityforum.org

Purpose/ Learning Objectives:

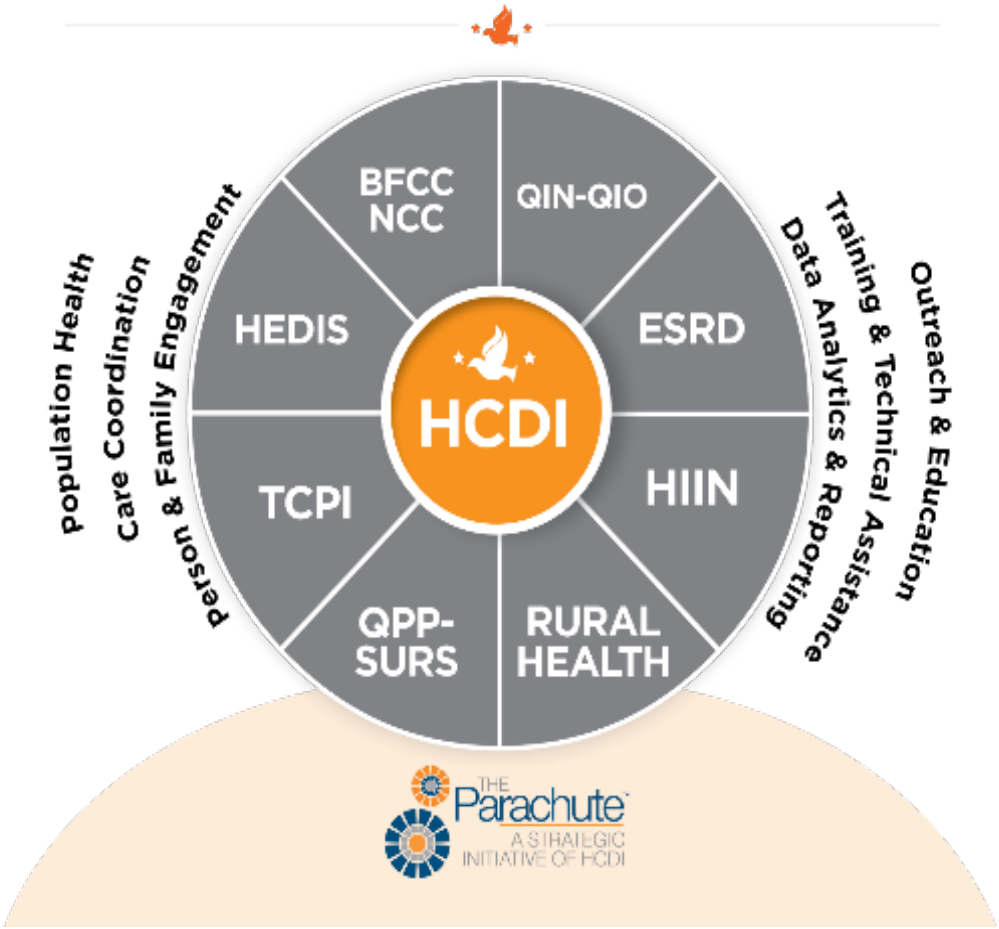
- Share highlights of the 'on the ground' experience capturing real-time actionable health-related social needs (HRSN)
- Share the thought leadership related to social needs beyond health across the life span
- Provide unique perspectives in serving the most vulnerable and implications for cancer measures
- Share practice insights to drive policies for meaningful measures to improve health outcomes, not just meet quality measures

HCDI Overview

- Our Vision: Improving the quality of health for all, especially for vulnerable populations
- Quality Improvement, Clinical Transformation & Population Health Firm
- Proven Methodologies that are **National** in Scale and Spread & **Local** in Impact
- NICHE: Policy to Practice
- Over 25 years experience in Federal, State, Local and Commercial marketplace
- HI-Trust Certified
- Minority, Woman-Owned Small Business
- Creating cost savings of **$41M** in 4 years
- Awarded one of CMS' top 2 small business in 2018



