Theme	Number of Comments Received
General Support	33
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Category	Organization	Name	Comment	Theme
1. Please provide comments on Step #1: Prioritize Disparities-Sensitive Measures	Hassanah	Janice Tufte	I was involved with the federal mandated "Ten Year Plan to End Homelessness" specifically related to efforts in Washington State. I want to say that our initial successes were because of effective leadership and collaborative development of system implementation changes. I agree with Chin et al; "interventions employed by government, communities, organizations, and providers (with improved patient/individual outcomes as the ultimate target of interventions).14 By leveraging multiple stakeholders throughout the system, these interventions can lead to improved outcomes for people with social risk factors, helping to demonstrate measurable progress towards achieving health equity"	General Support
1. Please provide comments on Step #1: Prioritize Disparities-Sensitive Measures	SPAN/Family Voices NJ	Lauren Agoratus	We support the set of criteria including prevalence, size of disparity, impact of quality process, and ease/feasibility of improving. We are concerned that some common measures such as disparities for those with developmental disabilities and even developmental screening inequities aren't listed, even though early intervention is the key to best outcomes. (Source: CDC https://www.cdc.gov/ncbddd/disabilityandhealth/features/unrecognizedpopulation.html.)	Measure Recommendations

Category	Organization	Name	Comment	Theme
1. Please provide comments on Step #1: Prioritize Disparities-Sensitive Measures	Asian & Pacific Islander American Health Forum	Kathy Ko Chin	Overall, the Asian & Pacific Islander American Health Forum appreciates the intersectional framework the Committee took that is expansive and acknowledges disparities across race, ethnicity, health literacy, language and many other social factors that influence health. We agree that measurement burden is a valid concern and must be balanced against the obligation and necessity to have measures that identify and ultimately eliminate health and healthcare disparities. While there are valid and important considerations about patient privacy in the context of small populations, we encourage the Committee to consider adding that where such concerns may prevent the public reporting of data, that methodologies such as oversampling and multi-year pooling techniques be considered. Overall, we agree that even if such data cannot be reported publicly, that should not be an excuse for failing to collect and stratify data internally. This distinction is critical for small but growing populations, such as Asian Americans, Native Hawaiians and Pacific Islanders who face different disparities compared to other groups and experience different disparities within specific subgroups (e.g. Native Hawaiians compared to aggregated Asian Americans).	Data Collection and Reporting
1. Please provide comments on Step #1: Prioritize Disparities-Sensitive Measures	SNP Alliance	Deborah Paone	We agree that it is important to prioritize disparities-sensitive measures. We appreciate the four criteria outlined to select such measures, however we note several challenges to using these criteria. First, populations with social risk factors are very diverse--in age, language, culture, medical, behavioral, functional conditions, community-level characteristics, and other conditions. Given this diversity of populations, we are concerned that there is not enough research to guide the answers to the four criteria/questions posed on prevalence, size, impact, and feasibility. For example, a condition may be prevalent among a subgroup of persons dually eligible—e.g., those under age 65 with a physical disability--where this condition is central to health outcomes and drives behavioral health management, social support, and medical care. However the same condition may not be prevalent among another subgroup of persons who are dually	Data Collection and Reporting

Category	Organization	Name	Comment	Theme
			eligible—e.g., age 80+ with significant medical comorbidities or functional limitations. This leads to a key question: How will stratification of “at risk” groups be defined--to allow for meaningful application of the other criteria? Paucity of data and evidence comparing quality improvement efforts of meaningful “at-risk” subgroups to the group with “the highest quality ratings” will be the limiting factor in applying all of these criteria. This is a significant limitation. We would suggest three steps to begin: (1) greater attention to defining and stratifying population subgroups using clinical, functional AND social risk characteristics, (2) quality reporting for current measures applied to those subgroups (e.g., under current payment programs) done at the population subgroup level (i.e., compare ratings for similar population groups and to overall population). This could help illuminate measures that are sensitive to specific social risk factors (as well as highlight measure specification anomalies), or at least provide insight into current measures—are they indeed meaningful measures of quality for these population subgroups (stratified according to similar clinical, functional, and social risk characteristics)? After population stratification, (3) report the stratification mix by provider and plan. This will increase the utility of reporting—allowing for comparison of measurement results among organizations with similar population distributions. Such stratification would also help identify opportunities or promising practices for more tailored care or effective approaches to addressing unique subgroup issues that impact health status.	
1. Please provide comments on Step #1: Prioritize Disparities-Sensitive Measures	Summit Health Institute for Research and Education, Inc. (SHIRE)	Ruth Perot	SHIRE applauds the use of the intersectional framework the Committee created that is expansive and acknowledges disparities across race, ethnicity, health literacy, language and many other social factors that influence health. We agree that measurement burden is a valid concern and must be balanced against the obligation and necessity to have measures that identify and ultimately eliminate health and health care disparities. While there are valid and important considerations about patient privacy in the context of	Data Collection and Reporting

Category	Organization	Name	Comment	Theme
			small populations, we encourage the NQF to consider adding language to the effect that such concerns can be ameliorated by using such methodologies as oversampling and multi-year pooling techniques. We agree that even if such data cannot be reported publicly, that should not be a rationale for failing to collect and stratify data internally. This distinction is critical for small but growing populations, such as Asian Americans, Native Hawaiians and Pacific Islanders, as well as subgroups of African descent, such as Ethiopians, who may face different disparities compared to other groups and experience different disparities within the racial/ethnic categories to which they belong.	
1. Please provide comments on Step #1: Prioritize Disparities-Sensitive Measures	Justice in Aging	Georgia Burke	Justice in Aging endorses the Committee's decision to prioritize measures that help to identify disparities and believes that the Committee's approach to tackling these issues is a sound one. We support the Committee's view that collecting stratifying data is critical to identifying disparities in ways that allow for targeted interventions. When small population sizes are involved, there are challenges, but it is important to find solutions and work-arounds. Otherwise health disparities can be masked.	Data Collection and Reporting
1. Please provide comments on Step #1: Prioritize Disparities-Sensitive Measures	Community Catalyst	Ann Hwang, MD	The number of measures that currently exist can be challenging to navigate, we agree that measures should be prioritized in order to help facilitate quality data from providers and healthcare systems. However, while we agree that there is a proliferation of measures, there is also a serious lack of the "right" measures – measures that would more broadly capture system performance in a way that is meaningful to consumers. We note that the Institute of Medicine's Vital Signs report (Vital Signs: Core Metrics for Health and Health Care Progress, 2015) suggested a slate of measures that are broad in their scope yet parsimonious in number. And we would emphasize the need to look beyond the health care sector in assessing quality and disparities.	Measure Recommendations

Category	Organization	Name	Comment	Theme
1. Please provide comments on Step #1: Prioritize Disparities-Sensitive Measures	America's Health Insurance Plans	Richard Bankowitz	We support this provision.	General Support
1. Please provide comments on Step #1: Prioritize Disparities-Sensitive Measures	California Pan-Ethnic Health Network	Caroline Sanders	CPEHN appreciates the broad, intersectional framework the Committee provides which is expansive and acknowledges disparities across race, ethnicity, health literacy, language and many other social factors that influence health. CPEHN appreciates the work of the Committee in demonstrating that it is possible to address health disparities while also alleviating measurement burden. We understand this is a very real barrier for health plans, hospitals and practitioners in engaging in this work. This was part of the challenge California's health benefit exchange faced when deciding how it would prioritize the elimination of health disparities as part of its quality improvement strategy. NQF's revised set of Disparities-Sensitive Measure Selection criteria (below) which we strongly support will help practitioners reduce measurement burden while identifying where to begin in addressing health disparities as part of quality improvement efforts: The prevalence is great Disparities are large and well-documented There is strong evidence linking quality improvement to better health outcomes The measures selected are actionable The Criteria is intuitive, but also carefully laid out to assist those	General Support

Category	Organization	Name	Comment	Theme
			interested in achieving health equity in an evidence-based prioritization process that will result in measurable, demonstrable results. We agree with the authors that even data for smaller subpopulations should be collected and stratified internally, even if data is too small to be publically reported for privacy reasons or lack of statistical significance. This is especially true for smaller subpopulations such as American Indian and Alaska Native (AIAN) and Asian and Pacific Islander (API) where specific measures may yield very small numbers. This qualitative information is important and can still be used to inform interventions and improve the quality of care.	
2. Please provide comments on Step #2: Identify Evidence-Based Interventions to Reduce Disparities	Hassanah	Janice Tufte	I think it is very important to develop measures that address improving our health systems to effectively tackle disparities in populations with social risk factors. It is true most measures are written focusiing on individual patients' engagement, lifestyle and activation. I am of the belief that changing the culture of the health system with "buy in from the top",support of clinic and insttution change champions, should move equitable research and cultue change along faster. I appreciate the mention of encoraging future research specifically looking at individuals with differing abilities (disabiities), income levels, social networks, comunity context and health literacy. These are very important areas to develop as comparators within the individuals who live in the same area (zip code), and or from the same population to derive some significant findings that might be utilized for common good, better health and health care outcomes	General Support
2. Please provide comments on Step #2: Identify Evidence-Based Interventions to	SPAN/Family Voices NJ	Lauren Agoratus	We are concerned that the literature review focuses on outcomes “in populations socially at risk” but “existing interventions…focus on patient education, lifestyle modification, and culturally tailored programs. Far fewer…address…social risk factors.” We acknowledge that targets are “based on race and ethnicity” but are concerned that	Social Risk Factors

