Disparities Standing Committee Meeting

NATIONAL QUALITY FORUM

January 20-21, 2016

Welcome and Introductions

NQF Project Staff

NQF Project Staff

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- Elisa Munthali, MPH
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- Erin O'Rourke
  - Senior Director
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  - Project Manager
- Severa Chavez
  - Project Analyst

Disclosures of Interest

Standing Committee

(co-chair) **Marshall Chin, MD, MPH, FACP**, University of Chicago	**Nancy Garrett, PhD,** Hennepin County Medical Center
(co-chair) **Ninez Ponce, MPP, PhD,** UCLA Center for Health Policy Research	**Romana Hasnain-Wynia, PhD,** Patient Centered Outcomes Research Institute
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Kevin Fiscella, MD, University of Rochester	**Mara Youdelman, JD, LLM,** National Health Law Program

Review of Committee Charge and the Goals for the Day

Meeting Agenda: Day 1

- Review of Committee Charge and the Goals for the Day
- Building a Roadmap: Outline Critical Dimensions of a Roadmap and Clarify the Committee's Vision
- Building a Roadmap: Establish Guiding Principles for the Roadmap
- Building a Roadmap: Describe the Desired Future State for Measurement and Associated Policy Levers
- Building a Roadmap: Identify Stakeholders and their Roles and Action Items
- Building a Roadmap: Identify Opportunities and Challenges
- Building a Road Map: Develop a Path from the Current State to the Desired State
- Input from the Disparities Standing Committee on Meaningful Use Stage 3

Meeting Objectives

- Develop a roadmap for how measurement and associated policy levers can be used to proactively eliminate disparities
- Review implementation of the revised NQF policy regarding risk adjustment for SDS factors provide input on the evaluation of the SDS trial period
- Provide a cross-cutting emphasis on healthcare disparities across all of NQF's work

The National Quality Forum: A Unique Role

Established in 1999, NQF is a non-profit, non-partisan, membership-based organization that brings together public and private sector stakeholders to reach consensus on healthcare performance measurement. The goal is to make healthcare in the U.S. better, safer, and more affordable.

Mission: To lead national collaboration to improve health and healthcare quality through measurement

- An Essential Forum
- Gold Standard for Quality Measurement
- Leadership in Quality