CMS Quality Initiatives Experience



NQIIC 2019 Award Contract WINNER

Network of Quality Innovation Improvement Contractors

- **BFCC NCC**-Beneficiary and Family Centered Care National Coordinating Center
- **QIN-QIO**-Quality Innovation Network Quality Improvement Organization
- **ESRD**-End-Stage Renal Disease
- **HIIN**-Hospital Improvement Innovation Network
- **QPP-SURS**-Quality Payment Programs-Small Underserved Rural Support
- **TCPI**-Transforming Clinical Practice Initiative
- **HEDIS**-Healthcare Effectiveness Data and Information Set

Our Work: Focused on the Most Vulnerable

What we do:

Quality Improvement

Care Coordination

Provider Engagement

Patient Engagement

Community Engagement

ED Diversion

Clinical Transformation

How we do it:

Human Centered Design

Culturally Competent

Person Centered

Data Driven

Asset-based approach

Empathic, Trauma-informed Approach

Grassroots

Stories of who we serve from the field- Focus on our work

John, a 25-year, homeless veteran with multiple behavioral health and medical conditions for service in 3 military wars

Louise, age 72, grandmother and caregiver of 6 children, ages 2-10. Her daughter was shot in drive-by and three of the fathers are incarcerated and one dead

Shimire, age 24 with 4 children, one born blind, two with learning disabilities and one with Sickle Cell Disease

Mary, speaks no English and recently reunited with her son, who was taken by federal agents at the border while he was searching for a vaccine

Sally, who has never received a mammogram because her mother, 2 aunts and close cousin died with breast cancer

A Shifting Paradigm
Social Determinants of Life

Our work has IMPACT across the Life Span

Gerald Family Care – Video Clip

"Caring For Your Health"™ Social Determinants of Health (SDoH) Indicator e-Tool

- Patient-facing social determinants assessment
- Very EASY 3-4 minute user-friendly, low-literacy tool
- Immediate results to provider, practice or payer
- Utilization of mobile technology
- Based on nationally recognized, validated questions
- Captures demographic, race, ethnicity, & language (REaL) data, SDoH data and customized data
- Facilitates real-time person-centered care coordination
- Successfully implemented in rural, urban and suburban settings
- Customized HL7/FHIR electronic medical record (EMR) integration
- Unique Patient Identifier
- Integrates person and family engagement principles
- Patient, provider, practice and population level data aggregation
- Incorporates and tracks Z codes
- Multiple workflow integration options

CARING FOR YOUR HEALTH©
Social Determinants Indicator Tool (CFYH Tool)

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qualityforum.org

CFYH e-Tool Data Collection Elements & Workflow

Demographics

- Name
- Age
- Zip Code
- Gender

REaL

- Race
- Ethnicity
- Language

Additional Options

- Diabetes
- Women's Health
- Mental Health
- Income
- Household Composition

Social Determinants of Health

- Food
- Housing
- Economics
- Education
- Medications
- Transportation
- Loneliness
- Utilities
- Employment
- Insurance status
- Interpersonal Violence
- Utilization

Caring for Your Health Demo

Focus your camera here

HCD INTERNATIONAL
Providing Excellence in Service

CFYH COVID-19 Practices Users

Search By

Name | Zipcode | Risk of Homelessness × | No money for more food × | Select Practices | 2020-07-01 ~ 2021-08-01

Filter | Email Link | Export

Submissions 43

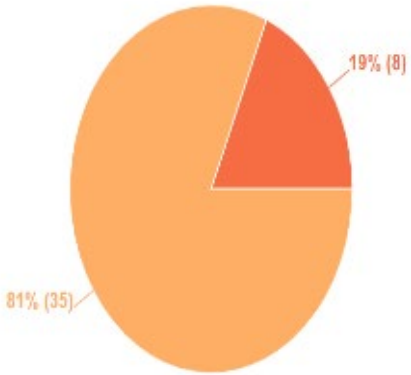
Sam Morrision
03162021_SamMorrision_000098
03/01/2000

Matt Mason
03052021_MattMason_000085
03/01/1985

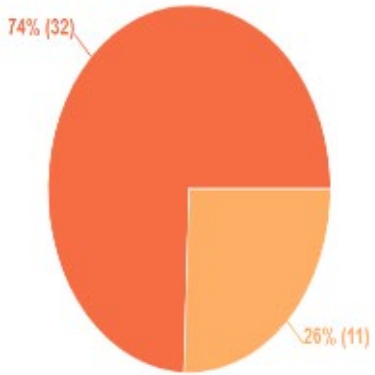
Mesa Test
03022021_MesaTest_000093
03/02/1894