Category	Organization	Name	Comment	Theme
Reduce Disparities			“few…are based on disability status…health literacy.” As previously mentioned, we know that there are health disparities for individuals with disabilities. In addition, health literacy is the single largest factor affecting health care access. We appreciate the acknowledgement that multiple conditions increases risk.	
2. Please provide comments on Step #2: Identify Evidence-Based Interventions to Reduce Disparities	Asian & Pacific Islander American Health Forum	Kathy Ko Chin	Overall, the Asian & Pacific Islander American Health Forum agrees that reducing disparities requires multi-level and sectorial interventions that address both resources, knowledge and institutional systems. As discussed throughout the Report, we note the critical nature and voice that persons who are directly impacted (patients and their caregivers/families) must have at different levels in disparity reduction programs to ensure such programs are responsive to their needs and ultimately address the various factors that influence health. Further, we welcome the need for interventions that address both racial and ethnic disparities, but also the intersections with health literacy, language, disability, income, education, etc. as a recognition that patients are whole people who experience multiple factors that influence their health in different ways.	Social Risk Factors
2. Please provide comments on Step #2: Identify Evidence-Based Interventions to Reduce Disparities	SNP Alliance	Deborah Paone	We wholeheartedly agree with the Committee’s findings that there needs to be significantly more resources focusing on developing and testing integrated approaches and interventions at the system level—across settings, disciplines, and services—that are tailored to meaningful population subgroups and take into account community and organizational context. These interventions need to take into account the multiple chronic conditions, functional limitations, and social risk factors that characterize the population subgroups. We have noted that these population subgroups need to be defined with as much specificity as possible to be meaningful and to guide efforts to address the multiple factors that impact health outcomes. Implementation and quality evaluation of such interventions or approaches would need to attend to the interaction between person, conditions, characteristics, and context. While challenging, this is	Social Risk Factors

Category	Organization	Name	Comment	Theme
			work that is desperately needed to guide efforts to tailor care, increase positive health outcomes, and reduce health disparities. Population stratification—using information to more effectively group individuals with similar medical, behavioral, long-term care, AND social risk factors—offers the opportunity for tailoring care and support. Care approaches being developed and best practices already tested need to take into account functional and social risk factors in addition to medical/clinical diagnoses. Those developing "best practice" programs or models need guidance to ensure robust examination and reporting of their testing results among various population subgroups (consistently defined) in order to highlight similarities or differences arising from population characteristics—independent of the program model. There may need to be customized tailoring of "best practices" to accommodate differences within the population—in order to achieve intended results. Guidance on program translation and customization of program approaches will help ensure fidelity, while also recognizing the diversity of intended population groups.	
2. Please provide comments on Step #2: Identify Evidence-Based Interventions to Reduce Disparities	Summit Health Institute for Research and Education, Inc. (SHIRE)	Ruth Perot	SHIRE agrees that reducing disparities requires multi-level interventions that address resources, knowledge and institutional systems. As discussed throughout the Report, we note the critical nature and voice that persons who are directly impacted (patients and their caregivers/families) must have at different levels in disparity reduction programs to ensure such programs are responsive to their needs and ultimately address the various factors that influence health. Further, we welcome interventions that address both racial and ethnic disparities, but also the intersections with health literacy, language, disability, income, education, etc. as a recognition that health care consumers patients have many experiences that influence their health in different ways.	General Support

Category	Organization	Name	Comment	Theme
2. Please provide comments on Step #2: Identify Evidence-Based Interventions to Reduce Disparities	Justice in Aging	Georgia Burke	Justice in Aging particularly appreciates the recognition in this section of the report on the importance of tailored interventions, many of which are not purely medical. For low-income older adults, issues of economic security, access to stable affordable housing, and reliable transportation to medical appointments are critical to positive health outcomes. In the dual eligible financial alignment demonstrations that CMS currently is undertaking, there has been an emphasis on care coordination that includes help for beneficiaries to access housing, food service, transportation, pest control and other services. See CMS, Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative (March 2017) at 16-17, available at cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CareCoordinationIssueBrief508032017.pdf Person-centered approaches that are culturally competent and language concordant are key and must be tested and evaluated.	Effective Interventions
2. Please provide comments on Step #2: Identify Evidence-Based Interventions to Reduce Disparities	Community Catalyst	Ann Hwang, MD	As stated in the report, findings from the literature review on evidence based interventions to reduce disparities demonstrate need for further investment in research and pilot projects to better understand the mediators of disparities. We believe that this is a critical step to create a validated evidence base to develop meaningful measures.	General Support
2. Please provide comments on Step #2: Identify Evidence-Based Interventions to Reduce Disparities	America's Health Insurance Plans	Richard Bankowitz	We support this provision.	General Support

Category	Organization	Name	Comment	Theme
2. Please provide comments on Step #2: Identify Evidence-Based Interventions to Reduce Disparities	California Pan-Ethnic Health Network	Caroline Sanders	CPEHN appreciates the Committee's decision to modify the Social-Ecological Model (SEM) to better apply to health systems. The need for interventions employed by government, communities, organizations and providers has been clearly demonstrated by Chin et al. We agree with the Committee that leveraging multiple stakeholders throughout the system can improve outcomes for people with social risk factors. We also agree with the Committee that intersectionality is important. As individuals and communities, we each hold different identities, relating to such factors as our race and ethnicity, language, gender, age, sexual orientation, national origin and ability. As multi-identity, multi-cultural individuals and communities, we encounter systems differently, in ways that either support or hinder our health. We appreciate the expansive nature of the Committee's spectrum which focuses on disparities beyond race and ethnicity to include age, gender, income, nativity, language, sexual orientation, gender identity, disability and geographic location amongst other social risk factors. Because of these multiple and at times overlapping identities, we strongly support the idea espoused by the Committee of addressing disparities for more than one social risk factor.	General Support
3. Please provide comments on Step #3: Select and Use Health Equity Performance Measures	Hassanah	Janice Tufte	Ensuring equitable access to care and actual equitable delivery of care are going to prove challenging from EHR patient portals to system non-interoperability. Patients involved with measurement subject matter prioritization, the development of equitable and balancing measures, will assist in ensuring that more relevant and effective measures will be utilized. Rural, Urban, Suburban health care providers and patients from diverse demographic, socio economic and nativity backgrounds should be involved.	Data Collection and Reporting
3. Please provide comments on Step #3: Select	Hassanah	Janice Tufte	RE Figure 4B Sub Domains: Community and Health System Linkages. I was a Patient Co-Investigator on the PCORI funded GHRI/ KPWHRI "Learning to Integrate Neighborhoods with Clinical Care-LINCC"	Measurement Gaps

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and Use Health Equity Performance Measures			project. I have noticed as missing measures from clinic-community linkages projects are the actual outcomes, documentation of useage, or utilization of community resorces once provided. If a CBO refers a client to a health system there is a record of some sort to gather data on, it is a bigger challenge to have a patient report back on if they have utilzed a community resource, and or access data from that CBO. "Linking medical care with community services to connect patients to resources more effectively" how to measure this? A community liaison or community resource specialist might refer to local resources though that resource has perhaps dried up, or takes months or even years to access. One way to address this accessibility gap is to build and nurture valuable community partnerships that might come from unlikely corners sometimes.	
3. Please provide comments on Step #3: Select and Use Health Equity Performance Measures	SPAN/Famiy Voices NJ	Lauren Agoratus	We agree that equity can be achieved by “collaborating and partnering with other organizations.” We would suggest partnering with federally funded Family-to-Family Health Information Centers which are family-staffed organizations that assist families of children with specialhealth care needs and the professionals who serve them. We also strongly support a “culture of equity.” We agree this will be enhanced by creating “structures that support…equity, equitable access to healthcare, and high-quality care.” We are concerned that “few measures assess data collection efforts to improve health equity.”	General Support
3. Please provide comments on Step #3: Select and Use Health Equity Performance Measures	Asian & Pacific Islander American Health Forum	Kathy Ko Chin	Part 1/3: We at the Asian & Pacific Islander American Health Forum welcome the scanning of existing performance measures that can be used in quality improvement programs. Such measures aim to minimize measurement burden on covered entities, while leveraging existing measurement infrastructure. In addition, we appreciate the identification and consideration given to gaps in measures that must	General Support

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			be developed. We encourage NQF to consider, as done with this Report, broad stakeholder input in the development of such measures to address these gaps. Similarly, we welcome the explicit emphasis and inclusion of community, educational and other entities, who while not traditionally part of the healthcare delivery system, play a role in achieving health equity and provide critical supports to patients. We strongly support the finalization of four domains of health equity. In particular, we emphasize the “Collaborate with other organizations or entities that influence the health of individuals” and inclusion of measures that address the social determinants of health in concrete and actionable ways. One such area is the community and services linkage, which has the potential to improve quality for persons who are limited English proficient. As outlined in our “Connecting Limited English Proficient Indviudals to Healthcare Systems Report,” (available at www.apiahf.org), there is a recognition amongst various sectors of the need to include community-based organizations (CBOs) within the healthcare system, yet operational challenges to doing so. CBOs and other trusted community partners play a vital role in supporting a person’s “whole health” as they relate to language access, faith, mental and social support, education, financial security, etc. As noted in the Report, it is critical that there be collaboration and linkage amongst health providers of different types and amongst those who are in non-health/non-clinical areas. Such non-health/non-clinical entities provide essential services that are often not reimbursed by many payers (public or private), including patient navigation at the onset of enrollment, selection of appropriate primary care provider, resolution of and filing of appeals and other benefits claims. In addition, CBOs, for example, help patients understand what services are covered by their plans, provide assistance with scheduling appointments and help them obtain	