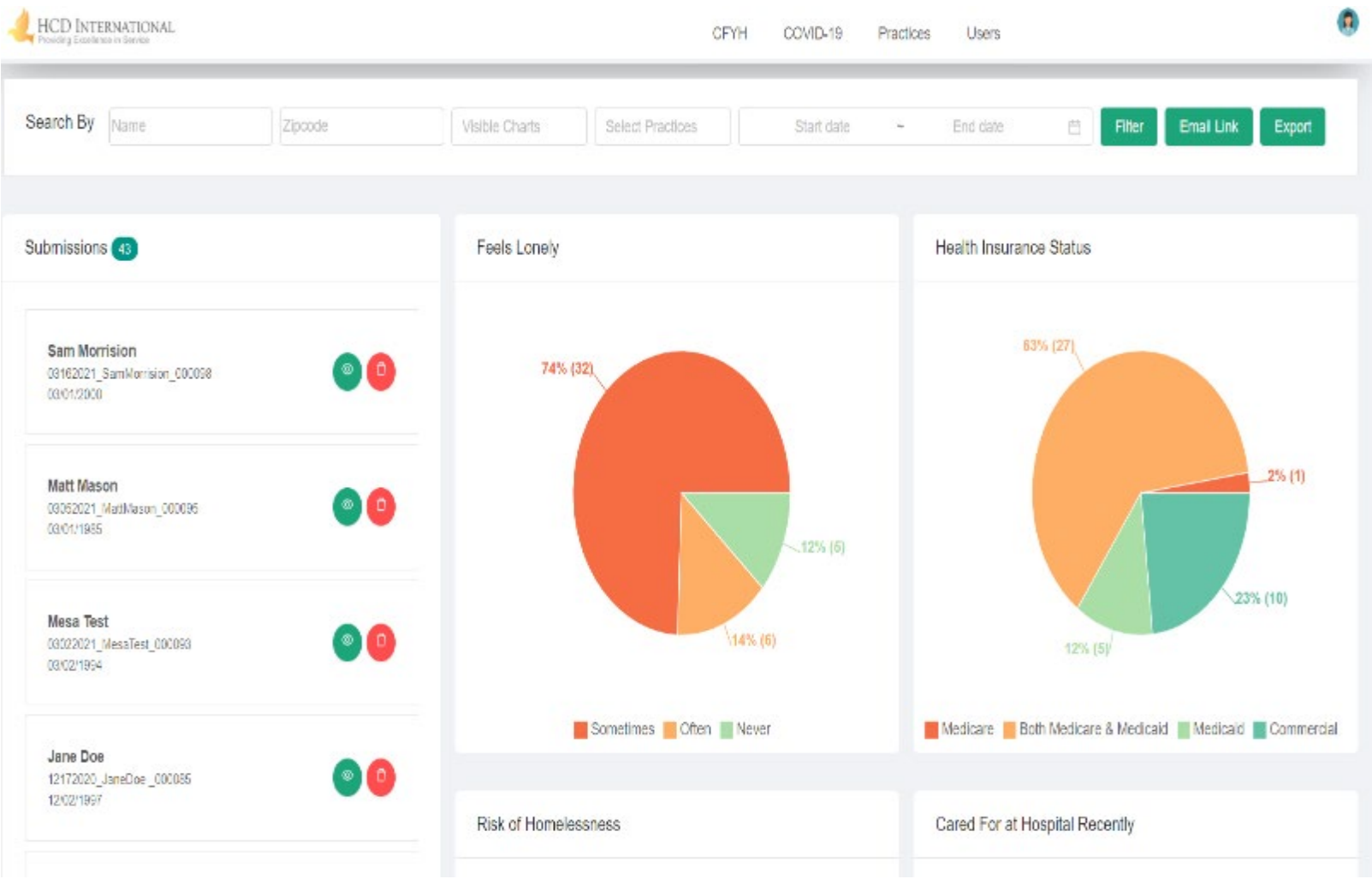
Jane Doe
12172020_JaneDoe_000085

Risk of Homelessness



No money for more food





Case Study 1: Breast Cancer Screening Measure

HCDI was given data on **4500** number of difficult to reach, non-compliant members requiring mammograms, and was required to close the gaps in 6 months.

Innovations HCDI implemented:

- Focused on **listening** to **relationship vs. transaction,** applying culturally and linguistically appropriate standards
- Sponsored educational programs for breast cancer prevention to engage and inform the general population on the different types and stages of breast cancer
- Implemented communication between members and their primary care team to encourage members to obtain their yearly mammogram
- **Created partnerships** with members, primary care physicians, and radiology centers facilitated by **certified community health workers**
- Addressed **SDOH** and provided incentives for members to complete the mammogram screening
- Initiated partnerships with local radiology centers to ease the process of scheduling and completing the mammogram screening
- Implemented **peer-2-peer relationships** and referrals process

Breast Cancer Screening Measure Barriers: 2020-2021

Covid-19 insecurities/fear

Loss of jobs and medical insurance benefits

Childcare for families with kids doing virtual learning and the transition to hybrid learning

Childcare was not available to members on the day of their appointments because they were not able to accompany the parent due to Covid-19 regulations

Limited resources for food and medication scarcity

Prioritizing secondary health issues due to Covid-19 restrictions

Members taking on guardianship of other sick family members and their expenses

Some member's have not had communication with their primary care physician in years

Members who are essential workers were not able to keep scheduled appointments

Members were reluctant/could not afford to take public transportation or rideshare (Lyft/Uber) transportation due to the pandemic

Members being afraid due to previous experience with the screening and the pain and discomfort afterwards

Understanding religious restrictions

Primary care physicians (PCPs) often do not inform members about getting mammograms so they are unaware that they need one

Results of BCS DRAFT

Measure	Actual*	Target	Percentage
BCS	120	300	40%
CCS	35	240	14%
PPC	148	600	25%
SSI Adult	405	1500	27%
SSI Child	259	1000	26%
Lead	241	1500	16%

BCS			
	Actual	Target	Percentage
2019	156	500	31%
2020	250	250	100%
2021	120	300	40%

CCS			
	Actual	Target	Percentage
2021	35	240	14%

*BCS- Breast Cancer Screenings

CCS- Cervical Cancer Screenings
PPC- Postpartum Care
SSI- Social Security Insurance
Lead- Lead Screenings

Case Study 2: Cervical Cancer Screening Measure, 2021

HCDI was given data on **21,500** number of difficult to reach, non-compliant members requiring mammograms and was required to close the gaps in 12 months.

- Lack of health literacy on anatomical part of the body and the need for cancer screening. Members are unaware they need a screening
- Comfort issues; very sensitive subject for members. Some members are not comfortable with male providers
- Member does not have an obstetrician and gynecologist (OB/GYN) or has never seen a gynecologist
- Unable to locate OB/GYN
- Provider does not advise member to get screening
- Lack of childcare
- Other health issues take priority
- Religious restrictions

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Real-Time Actionable Data

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2020 FINAL REPORT

PROJECT DESCRIPTION: Client engaged HCDI to close HEDIS quality care gaps for a population of over 49,000 members across 5 HEDIS measures, AWC, BCS, Lead, SSI Adult and SSI Child; and CCS was added at the end of October. Even through the COVID-19 pandemic, various stay-at home orders and shutdowns, HCDI touched over 11,000 members and met the target for all 5 measures; closing over 6,000 gaps in care.

GAPS CLOSED

	ACTUAL	TARGET
AWC*	1,594	1,500
LEAD*	1,231	1,200
SSI ADULTS*	2,112	2,000
SSI CHILD*	1,019	1,000
BCS*	250	250

BARRIERS TO CARE

- COVID-19 concerns
- Limited appointment availability/shutdowns
- Loss of job/opportunities
- Food insecurities
- Issues paying for utilities

2020 TIMELINE
APR 1 - DEC 30

OF MEMBERS
49,000+

HOW WE DO WHAT WE DO

- Member-Centered
- Data Driven
- Culturally Competent
- HIPAA Compliant
- Compassionate

CHALLENGES

- COVID-19 Pandemic
- Stay-at-Home Order
- State Mandated Shut Downs
- Student Virtual Learning
- PCP Offices Closing
- Limited Hours/Staff

IMPACT/RESULTS

6,210 GAPS CLOSED
41,398 CALLS MADE
11,069 MEMBER TOUCHES

MEMBER STORY

MEMBER S.G.: Member with a heart condition is very concerned about the current pandemic which limits her travel and she has not seen her children or grandchildren in quite some time. A representative from HCDI was the first person she spoke with in over a week. The member agreed to a follow-up call and will consider getting her BCS in 2021 or once COVID-19 has subsided.