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			prescription drugs. These services are often provided with little to no reimbursement or resources to the CBO and are relied upon by racial and ethnic minorities and those with limited literacy, health literacy and English proficiency.	
3. Please provide comments on Step #3: Select and Use Health Equity Performance Measures	Asian & Pacific Islander American Health Forum	Kathy Ko Chin	Part 2/3: Although more LEP individuals have coverage, language continues to present a significant barrier when accessing health care services. Spoken language differences between patient and provider, the lack of appropriate interpretation services, and inadequate translated materials for patients all contribute to communication barriers that adversely affect health outcomes and contribute to the existence of health disparities. Patients who are LEP are less likely to seek care, even when insured, and experience lower quality of care and more adverse health outcomes, such as longer hospital stays and a greater chance of hospital readmission for certain chronic conditions, compared to those who speak English well. Many of those who need interpretation services are not aware of their rights to receive language assistance at a hospital or clinic. CBOs serving Asian American, Native Hawaiian and Pacific Islander (AA and NHPI) communities often focus on providing services to specific AA and NHPI ethnic subgroups that are most represented in the community. Others provide services for segments in a community, such as immigrants and refugees, that often have a large proportion of individuals who came to the U.S. from an Asian or Pacific Island nation. Many of these individuals are LEP, and therefore CBOs frequently have multilingual staff and volunteers who come from the community with the necessary cultural understand to competently provide in-language assistance to the individuals they serve. CBOs can function as a hub for LEP individuals who want to access	Effective Interventions

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			care, but who need culturally and linguistically appropriate assistance to navigate the health care system. Although CBO staff may not be certified community health workers (CHWs), they still provide culturally competent in-language enrollment assistance and assistance in helping people access care and navigate the health care system. CBOs can serve as important members of a care coordination system designed to improve health care access and quality for LEP individuals and receive compensation for services provided by staff, just as CHWs are compensated for helping individuals navigate the health care system. This compensation could come in the form of contracts between CBOs and hospitals, insurers, and provider networks in which CBO staff provide interpretation and health system navigation for LEP individuals. Health plans could contract with CBOs to help their LEP members find providers, describe services covered under their plan, make appointments with providers, and provide interpretation assistance during clinic visits.	
3. Please provide comments on Step #3: Select and Use Health Equity Performance Measures	Asian & Pacific Islander American Health Forum	Kathy Ko Chin	Part 3/3: With respect to the “Culture of Equity” subdomain, we support protecting access to care though critical public programs, including Medicaid and the Children’s Health Insurance Program (CHIP). Similarly, with respect to “Equitable Access to Care,” we welcome the addition of language accessibility as a measurement and strongly agree with equity in access to care as being a core tenant in achieving health equity. With respect to the “Structures of Equity” subdomain, we agree with the integrated nature of data, both in terms of collection, reporting and analysis and having the systems and infrastructure in place to support robust, timely and accurate data collection. Overall, the equity measures provide concrete ways to operationalize a drive to improve health equity and should be leveraged so that	General Support

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			payers have an incentive to integrate them into their quality improvement programs. These measures are critical to assessing progress and eventually, as the report notes, creating incentives for adoption.	
3. Please provide comments on Step #3: Select and Use Health Equity Performance Measures	SNP Alliance	Deborah Paone	We support the Committee's recognition that to reduce disparities, factors outside of the healthcare system must be included. A growing body of evidence shows that community resources, education, employment, and the justice system can signficantly affect health status. These influences may persist over a lifetime or even over generations. Achieving health equity requires collaboration. Healthcare providers and plans in resource-poor communities, disproportionately serving low-income and social risk populations especially need help. We appreciate the subdomains and the environmental scan to find relevant measures. The collaboration and partnership domain is an area of particular interest, specifically, the integration between care settings. Special needs plan members (consumers) frequently require home services, medical care, and behavioral health support. These "systems" of care are still largely separate (not integrated) and this fragmentation adversely affects these individuals. To integrate effectively, policy, regulatory, and payment changes are needed—for example allowing for streamlined information transfer across settings, paying for services outside of current benefit definitions, and identifying consumer decisions on goals that impact the ability to follow standard condition-based guidelines. States currently drive Medicaid benefit definitions for low-income individual and the federal government sets Medicare benefit criteria. When a person is in both these programs, there are overlapping and conflicting policies--this can impact what, how, and when the individual receives care. Quality measures also do not align. We agree with Avedis Donabedian's framework for quality, attending	General Support

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			to availability, accessibility, accommodation, amenability, and affordability—however many of the current "quality" measures, even when they focus on these issues, do not take into account the diversity of social risk populations and their ability to participate in quality surveys. For example, HOS or CAHPS self-report survey data has known limitations arising from: survey instrument and survey design elements that do not match the diverse dual population (e.g., 2-year look-back longitudinal survey), lack of robust language accommodation, inadequate methods of administration (assumes communication device, stability in residence, health or other literacy), and sampling (lack of oversampling of ethnic/language diverse populations)—all limitations which may bias results. We urge attention to refining these tools and methods to accommodate diverse and social risk populations. Then stratifying the results by social risk groups will be the second step to ensuring meaningful interpretation of results that could help drive health equity improvement.	
3. Please provide comments on Step #3: Select and Use Health Equity Performance Measures	Summit Health Institute for Research and Education, Inc. (SHIRE)	Ruth Perot	SHIRE welcomes the explicit emphasis and inclusion of community, educational and other entities, who while not traditionally part of the health care delivery system, play a role in achieving health equity and provide critical support to health care consumers. Community based organizations and other trusted community partners play a vital role in supporting a person’s “whole health” as they relate to language access, wellness promotion and disease prevention, mental and social support, education, financial security, etc. It is critical that there be collaboration and linkage among health providers of different types and among those who are in non-medical/non-clinical areas. Such entities provide essential services now that are often not reimbursed by many payers (public or private), including patient navigation at the onset of enrollment in coverage, selection of appropriate primary care provider, resolution of and filing of appeals and other benefits claims. In addition, CBOs,	Effective Interventions

Category	Organization	Name	Comment	Theme
			for example, help patients understand what services are covered by their plans, provide assistance with scheduling appointments and help them obtain prescription drugs, as well as such wellness promotion services as nutrition education, stress management, etc. These services are often provided with little to no reimbursement or resources to the CBO and yet are relied upon by racial and ethnic minorities and those with limited literacy and health literacy and English proficiency. Language continues to present a significant barrier when accessing health care services. Spoken language differences between patient and provider, the lack of appropriate interpretation services, and inadequate translated materials for patients all contribute to communication barriers that adversely affect health outcomes and contribute to the existence of health disparities. Patients who are LEP are less likely to seek care, even when insured, and experience lower quality of care and more adverse health outcomes, such as longer hospital stays and a greater chance of hospital readmission for certain chronic conditions, compared to those who speak English well. Many of those who need interpretation services are not aware of their rights to receive language assistance at a hospital or clinic. CBOs can serve as important members of a care coordination system designed to improve health care access and quality for LEP, Medicaid and other individuals with special needs. They should therefore be able to receive compensation for services provided by staff, just as community health workers and other outreach personnel are compensated for helping individuals navigate and fully benefit from the health care system. This compensation could come in the form of contracts between CBOs and hospitals, insurers, health plans, clinics and provider networks.	
3. Please provide comments on	Justice in Aging	Georgia Burke	In this section, Justice in Aging particularly appreciates the work of the Committee on the Culture of Equity domain and subdomains, the	General Support

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Step #3: Select and Use Health Equity Performance Measures			Equitable Access to Care domain and subdomains and the Equitable High Quality Care domain and subdomains. For dual eligible beneficiaries, who rely on both Medicare and Medicaid, improvements in these areas, and measures that track progress, are critically important. We strongly encourage continued measures development in these areas.	
3. Please provide comments on Step #3: Select and Use Health Equity Performance Measures	Community Catalyst	Ann Hwang, MD	We are pleased to see the following domains in the report as a way to achieve equity: collaboration and partnership, culture of equity, structure for equity, equitable access to care and equitable high-quality care. We note that there are critical gaps in the available measures in these domains, particularly for consumer-centered measures that capture overall system performance, and we urge NQF to create or identify measures that will more fully assess performance in these domains. We are encouraged to see importance placed on stratifying outcome and process measures to identify disparities. We urge stratification by the spectrum of disparities identified on page 6 of the report.	General Support
3. Please provide comments on Step #3: Select and Use Health Equity Performance Measures	America's Health Insurance Plans	Richard Bankowitz	We support this provision and the domains of health equity performance measurement described in the report. We feel it would be helpful to develop standardized performance measures in these areas to facilitate collaboration between health plans, providers, and other stakeholders. The committee should also provide guidance on how to demonstrate that measurement goals are being met, how to distinguish between good and poor performance, and how to determine the impact of measurement. Measures that address structure for equity, culture of equity and partnerships and collaboration are much harder to identify compared to measures that address high-quality care and access to care.	Measure Recommendations
3. Please provide comments on Step #3: Select	Family HealthCare Center	Paul Nelson	* Of the performance measures listed, there is a recurring emphasis on measures related to infant mortality. I found none related to maternal mortality. State by state, the last data set available is 2001-	Measure Recommendations

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and Use Health Equity Performance Measures			2006, maternal mortality rates are highly related to a state's poverty level. Given the UN/WHO/IMF report for 2015, our nation ranks 41st out of the 51 advanced/developed nation's. Given the best 10 of these nations, we would need to reduce our nation's maternal mortality incidence by 70% to rank among these nations. We are the ONLY developed nation with a worsening maternal mortality incidence for 25 years. * Its possible that I missed a Lead Poisoning indicator. But if not, it is highly correlated with poverty.	
3. Please provide comments on Step #3: Select and Use Health Equity Performance Measures	California Pan-Ethnic Health Network	Caroline Sanders	CPEHN agrees with the need for disparities sensitive measures and measures that directly assess equity. We support including measures of Collaboration and Partnerships including collaboration across health and non-health sectors, community and health system linkages, building and sustaining social capital and social inclusion. We support the Committee's framework of measurement beyond clinical settings, structures, and processes of care to include for example, an assessment of collaboration between healthcare and other sectors (e.g., schools, social services, transportation, housing, etc.) to reduce the impact of social risk factors. A hospital may discharge a patient in "good condition." However without the social supports needed to recuperate such as adequate housing and access to healthy foods, that patient has a much higher likelihood of being readmitted. As the Committee notes, "achieving equity is a process and that different organizations may be in different places in that process and have different resources available" (p. 11). The Committee's Domains of Health Equity Performance Measurement is a helpful tool as it takes into account these differences in organizational progress and capacity towards meeting these ambitious goals.	General Support

Category	Organization	Name	Comment	Theme
4. Please provide comments on Step #4: Incentivize the Reduction of Health Disparities and Achievement of Health Equity	Hassanah	Janice Tufte	This section is well thought out with very effective strategies and recomendations. Thank you I will read a couple times to digest the full report	General Support
4. Please provide comments on Step #4: Incentivize the Reduction of Health Disparities and Achievement of Health Equity	SPAN/Famiy Voices NJ	Lauren Agoratus	We understand that "performance measurement is increasingly used for accountability." However, what appears to be missing is that by reducing health disparities, the result is cost savings and more importantly, better health outcomes for underserved populations. We support the strategies developed to address equity through implementation of health equity measures, incentivized payment, support of organizations that disproportionately serve individuals with social risk factors, and demonstration projects.	General Support
4. Please provide comments on Step #4: Incentivize the Reduction of Health Disparities and Achievement of Health Equity	Asian & Pacific Islander American Health Forum	Kathy Ko Chin	The Asian & Pacific Islander American Health Forum agrees that data are the bedrock of all measures and ability to understand, access, monitor and eliminate disparities and that such data should be stratified to the greatest extent possible, using systems that create ease in operation as much as possible (e.g. social risk factors in electronic health records). We welcome the strong emphasis on the levels of stratification and levels from which data is collected: clinical (Claims or administrative; patient-reported data; community and systems level). Moreover, we underscore the Committee's recommendation on accountability and transparency. Public reporting of measures and activities is relevant not only to hold systems and providers accountable, but also empowers patients by providing them with information to take an active role in quality improvement and their care. It is difficult to imagine patients being	Data Collection and Reporting

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			able to play active, empowered roles in quality improvement without access to data most useful for the patient and provided in a form and manner that is responsive to patients (e.g. health literacy and linguistic competency). APIAHF underscores performance measures can be used to continuously identify disparities in health and healthcare, used to hold various stakeholders accountable (providers, payers, policymakers) and to create incentives to reduce disparities and provide assistance to providers who are striving to improve quality and have a patient population that experiences a multitude of risk factors. As such, we recognize the importance of adjusting for social risk factors in payment programs and share concern about both the burden on clinicians who disproportionately serve those with more social risk factors, while at the same time not creating lower standards for improving health outcomes in disadvantaged populations. We agree that one method of doing so is to directly adjust payment for social risk factors, stratify data across social risk factor groups to provide transparency and link health equity measures to accreditation programs. Lastly, we strongly endorse the recommendation to conduct policy simulations and demonstration projects to test how interventions can mitigate disparities. For example, community-based organizations (CBO) represent a trusted and reliable connection to patients who come from diverse backgrounds, including those who are limited English proficient. We agree that there is a need to conduct such	

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			demonstration projects to determine how to effectively integrate CBOs into the healthcare delivery system, how to create sustainable funding models and ensure partnerships with payers and providers.	
4. Please provide comments on Step #4: Incentivize the Reduction of Health Disparities and Achievement of Health Equity	SNP Alliance	Deborah Paone	We applaud the Committee for attending to the ASPE and NAM reports and recognizing the danger that current value based payment methods add to inequities in resource distribution. The safety net providers and plans that disproportionately serve low-income and social risk populations may be negatively impacted, as these independent research committees and experts have concluded. The Disparities Committee rightly points out that low reimbursement rates or lack of bonus payments can end up restricting resources to the providers and plans that are serving the most at-risk populations. We particularly note the opportunities to add social complexity factors to risk adjustment and payment models and the need to support organizations that disproportionately serve these individuals with social risk factors (Strategies 2 and 3). The recommendations offer practical approaches that could be implemented under current statutory authority by the Secretary. We agree that there needs to be standardization in data elements and definitions related to social risk factors. We note the existing challenges with accessing electronic health record information—additional technical support and capacity will be needed to effectively add and collect uniform social risk data. In addition, we note that individuals (consumers/patients) may resist the collection of some of these data elements—as they may not understand why or agree with the need for healthcare providers to have information about their employment, marital, education, or housing status. As others have pointed out, the need for person-level data to identify risk areas and address underlying issues that impact health status will have to be balanced with individual rights to privacy.	General Support

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			Plans and providers serving unique special needs populations may have small tailored programs that are customized to these unique groups. We hope that any collection or reporting of quality measurement data recognizes and respects the uniqueness of specialty populations and allows for accommodation in care. Small sample sizes within any one organization are a limitation, but pooling information may assist in quality improvement strategies. With a better understanding of the subgroups within populations--needs, characteristics, preferences, and what works--we will be able to more effectively target resources and tailor care.	
4. Please provide comments on Step #4: Incentivize the Reduction of Health Disparities and Achievement of Health Equity	Summit Health Institute for Research and Education, Inc. (SHIRE)	Ruth Perot	SHIRE agrees that data are the bedrock of all measures and are essential to understand, access, monitor and eliminate disparities. We concur that such data should be stratified to the greatest extent possible, using systems that create ease in operation as much as possible (e.g. social risk factors in electronic health records). We welcome the strong emphasis on the levels of stratification and levels from which data are collected: clinical claims or administrative data; patient-reported data; community and systems level data. Moreover, we underscore the Report's recommendation on accountability and transparency. Public reporting of measures and activities is relevant not only to hold systems and providers accountable, but also empowers patients by providing them with information to take an active role in quality improvement and their care at the patient-level. It is difficult to imagine how patients might play active, empowered roles in quality improvement without access to data provided in a form (e.g. linguistically and culturally appropriate) that meets their needs. SHIRE underscores the recommendation that performance measures can be used to continuously identify disparities in health and health care, used to hold various stakeholders accountable (providers, payers, policymakers) and to create incentives to reduce disparities and provide assistance to providers who are striving to improve	Data Collection and Reporting

Category	Organization	Name	Comment	Theme
			quality and have a patient population that experiences a multitude of risk factors. Lastly, we strongly endorse the recommendation to conduct policy simulations and demonstration projects to test how interventions can mitigate disparities. For example, community-based organizations (CBO) represent a trusted and reliable connection to patients who come from diverse backgrounds, including those who are limited English proficient. We agree that there is a need to conduct such demonstration projects to determine how to effectively integrate CBOs into the health care delivery system, how to create sustainable funding models and ensure partnerships with payers and providers. For maximum effectiveness, these programs should be funded adequately and over a sufficient period of time to be able to document results. Thank you for the opportunity to comment on this Report. If you have questions, please contact Ruth Perot, Executive Director/CEO at rperot@shireinc.org.	
4. Please provide comments on Step #4: Incentivize the Reduction of Health Disparities and Achievement of Health Equity	Justice in Aging	Georgia Burke	The Committee accurately notes that performance measurement is increasingly used for accountability including for determining payments under Medicare and Medicaid. Justice in Aging believes that this trend increases the importance of the work of the Committee, particularly the implementation strategies in this section. Looking at the policy recommendations in this section, we particularly support the recommendation of supporting organizations that disproportionately serve individuals with social risk factors. It is our experience that many safety net providers, though making do with inadequate funding, have developed innovative culturally competent programs and effective interventions to address disparities. Providing these programs with stable support at reasonable levels is important. It is important that payment models do not unfairly penalize them because they disproportionately serve the very	General Support

Category	Organization	Name	Comment	Theme
			populations that are most in need of culturally competent, qualify care.	
4. Please provide comments on Step #4: Incentivize the Reduction of Health Disparities and Achievement of Health Equity	Community Catalyst	Ann Hwang, MD	We are encouraged to see in the report detailed recommendations on incentivizing the reduction of disparities and achieving health equity. Promoting payment models that will address disparities with a goal to achieve health equity is a step in the direction of an equitable healthcare system for vulnerable populations.	General Support
4. Please provide comments on Step #4: Incentivize the Reduction of Health Disparities and Achievement of Health Equity	America's Health Insurance Plans	Richard Bankowitz	We support this provision. We support the recommendation that health equity measures be incorporated into accountability programs and aligned across payers to facilitate adoption. We also support the recommendation that social determinants of health be an integral part of any efforts to address health disparities.	General Support
4. Please provide comments on Step #4: Incentivize the Reduction of Health Disparities and Achievement of Health Equity	California Pan-Ethnic Health Network	Caroline Sanders	We agree with the Committee that financial incentives are an important policy lever to hold health plans, hospitals and providers accountable for reducing disparities and achieving health equity. Large payers like Medicaid and Medicare are increasingly turning to payment incentives as a strategy for improving quality by holding health plans, providers, and hospitals accountable for measurable results. We agree with the Committee that value-based purchasing represents a chance to reward providers for reducing disparities or for the use of effective interventions to reduce disparities as does the shift to global payment, capitated payment, and bundled payment. Additionally we support the use of social and population health	General Support