*AWC: Adolescent Well Child, BCS: Breast Cancer Screening, Lead: Lead Screening, SSI Adult/Child: Supplemental Security Income Adult/Child

COMPLETED BY HEALTHCARE DYNAMICS INTERNATIONAL
WWW.HCDI.COM | MICHELLE PASCARAN MPASCARAN@HCDI.COM

END OF THE YEAR Q.I. PUSH

PROJECT DESCRIPTION: HCDI was engaged to conduct a Year End Quality Improvement project, during the COVID-19 pandemic focused on engaging 15,000 members to capture the leading barriers to care and services for members. HCDI also provided influenza vaccine education to BCS members. In 24 days, over the Thanksgiving holiday and stay at home advisory, HCDI exceeded the goal by reaching out to all 15,000, making more than one call to over 17%, identified the barriers which for both BCS and WCV were related to COVID-19 fears. As a value-add, a significant number of gaps were closed in both BCS and WCV members during the project.

2020 PILOT TIMELINE

NOV 16 - DEC 21

 # OF MEMBERS
15,000

2,375 BREAST CANCER SCREENING

12,625 WELL CHILD VISITS

BARRIERS TO CARE

89% BCS COVID-19 CONCERNS
3% DIFFICULTY BUYING FOOD
2% ELECTRICITY/UTILITIES CONCERNS

79% WELL CHILD COVID-19 CONCERNS
7% DOCTOR NOT COVERED
7% DIFFICULTY BUYING FOOD
4% ELECTRICITY/UTILITIES CONCERNS

HOW WE DO WHAT WE DO

- Member-Centered
- Data Driven
- Culturally Competent
- HIPAA Compliant
- Compassionate

VALUE ADD - GAPS CLOSED

52 BCS

696 WELL CHILD VISITS

IMPACT/RESULTS

17,591 CALLS MADE

3,657 TOUCHES MADE

2,591 FOLLOW-UP CALLS MADE

CHALLENGES

- COVID-19 Pandemic
- Virtual Learning
- Stay-at-home Advisory
- Winter Months
- Holiday Season

INFLUENZA

88 FLU VACCINE
67% RECEIVED

137 FLU VACCINE EDUCATION
63% RECEIVED

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IMPACT

HCDI 2020 Impact Report

HCDInternational
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Committed to our legacy of improving the quality of health for all, especially vulnerable populations, within a national context of healthcare policy that has transformed our delivery and payment models, HCDI has the privilidge of reflecting upon the impact of its strategic initiatives and programming. Below shares a summary of our organizations reach in various facets of public health.

COVID-19 Hospital Admissions Savings	Individuals Served	Providers Served	Outreach Events Hosted	Facilitated Calls
$50,274,000	423,027	1,211	235	148,574

Dove Projects

ICCI Institute for Creative Community Initiatives

1,066	50	215	166	135
Pairs of Socks Distributed to Local Homeless Shelters	Giant Gift Cards distributed to Families for Thanksgiving	Surveys Completed Through Hispanic Heritage Outreach Month	Grocery Bags Distributed during the Dove Day Food Drive	Families Served during the Dove Day Food Drive

THANK YOU FOR YOUR TIME AND INTEREST IN HCDI

For more information, please contact:

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jdrummond@hcdi.com

NQF Member and Public Comment

Next Steps

Spring 2021 Cycle Updates

- Cancer Topical Webinar Summary to be posted online September 7, 2021

NATIONAL QUALITY FORUM

Project Contact Info

- Email: cancerem@qualityforum.org
- NQF phone: 202-783-1300
- Project page: http://www.qualityforum.org/Cancer.aspx
- SharePoint site: https://share.qualityforum.org/portfolio/Cancer/SitePages/Home.aspx

THANK YOU.