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			measures to ensure appropriate resource allocation to counteract the causes of social risk. We agree with the Committee that stratification of disparities-sensitive measures can promote transparency and help identify and address disparities. Lastly, we strongly endorse the recommendation to conduct policy simulations and demonstration projects to test how interventions can mitigate disparities. Researchers for example with RWJ's Finding Answers: Disparities Research for Change project conducted an exhaustive review and evaluation of promising practices for reducing racial and ethnic disparities in care. These models should be encouraged and supported and the results widely shared.	
4. Please provide comments on Step #4: Incentivize the Reduction of Health Disparities and Achievement of Health Equity	California Pan-Ethnic Health Network	Caroline Sanders	We agree with the Committee that financial incentives are an important policy lever to hold health plans, hospitals and providers accountable for reducing disparities and achieving health equity. Large payers like Medicaid and Medicare are increasingly turning to payment incentives as a strategy for improving quality by holding health plans, providers, and hospitals accountable for measurable results. We agree with the Committee that value-based purchasing represents a chance to reward providers for reducing disparities or for the use of effective interventions to reduce disparities as does the shift to global payment, capitated payment, and bundled payment. Additionally we support the use of social and population health measures to ensure appropriate resource allocation to counteract the causes of social risk. We agree with the Committee that stratification of disparities-sensitive measures can promote transparency and help identify and address disparities. Lastly, we strongly endorse the recommendation to conduct policy simulations and demonstration projects to test how interventions can mitigate disparities.	General Support

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5. Please provide general comments on the report	James P. Scanlan, Attorney at Law	James Scanlan	In its current form, the July 21, 2017 Draft Report (DR) titled "A Roadmap to Reduce Health and Healthcare Disparities through Measurement" will do a great disserve to health and healthcare (HHD) disparities research, as the NQF's Commissioned Paper: Healthcare Disparities Measurement (CP) also did. Standard measures of differences between health and healthcare (HHC) outcome rates tend to be systematically affected by the prevalence of an outcome. As HHC generally improves, relative differences in favorable outcomes (e.g., survival, receipt of appropriate care) tend to decrease, while relative differences in the corresponding adverse outcomes (e.g., mortality, non-receipt of appropriate care) tend to increase. Thus, as the NCHS recognized more than a decade ago, whether HHC disparities are deemed to be increasing or decreasing commonly turns on whether one examines relative differences in the favorable outcome or relative differences in the adverse outcome. Absolute differences tend also to be affected by the prevalence of an outcome, though in a more complicated way than the two relative differences. Roughly, as uncommon outcomes become more common, absolute differences tend to increase; as common outcomes become even more common, absolute differences tend to decrease. All measures may change in the same direction as prevalence changes. But anytime a relative difference and the absolute difference change in opposite directions, the other relative difference will necessarily change in the opposite direction of the first relative difference and the same direction of the absolute difference. See references below. See ref. 2 (at 337-339) and 5 (slides 113-118) regarding	

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			Massachusetts's inclusion of a disparities element in its Medicaid P4P program that would tend to increase healthcare disparities. See ref. 2 (at 343-344) regarding that fact that, while CP recognized that different measures might yield different conclusions about directions of changes in disparities, it failed to recognize patterns by which the measures tend to be affected by the prevalence of an outcome and the need to consider those patterns when determining what observed patterns indicate about underlying processes. See ref. 6 urging withdrawal of the CP. The DR, however, fails even to indicate that choice of measure might make a difference in determining whether HHC disparities are increasing or decreasing. 1. http://www.jpscanlan.com/images/The_Mismeasure_of_Health_Disparities_JPHMP_2016_.pdf 2. http://jpscanlan.com/images/Race_and_Mortality_Revisited.pdf 3. https://www.regulations.gov/document?D=USBC-2016-0003-0135 4. http://jpscanlan.com/images/2013_Fed_Comm_on_Stat_Meth_paper.pdf 5. http://jpscanlan.com/images/Univ_Mass_Medical_School_Seminar_Nov._18,_2015_.pdf 6.	

Category	Organization	Name	Comment	Theme
			http://jpscanlan.com/images/Harvard_et_al._Commissioned_Paper_Letter.pdf	
5. Please provide general comments on the report	American Association on Health and Disability	E. Clarke Ross	Recognition of Disability We appreciate the acknowledgement of persons with disabilities - Pages 2, 6, 10, 16. However, completely missing from the report is a discussion of disability as a disparity factor/consideration. We encourage the addition of a discussion of this topic. Such as discussion could include a summary of the following peer reviewed professional journal literature and related materials: 1.NQF disparities committee member, Lisa Iezzoni, M.D.. Among her many articles are April 2017 Disability and Health Journal on “Do prominent quality measurement surveys capture the concerns of persons with disabilities;” 2016 Disability and Health Journal on “Trends in Colorectal Cancer Screening Over Time for Persons with Chronic Disability;” and similar journal articles on breast cancer and disability, physical access barriers, and treatment disparities facing Medicare beneficiaries. 2.Former CDC NCBDDD division director Gloria Krahn, Ph.D. Among her many publications are February 2015 American Journal of Public Health on “Persons with Disabilities As An Unrecognized Health Disparity Population;” and September 8, 2015 CMS OMH health equity symposium presentation and resources on health inequity and persons with disabilities. 3.Froehlich-Grobe et al, October 2016 Disability and Health Journal on “Impact of Disability and Chronic Conditions on Health.” 4.Henan Li, et al, March 2017 Disability and Health Journal on “Health of U.S. Parents with and without Disabilities.”	Social Risk Factors

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			5.Havercamp, et al, 2015 Disability and Health Journal on "National Health Surveillance of Adults with Disabilities, Adults with Intellectual and Development Disability, and Adults with No Disabilities." 6.Ohio Disability and Health Program 2015 free-standing publication with references, "The Double Burden: Health Disparities Among People of Color Living with Disabilities." 7.Network for Public Health Law-CDC 2017 webinar materials including April 20 on "The Built Environment as a Social Determinant of Health" and May 18 on "Housing as a Social Determinant of Health." Further, an analysis of disparities should examine the NQF MAP December 2012 identified "high need" subgroups of persons dually eligible for Medicare and Medicaid: (1) persons with physical or sensory disabilities; (2) persons with serious mental illness and/or substance use disorder; (3) persons with cognitive impairment (e.g., dementia; intellectual disability and/or developmental disability); and (4) "medically complex adults age 65 or older with functional limitations and co-occurring chronic conditions." American Association on Health and Disability and Lakeshore Foundation, part 1, Clarke Ross	
5. Please provide general comments on the report	American Association on Health and Disability	E. Clarke Ross	Person and Family Centeredness and Experience of Care We appreciate the pages 16-17 importance of person and family centeredness; page 21 recognition of NQF endorsed experience of care, including ECHO and CAHPS HCBS Experience of Care Survey; page 27 – the potential of CAHPS surveys on convenience, timeliness, and accessibility; and page 28 – the importance of Patient-Centered Medical Homes Patients' Experience and CAHPS HCBS Experience of Care Survey	General Support

Category	Organization	Name	Comment	Theme
			When examining persons with disabilities, two disability quality measurement programs have each operated for over 20 years - the National Core Indicators and Personal Outcome Measures. These programs were initially designed for persons with intellectual and other developmental disabilities, but have evolved for other populations of persons with disabilities over recent years. Other NQF committees and workgroups have examined the NCI & POM and should be referenced in the disparities report. Recognition of Mental Illness/Mental Health Thank you for the pages 5, 24, 27, and 30 recognition of mental illness. We particularly applaud the page 19 focus – Gaps in the integration of physical and mental health and recognition of the SAMHSA 4 Quadrant Model. Recognition of Low-Birth Rate Thank you for the page 5 and 24-28 recognition of low-birth rate. American Association on Health and Disability and Lakeshore Foundation, part 2, Clarke Ross	
5. Please provide general comments on the report	American Association on Health and Disability	E. Clarke Ross	Importance of Collaboration Between Health Care and Community/Social Sectors Particularly important are the page 7 importance of Collaboration Between Health Care and Community/Social Sectors; page 11 – Influence of Community Organizations; page 11 – health care sectors must collaborate and partner with other organizations and agencies that influence the health or individuals; page 13 – Collaboration Across Health and Health Care Sectors, Community and Health Systems Linkages, Social Inclusion; pages 18-20 discussion of	General Support

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			Collaborations and Partnerships; and pages 36 & 37 – a step to incentivize the reduction of health disparities and achievement of health equity includes: (1) ensure that organizations that disproportionately serve individuals with social risk factors can compete in value-based purchasing, and (2) consider additional payment for organizations that fall outside the control of safety net organizations and providers. Pivotal Role of Continuity of Care Thank you for the page 27 identification of the pivotal role of continuity of care Pivotal Role of Primary Care We agree with the page 27 – pivotal role of primary care and page 34 – a step to incentivize the reduction of health disparities and achievement of health equity includes direct investment in preventive and primary care for patients with social risk factors Population Health Management We agree with the page 15 observation – importance of population health management – and pages 24-26 – need for better population health for individuals with social risk factors as an important measure gap. American Association on Health and Disability and Lakeshore Foundation, part 3, Clarke Ross	
5. Please provide general comments on the report	SPAN/Family Voices NJ	Lauren Agoratus	In general, we appreciated the framework based on the National Academy of Medicine (NAM) Conceptual Framework of Social Risk Factors and Performance Indicators for Value-Based Payment regarding access to care including affordability, availability,	Social Risk Factors

Category	Organization	Name	Comment	Theme
			accessibility, and accommodation. We agree with using the NAM domains of quality including effectiveness, safety, timeliness, patient/family-centeredness, access, and efficiency. However, we are deeply concerned with the current climate regarding cutting healthcare protections and Medicaid both under the ACA repeal and budget. We were unable to locate any measures on insurance status. The NJ Hospital Association conference on the uninsured indicated that individuals without coverage could be diagnosed on average 2-4 years after their insured peers, when disease is less treatable and most costly, resulting in increased morbidity and mortality. Looking through the appendices, we are deeply concerned that the focus is mostly on adults as illness affect the pediatric population differently (e.g. renal disease can cause cognitive and growth adverse effects.) In addition, there was no focus on children with special health care needs, yet 1 in 5 children have special needs (Source: CAHMI http://childhealthdata.org/) other than some condition-specific information on sickle cell, cardiac, and renal disease. We did appreciate inclusion of mental health. We were also unable to locate measures regarding screening other than adult screenings for cancer, obesity, etc.; besides developmental screenings, other screenings of importance for children are newborn screenings, immunizations, and lead particularly with the recent findings of lead in water, even in schools. Overall, we strongly support addressing health disparities but unless some of the key factors previously mentioned are addressed, there will continue to be underserved populations resulting in poorer health outcomes.	
5. Please provide general comments on the report	Asian & Pacific Islander American	Kathy Ko Chin	The Asian & Pacific Islander American Health Forum (APIAHF) is the nation's leading health policy group working to advance the health and well-being of over 20 million Asian Americans, Native Hawaiians and Pacific Islanders (AAs and NHPIs) across the U.S. and territories.	General Support

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	Health Forum		As such, APIAHF works to improve access to and the quality of care for communities who are predominately immigrant, many of whom are limited English proficient, and may be new to the U.S. health care system or unfamiliar with private or public coverage. APIAHF appreciates the opportunity to review and comment on the draft report “A Roadmap to Reduce Healthcare Disparities Through Measurement,” (Report). Overall, we wish to express our strong support for and adoption of the Report and the National Quality Forum’s (NQF) work to develop an integrated roadmap to identifying and eventually eliminating health and healthcare disparities. The Report contains an extensive framework for identifying performance measures that address social risk factors for chronic diseases as a way to eliminate disparities and achieve health equity. Such work is critical at a time of rapid change in the healthcare delivery system and underscores, as outlined in the Report, the need for integration and emphasis of achieving health equity as an explicit goal in the process. Having performance measures that are evidence-based, broad in their scope so as to address various social risk factors for chronic conditions that disproportionately impact racial and ethnic minorities and others who are limited English proficient and/or experience other barriers to good health and quality health care, is critical to monitoring, assessing, evaluating and eventually eliminating disparities. Performance measures are a critical lever in achieving health equity and APIAHF welcomes NQF’s Report on the issue. We agree with the four-part model as a way of recognizing the value and accountability that all sectors, including payers, policymakers, providers and patients have in eliminating disparities. The Report and emphasis on sector-specific analysis recognizes the unique roles,	

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			assets and obligations each have in eliminating disparities. In particular, we welcome the inclusion of policymakers as well as community organizations that serve diverse groups and can serve as aggregators of information and resources and trusted messengers.	
5. Please provide general comments on the report	SNP Alliance	Deborah Paone	As the Committee points out, health disparities arise as a symptom of deeper issues, and need to be addressed in collective action. The medical, behavioral health, long-term care, and social services systems will need to join with public health and other community efforts. Policy, legislative and regulatory changes, advocacy, and local action will be needed to make progress in connecting efforts to improve health equity outcomes--across settings and services, government and private agencies, and with individuals and the communities affected. While these efforts are underway, we need to be judicious about how we measure and who we determine is accountable for measurement results. A core set of meaningful structure, process, and outcome measures should be used across settings and over time. To be useful for quality improvement, this core set of measures must be amenable to action/change from one reporting period to the next. Focusing across services on one set of core measures for key vulnerable population groups that require care and support across settings/disciplines--will combine and enhance rather than splinter efforts around quality improvement. Reducing the number of measures to focus on what is meaningful for at-risk populations will help target action. We underscore the importance of taking action to recognize that organizations serving a high proportion of individuals with social risk factor issues on top of medical, long-term care, and behavioral health needs—are currently being penalized in quality measurement and value-based payment systems.	Measure Recommendations

Category	Organization	Name	Comment	Theme
			The Committee's examination and recommendations are well thought out and provide a blueprint for addressing vital issues in addressing health disparities through increased attention to social risk factors in vulnerable populations. Thank you for the opportunity to comment. We are pleased to assist you in any way in the future.	
5. Please provide general comments on the report	Summit Health Institute for Research and Education, Inc. (SHIRE)	Ruth Perot	Summit Health Institute for Research and Education, Inc. (SHIRE) has been involved in combating disparities in health and health care for twenty years with focus directed toward improving the health status of communities of color. Since 2013, SHIRE has worked in concert with AmeriHealth Caritas District of Columbia to implement data collection/reporting strategies at the community level. SHIRE has conducted Wellness Circles for AmeriHealth members who have diabetes and hypertension. The collection and analysis of health outcomes data, including weight loss, blood pressure indicators, and HbAic levels, plays an essential role in determining to what extent gaps in chronic disease rates between Medicaid beneficiaries of color and the total District of Columbia population are narrowing. Thus, our organization has first-hand knowledge of the importance of measuring and monitoring health disparities and progress toward their elimination. Accordingly, we appreciate the opportunity to review and comment on the draft report "A Roadmap to Reduce Healthcare Disparities Through Measurement" (the Report). We are pleased to express our strong support for the Report and for the work of the National Quality Forum (NQF) to develop an integrated roadmap to identifying and eventually eliminating health and health care disparities. The Report contains an extensive framework for identifying performance measures that address social risk factors for chronic diseases as a way to eliminate disparities and achieve health equity. Such work is critical at a time of rapid change in the health care delivery system and underscores, as outlined in the	General Support

Category	Organization	Name	Comment	Theme
			Report, the need for integration and emphasis on achieving health equity as an explicit goal in the process. It is essential to have performance measures that are evidence-based and broad in their scope. These measures can address various social risk factors for chronic conditions that disproportionately impact racial and ethnic minorities and others who are limited English proficient and/or experience other barriers to good health and quality health care. Such measures are critical to monitoring, assessing, evaluating and eventually eliminating disparities. We believe that performance measures are a critical lever in achieving health equity. SHIRE welcomes NQF's Report on these critically important issues. We agree with the four-part model as a way of recognizing the value and accountability that all sectors, including payers, policymakers, providers and patients have in eliminating disparities. The Report and emphasis on sector-specific analysis recognizes the unique roles, assets and obligations each have in eliminating disparities. In particular, we welcome the inclusion of policymakers as well as community organizations that serve diverse groups and can play an important role in identifying and even aggregating information and resources in their role as trusted messengers and community partners.	
5. Please provide general comments on the report	Institute for Healthcare Improvement	Amy Reid	Thank you for your incredible work to advance equtiy. We're grateful for the time you took and the opportunity to dialogue through this open comment period. 1. Domains to advance equity: In the report, the committee proposes five domains of measurement that should be used together to advance equity: collaboration and partnerships, culture of equity, structures for equity, equitable access to care, and equitable high-quality care. The Institute for Healthcare Improvement has outlined the following 5 pillars for health care to advance equity: 1) make equity a strategic priority, 2) infrastructure that supports equity, 3)	Measurement recommendations

Category	Organization	Name	Comment	Theme
			impacting multiple determinants of health over which healthcare can have an impact (eg improving clinical processes, improving SES of employees), 4) address institutional racism, and 5) community partnerships. There is overlap in our frameworks in the following areas: equity culture/priority, supportive equity structures, partnerships, and equitable care. You may consider two additional areas: 1) other determinants of health that healthcare can impact to advance equity such as SES and educational attainment of employees, and 2) addressing institutional racism – equitable access to care is one part of that. We suggest explicitly naming racism, socializing an institution to these discussions, and reviewing policies, practices, decisions, and regulations with a racial equity lens to understand differential impact of institutional policies. 2. Simplifying measures: Currently, equity is not regarded as strategically important by the majority of policy-makers, payers or health system leaders. One or two measures tied to reimbursement and accreditation would have an important impact and promote a pragmatic approach. We suggest a clear emphasis on stratification. REAL data may not be granular enough to fuel true community partnerships. It will be key to move towards collection and understanding the self-identified race and ethnicity of individuals served by the system as a standard – e.g., Chinese, Japanese, etc instead of 'Asian', Hmong, Somali, Mexican American, etc. In addition, we want to move beyond cultural competency to cultural sensitivity or humility. 3. Simplifying implementation guidance: Pairing suggested measures with comments on implementation is incredibly helpful. We suggest that a simplification would aid utilization. Perhaps 'pay for reporting	

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			of stratified data' and 'adjust payment for social risk factors' and 'link health equity measures to accreditation programs' all under the rubric of 'redesign payment models to support equity'. The main issues do not relate to defining a reasonable measure set, but rather how to deploy and collect them without unduly burdening health systems, and your work in this area will be of great value.	
5. Please provide general comments on the report	Federation of American Hospitals	Jayne Chambers	The Federation of American Hospitals ("FAH") appreciates the opportunity to comment on the National Quality Forum report: A Roadmap to Reduce Health and Healthcare Disparities through Measurement. FAH and our members continue to work toward reducing health and healthcare disparities. To that end, FAH hoped that the report would provide practical guidance on current issues in addition to the conceptual model and measures proposed. We urge the Committee to provide recommendations on how to improve the current methods used by the Centers for Medicare & Medicaid Services (CMS) and others to fairly report and pay for those healthcare systems and providers who care for these at risk populations. Many of the current and future activities can lead to negative unintended consequences, particularly the current practices around accounting for social risk in performance measures and payment programs. FAH encourages the Committee to address steps that can be taken to mitigate and minimize this potential harm to our healthcare system and patients. FAH also notes that the report is not specific on which healthcare entities can drive the greatest improvements through the proposed measure concepts and recommendations. Currently, it appears that the report focuses on what larger systems such as health plans and accountable care organizations can do since many of the measures and measure concepts identified under the subdomains of the health equity section would only be applicable at the system level. Additional recommendations or guidance on how providers at every level can work to reduce disparities would be beneficial and help all	Future Work

Category	Organization	Name	Comment	Theme
			of us move toward the collective goal. FAH supports that many of the measure concepts are considered appropriate for quality improvement (QI) only and not accountability. In addition, several of the concepts are focused on structures and processes and at times it is difficult to know how each proposed concept can positively impact patient outcomes. For example, it is not clear how the concept calling for equity to be explicitly stated in the mission statement and/or strategic plan can drive improvements and reduce disparities. Many of the measure concepts seem to be more suited as best practices rather than measures for QI. FAH thanks the Disparities Standing Committee for their thoughtful report. The comments we provide are intended to further improve and refine this work.	
5. Please provide general comments on the report	American Optometric Association	Christopher Quinn, O.D.	The American Optometric Association (AOA) appreciates the opportunity to comment on the draft report, “A Roadmap to Reduce Health and Healthcare Disparities through Measurement” from the National Quality Forum (NQF). The AOA represents approximately 33,000 doctors of optometry and optometry students. Doctors of optometry are eye and vision care professionals who diagnose, treat and manage diseases, injuries and disorders of the eye, surrounding tissues and visual system and play a major role in a patient’s overall health and well-being by detecting and helping to prevent complications of systemic diseases such as hypertension, cardiovascular disease, neurologic disease, and diabetes - the leading cause of acquired blindness. Doctors of optometry serve patients in nearly 6,500 communities across the country, and in 3,500 of those communities we are the only eye doctors available. Providing more than two-thirds of all primary eye and vision health care in the United States, doctors of optometry deliver up to 80 percent of all primary vision and eye health care	General Support

Category	Organization	Name	Comment	Theme
			provided through Medicaid. Recognized as Medicare physicians for more than 25 years, doctors of optometry provide medical eye care to nearly six million Medicare beneficiaries annually. The AOA generally supports NQF's efforts to reduce disparities in health and health care. Eye and vision health is no different from the rest of health – disparities in both health and healthcare exist for a variety of reasons. Furthermore, a number of systemic diseases with disparate health outcomes and experiences for different groups manifest with ocular symptoms and doctors of optometry play a key role in the management of those diseases. Diabetes is a particular concern for our doctors - diabetic retinopathy, the most common microvascular complication of diabetes, is the leading cause of new cases of blindness and low vision for Americans ages 20 to 74 and accounts for about twelve percent of all new cases of blindness each year. [1] As the draft report identified, there are significant socioeconomic disparities in the prevalence of diabetes that must be addressed. CONTINUED [1] Klein R, Klein B. Vision disorders in diabetes. In: National Diabetes Data Group, ed. Diabetes in America, 2nd ed. Bethesda, MD: National Institutes of Health, National Institutes of Diabetes and Digestive and Kidney Disease; 1995: 293-337	
5. Please provide general comments on the report	American Optometric Association	Christopher Quinn, O.D.	CONTINUED However, we are concerned that the eye exam measures for patients with diabetes that NQF identifies as part of the compendium of measures remain flawed, as we have expressed to NQF previously. NQF measure #0055, Comprehensive Diabetes Care: Eye Exam,	Measure Recommendations

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			measures the number of individuals who have had an eye exam in the measure year OR who had an eye exam that was negative for retinopathy in the previous measure year. This effectively endorses a schedule of an eye exam every two years for patients with diabetes, which is counter to current best practices for these patients. The evidence-based clinical practice guideline for Eye Care of the Patient with Diabetes Mellitus indicates that patients with diagnosed diabetes should receive a dilated, comprehensive eye exam at least annually and this frequency should be reflected in the NQF's quality measures. More frequent examination may be needed depending on changes in vision and the severity and progression of diabetic retinopathy. [2] Relying on a flawed measure to improve disparities in care does a disservice to those the NQF is trying to help. The best way to improve the health outcomes of disadvantaged populations is to ensure that they're receiving the accepted standard of care – and the only way to know that is if the measures accurately reflect that standard. The AOA supports NQF's efforts to reduce disparities, but urges a critical review of the relied-upon measures. [2] http://aoa.uberflip.com/i/374890-evidence-based-clinical-practice-guideline-diabetes-mellitus	
5. Please provide general comments on the report	Justice in Aging	Georgia Burke	Justice in Aging appreciates the opportunity to comment. Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. Justice in Aging uses the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We are most appreciative of the thorough and thoughtful analysis that went into the report. We encourage the Committee to continue to focus on developing and implementing measurements to address	General Support

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			health disparities and prioritizing those measures. As the Committee report demonstrates, measures are not an end in themselves. They exist to promote the development and implementation of effective person-centered interventions that improve lives and reduce disparities. We support continued efforts to develop and refine disparities-related measures and to incorporate those measures into program evaluations.	
5. Please provide general comments on the report	Community Catalyst	Ann Hwang, MD	Community Catalyst appreciates the opportunity to comment on the 2017 draft report: A Roadmap to Reduce Health and Healthcare Disparities through Measurement. Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1998, Community Catalyst has been working to build the consumer and community leadership required to transform the U.S. health system. The Center for Consumer Engagement in Health Innovation (the Center) is a hub devoted to teaching, learning, and sharing knowledge to bring the consumer experience to the forefront of health. The Center works directly with consumer advocates to enhance their skills and power to establish an effective voice at all levels of the health care system. We collaborate with innovative health plans, hospitals, and providers to incorporate the consumer experience into the design of their systems of care. We work with state and federal policymakers to spur change that makes the health system more responsive to consumers. The Center has placed high priority on addressing disparities and achieving health equity, as evidenced by our policy priorities (https://www.communitycatalyst.org/resources/publications/document/Consumer-Policy-Platform-for-HST-web.pdf?1473712433). We appreciate NQF's continued focus and investment in addressing health and healthcare disparities. Overall, we believe the framework outlined in the draft report is a step in the right direction. We agree	General Support

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			that health is influenced beyond the factors in control by traditional healthcare system. The social and economic determinants are a major player in determining health outcomes. The role of structural racism is also key to understanding the impacts on health disparities, as noted in the report. We encourage continued research and application of measures that can unearth the systemic causes of health disparities. The compendium of measures shows that we have a long way to go—while there are numerous highly granular measures that measure narrow aspects of quality, we note the serious deficit in “big-dot” consumer-centered measures that would allow consumers, providers, policymakers, and payers alike to understand the overall performance of the health system. We urge NQF to actively engage diverse consumers, consumer advocates and the community when developing measures. We believe that the strong participation of patients, families, caregivers, and communities will be critical to ensuring that we create measures that are meaningful to consumers and help achieve equity.	
5. Please provide general comments on the report	Men's Health Network	Colin Stephenson	Thank you for the opportunity to comment. At Men’s Health Network we believed that disparities in health care have been correlated with the prevalence of many chronic diseases. Furthermore, inadequate health care could affect individual’s overall health and quality of life. We appreciate that the Report focuses on disparities-sensitive measures and other research to design evidence-based interventions. One of the solutions suggested, incentivizing providers to use interventions for health equity through payment reform, is beneficial because numerous healthcare programs in the past have shown successful outcomes by using incentives to motivate healthy behaviors. In order to successfully implement the program, it would be very important to promote the intervention to the providers and health care institutes before the implementation. The Report summary states that some of the health equity measurement would be obtained from surveys and it would be helpful to see a sample of survey(s) for the patients and providers along with the measurement	Social Risk Factors

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			description of the draft report. There are many factors that are linked to disparities in health and health care and MHN would like to emphasize gender barriers including gender minorities and sexual orientation."Modern American males are conditioned from a young age to view health care as falling under the purview of women. Part of this is due to men's anthropologically ingrained predisposition to ignore pain and discomfort, to 'play through it,' and to be providers of their family unit"(Giorgianni et al., pg. 2, 2013). It is often underestimated how difficult it is to correctly diagnose the opposite sex. Poor patient-provider communication could be caused by a gender barrier as much as lack of cultural or linguistic competence in health care setting. Health care providers, both male and female, claim that they do not feel comfortable communicating health issues with men. The poor patient-provider communication is linked to healthcare disparities and there needs to a specialized health care practitioner for males. Again, thank you for this opportunity to provide comments on the Report.	
5. Please provide general comments on the report	America's Health Insurance Plans	Richard Bankowitz	We appreciate the compendium of measures by domain in Appendix D, and feel that providing a link to the measure specifications would be useful.	Measure Recommendations
5. Please provide general comments on the report	ACL/NIDILRR	Amanda Reichard	Congratulations! You have made great strides in addressing the difficult task of reducing health and health care access disparities. The document is well-organized, easy to read, and comprehensive. Please consistently include people with disabilities as a health disparity group of interest. Although this group is named in some places throughout the document, the document does not regularly use examples of the unique needs of individuals with disabilities and discussion of what solutions are necessary to eliminate disparities. As	General Support

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			a result, people with disabilities are underemphasized, and as it is written now, the reader could easily forget this population as an important one for which to address health disparities. The literature clearly documents the disparities experienced by this group (Krahn & Fox 2014; Reichard, Stolzle & Fox, 2011; Horner-Johson, et al., 2014), their disproportionately higher levels of health care need and cost (Reichard, Gulley, Rasch & Chan, 2015), and frequently provides evidence and suggested solutions to the group's unique needs (e.g. Krahn & Fox, 2014). However, this group typically does not receive a consummate level of attention in policy and practice as a health disparity group with substantial and frequently unique needs (Krahn, Walker, Correa-de-Araujo, 2016). Thus, it is crucial that we continue to work toward addressing health and health care disparities experienced by people with disabilities.	
5. Please provide general comments on the report	ACL/NIDILRR	Amanda Reichard	Below are some examples of where you could highlight the disability population more consistently throughout the document: (p. 4). At the bottom of the second paragraph: add in a similar disability example. The Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities (2005) is a great resource for such examples. (p. 5). In the last paragraph before Project Overview, add into the sentence that begins “For example”: implement universal design to improve physical access. (p. 6). In the first paragraph under Measurement Framework, add in a sentence about disability with supporting documentation, (similar to what is written about race/ethnicity). The Surgeon General's Report (referenced above) and the Surgeon General's Report, Closing the Gap (2001), also provide great examples for use here.	Social Risk Factors

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			(p. 9). Bottom of the last paragraph, it is important to specify the disparity groups here rather than listing them as "social risk". (p. 13). Collaboration and Partnership: The subdomain "Build and sustain social capital and social inclusion" could benefit from some example concepts that highlight topics relevant to people with disabilities, specifically. Some ideas for inclusion: Improvement of physical accessibility of housing, to improve ability of people with disabilities' to enter/exit their home, and to make houses in the community more visitable by people with physical limitations Improvement of transportation (e.g., physical accessibility of public transit, greater affordable and reliable paratransit systems), to improve ability of people with disabilities ability participate in necessary health care activities (e.g., health promotion, health care visits, health education).	
5. Please provide general comments on the report	ACL/NIDILRR	Amanda Reichard	(p. 14). Safe and accessible environments for individuals from diverse backgrounds. 1. Recommend separating out accessibility from safety, and rename this subdomain to: "Safe environments for all." 2. Add new Subdomain could/should for accessibility; including it with safety minimizes its importance in establishing equity. However, this Subdomain should be included under the Domain: Structure for Equity, as accessibility environments are critical to ensuring that people with disabilities can use all components of the environment (e.g., transportation, housing) necessary for managing, improving, and maintaining their health. The title could be: Accessible environments. Example Concepts could include:	Social Risk Factors

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			Systematic identification of physical access barriers related to receiving necessary care (e.g. transportation, health care buildings, examination tables) Systematic identification of physical access barriers to health promotion activities (e.g. inaccessible exercise facilities, reliable/accessible transportation, inaccessible sidewalks) (p. 14). Culture of Equity/Cultural Competency. This subdomain could benefit from a bullet addressing the need for Disability Etiquette competency. (P. 14). Policies and procedures that advance equity. This subdomain could benefit from a bullet such as: * Require cultural competency training, including disability etiquette (p. 15). Structure for Equity/Collection of data to monitor the outcomes of individuals with social risk factors. 1. Recommend changing the name of this subdomain: Collection of data to monitor the outcomes of groups with known health disparities. 2. This subdomain's example concepts would benefit from a disability-related bullet, such as "Ensuring that metrics include means for accurately identifying the groups (especially disability identifiers) experiencing health disparities." Disability identifiers in surveys continue to presents barriers to monitoring outcomes for this population. (see Altman, 2014; Burkhauser et al., 2014; McDermott & Turk, 2011).	

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			(p. 15). Systematic community needs assessments. I recommend adding a phrase such as "as well as additional equity priorities" to the end of the third bullet. Although it is very important to target interventions to the community-prioritized needs, the community may have blind spots for additional areas that must be addressed to create equity. (p. 17). Use of effective interventions to reduce disparities in healthcare quality. Add a reference to expanding/changing programs designed to address the needs of people without disabilities to be able to accommodate people with disabilities (e.g. Rimmer et al). (p. 20). I recommend adding in the highlighted words to the last bullet in the table: Community outreach gatherings, public health screenings in accessible community settings	
5. Please provide general comments on the report	ACL/NIDILRR	Amanda Reichard	In addition, we strongly suggest that the report summarize the findings of the NQF HCBS Quality Group in the background section with an emphasis on the HCBS quality framework, quality domains, gaps analysis http://www.qualityforum.org/Measuring_HCBS_Quality.aspx Finally, the section on cultural competency should include a broader discussion on the disparities cross-culturally. An emerging literature that refines cultural variation across an number of disciplines (e.g. cognitive psychology, sociology, anthropology, etc.) suggests that some of the things that are taken as human universals may not resonate well outside the relatively narrow cultural grouping of large scale industrialized, western societies. For instance, there is	Social Risk Factors

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			significant variation across the individual/collectivist continuum which may have implications for many aspects of health care conceptualization, delivery, and measurement.	
5. Please provide general comments on the report	ACL/NIDILRR	Amanda Reichard	References Altman, Barbara M. "Another perspective: capturing the working-age population with disabilities in survey measures." Journal of Disability Policy Studies 25.3 (2014): 146-153. Burkhauser, Richard V., Andrew J. Houtenville, and Jennifer R. Tennant. "Capturing the elusive working-age population with disabilities: Reconciling conflicting social success estimates from the Current Population Survey and American Community Survey." Journal of Disability Policy Studies 24.4 (2014): 195-205. Horner-Johnson, Willi, et al. "Breast and cervical cancer screening disparities associated with disability severity." Women's Health Issues 24.1 (2014): e147-e153. Krahn, Gloria, and Vincent A. Campbell. "Evolving views of disability and public health: The roles of advocacy and public health." Disability and health journal 4.1 (2011): 12-18. Krahn, Gloria L., and Michael H. Fox. "Health disparities of adults with intellectual disabilities: what do we know? What do we do?." Journal of Applied Research in Intellectual Disabilities 27.5 (2014): 431-446. Krahn, Gloria L., Deborah Klein Walker, and Rosaly Correa-De-Araujo. "Persons with disabilities as an unrecognized health disparity population." American journal of public health 105.S2 (2015): S198-S206. McDermott S., Turk M. (2011). The myth and reality of disability	Social Risk Factors

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			prevalence: Measuring disability for research and service. Disability and Health Journal, 3, 1–5. Reichard, Amanda, Hayley Stolzle, and Michael H. Fox. "Health disparities among adults with physical disabilities or cognitive limitations compared to individuals with no disabilities in the United States." Disability and health journal 4.2 (2011): 59-67. Reichard, Amanda, et al. "Diagnosis isn't enough: understanding the connections between high health care utilization, chronic conditions and disabilities among US working age adults." Disability and health journal 8.4 (2015): 535-546. Rimmer, J. H., Vanderbom, K. A., Bandini, L. G., Drum, C. E., Luken, K., Suarez-Balcazar, Y., & Graham, I. D. (2014). GRAIDs: a framework for closing the gap in the availability of health promotion programs and interventions for people with disabilities. Implementation Science, 9(1), 100.	
5. Please provide general comments on the report	Family HealthCare Center	Paul Nelson	In 1960, health spending as a portaion of our nation's economy (GDP) was 5.0%. By 2016, it was 16.2%. All of the other OECD nation's cluster around 12.0% of their GDP for their health spending. The difference for our nation was @$ 1 Trillion in 2016. Furthermore, we have largely solved the scientific mandate for the health care of Complex Healthcare Needs to the detriment of our nation's humanitarian mandate for the health care of each citizen's Basic Healthcare Needs. The current Paradigm Paralysys of our nation's healthcare industry also means that there is unlikely to be any benefit from an effort to reverse the current level of health inequity. Prominent for any paradigm shif to improved the cost and quality problems of our nation's healthcare, I recommend a need to clarify for Quality purposes a clear definition for CARING RELATIONSHIPS, COLLECTIVE ACTION, COMMON GOOD, HEALTH, INSTITUTION and	Social Risk Factors

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			SOCIAL CAPITAL. As a prelude to improved capitalization of Primary Healthcare, I would recommend that a set of qualifying criteria be proposed to recognize its capability to participate in a community's equitably available, ecologically accessible, justly efficient and reliably effective healthcare for their citizen's Basic Healthcare Needs. Ultimately, the success of improved Primary Healthcare will be related to their community's effort to support the Social Capital required for improving the level of its Common Good. Any definition of Social Capital must recognize the long-term character of its impact, basically very poorly measurable given current research strategies. I offer the following as a definition for Social Capital: The prevalence of caring relationships occurring throughout the generational networks of a community's citizens that promotes a spontaneous expression of collaboration, reciprocity and trust for resolving the social dilemmas encountered daily by each citizen within their community's civil life. In effect, this definition for Social Capital implies that the cost and quality problems of our nation's health spending will not be solved without a community by community driven strategy. The Cooperative Extension Service intiated in 1914 by Congress for agriculture would be a relavent model. The Design Principles for managing a common pool resource should be applied. Defined originally by Nobel Prize (2009) winner Professor Elinor Ostrom, they have been tested and validated by many of her colleagues.	
5. Please provide general comments on the report	California Pan-Ethnic Health Network	Caroline Sanders	The California Pan-Ethnic Health Network (CPEHN) strongly supports the National Quality Forum's (NQF) "A Roadmap to Reduce Health and Healthcare Disparities through Measurement," Draft Report, July 21, 2017. CPEHN is a statewide multicultural health advocacy organization dedicated to improving access to health care and eliminating health disparities by advocating for public policies and sufficient resources to address the health needs of communities of	General Support

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			color in California. Health disparities are pervasive, particularly among communities of color and limited English proficient communities. Recent data from the Agency on Quality Health Care Research shows that despite consistent calls to end health disparities they continue to worsen among certain populations. Rather than continuing to see quality improvement and disparities reduction as separate objectives, health equity and quality improvement must be linked. Even the Centers for Medicare and Medicaid Services (CMS) now recommend that agencies evaluate the impact of disparities and integrate equity solutions across all programs. Without an explicit focus on disparities reduction, quality interventions run the risk of leaving disparities constant or could have the unintended consequence of worsening them. While a consensus is forming that eliminating disparities must be prioritized, figuring out how to do so requires knowledge of the appropriate measures, interventions and incentives. This draft Report provides a critical roadmap for health care purchasers, plans and practitioners who desire to prioritize health equity as part of their quality improvement strategies. The Report lays out a clear four-step process that includes: Prioritizing disparities-sensitive measures Identifying evidence-based interventions to reduce disparities Selecting and using health equity performance measures Incentivizing the reduction of health disparities and achievement of health equity If followed carefully and thoughtfully, this process will lead towards	

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			achievement of the Triple Aim of the National Quality Strategy: better quality of care, healthy people and communities, and affordable care.	