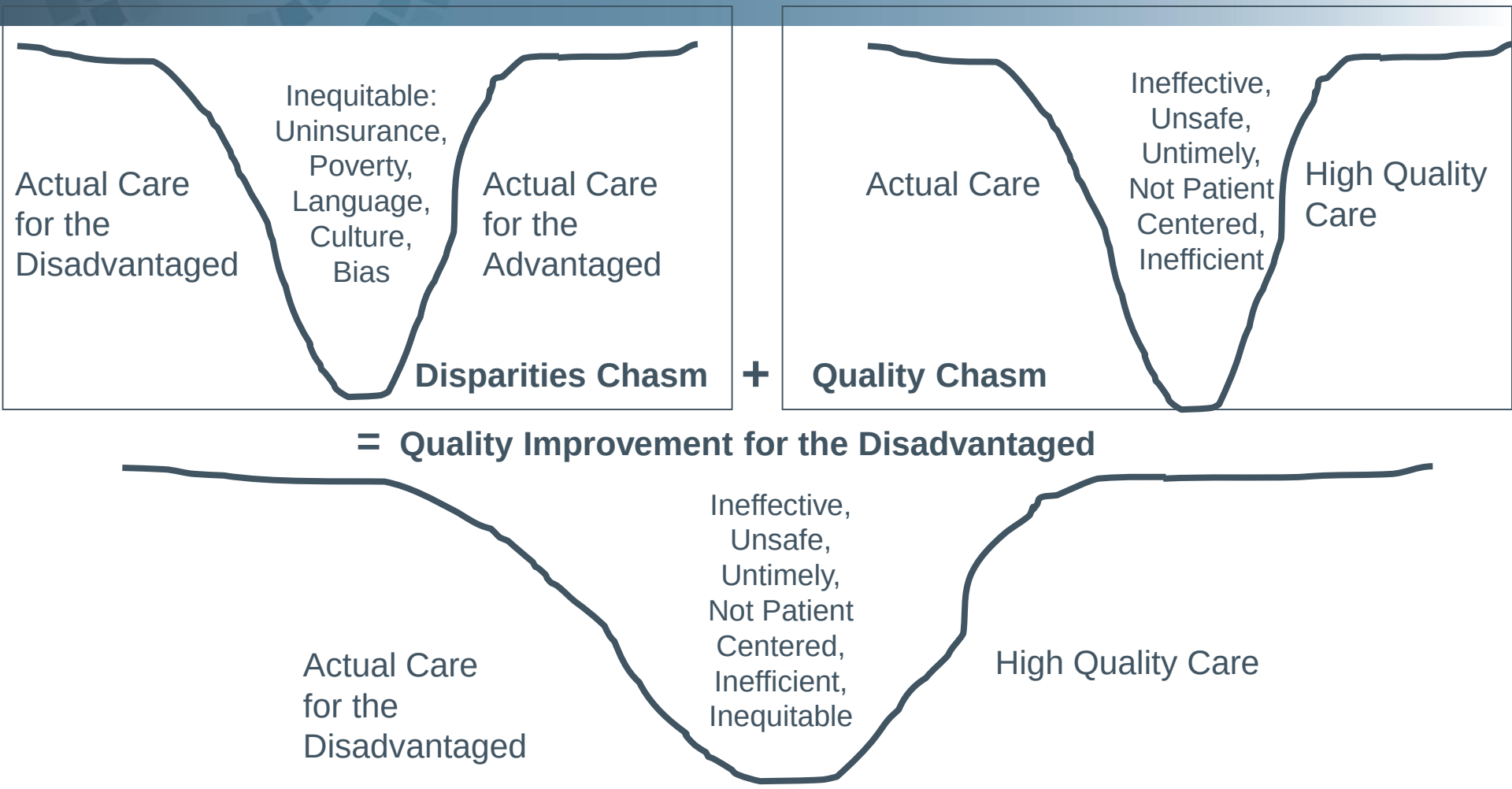
NQF Activities

- **Measure Endorsement**
  - 600+ NQF-endorsed measures across multiple clinical areas
  - 11 empaneled standing expert committees
- **Measure Application Partnership**
  - Advises HHS on selecting measures for 20+ federal programs, Medicaid, and health exchanges
- **Measurement Science**
  - Convenes private and public sector leaders to reach consensus on complex issues in healthcare performance measurement
- **National Quality Partners**
  - Convenes stakeholders around critical health and healthcare topics
  - Spurs action on patient safety, early elective deliveries, and other issues

How Quality is Evolving

- Measures increasingly reflect “best” performance
- Focus on outcome measures that are more patient centered (e.g., Patient Reported Outcomes)
- Transition to electronic platforms and eMeasures
- Address disparities in all we do
- Growing efforts to harmonize and align measures to reduce burden and accelerate improvement
- Build on cost and quality measurement to assess value, including appropriateness and overuse

Linking Disparities and Quality



Some Historical Context

- 2006 – Established criteria to evaluate dipartites sensitive measures for and endorsing 35 dipartites sensitive measures in the ambulatory care setting.
- 2009 – Developed a framework and set of 45 practices for measuring and reporting cultural competency.
- 2011 – Sought to establish a broader platform for addressing healthcare disparities and cultural competency in measurement though ***The Healthcare Disparities and Cultural Competency Consensus Standards Project***.
- 2014 – Exploring the risk adjustment of performance measures for sociodemographic factors when appropriate.

Disparities Committee Charge

1. Develop a roadmap for how measurement and associated policy levers can be used to proactively eliminate disparities

2. Review implementation of the revised NQF policy regarding risk adjustment for SDS factors and provide input on the evaluation of the SDS trial period.

3. Provide a cross-cutting emphasis on healthcare disparities across all of NQF's work.

Committee Charge #1

Task 1: Develop a roadmap for how measurement and associated policy levers can be used to proactively eliminate disparities

Committee Charge #2

Task 2. Review implementation of the revised NQF policy regarding risk adjustment for SDS factors and provide input on the evaluation of the SDS trial period.

Committee Charge #2

Committee Action Items

- Review and provide guidance related to methodologies for adjustment, stratification, and collection of standard sociodemographic data
- Provide input on evaluation of the SDS trial period
- Make a recommendation to CSAC and the NQF Board of Directors about the continued use of SDS factors in risk adjustment approaches

Committee Charge #3

Task 3: Provide a cross-cutting emphasis on healthcare disparities across all of NQF's work.

Committee Charge #3

Committee Action Items

- Provide advice and/or technical expertise on disparities to other committees
  - Provide guidance to Consensus Standards Approval Committee (CSAC), Measure Applications Partnership (MAP) and NQF Standing Committees.
  - As appropriate, the DSC may make recommendations regarding evaluation criteria to the CSAC and MAP Coordinating Committee.
- Provide strategic direction and guidance to NQF and the measurement field on measure development activity and enhancing growth of the NQF portfolio of disparity-sensitive and cultural competency measures.

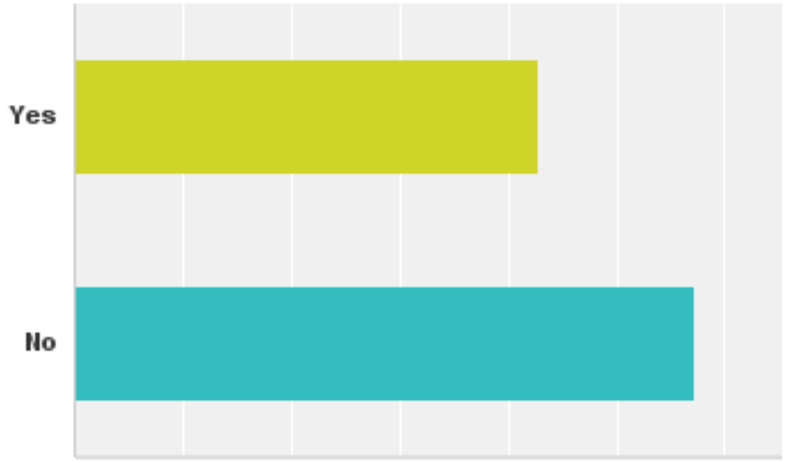
Building a Roadmap

What is a Roadmap?

- Describes a path for achieving a goal
- Outline actions needed to eliminate disparities
- Highlights stakeholders and their responsibilities

Building a Vision/Goal for this Roadmap

- Draft goal: Eliminating disparities in healthcare quality through measurement and associated policy levers
  - Survey response: 45% (6) Yes; 55% (8) No



Goal Statement Survey Themes

- Eliminating disparities in healthcare quality **and outcomes** through measurement and associated policy levers.
- Eliminating disparities in healthcare quality through **policy, measurement, and action.**
- Eliminating disparities in healthcare **(access, structure, processes and outcomes)** quality through measurement and associated policy levers
- Eliminating disparities in healthcare quality through measurement and associated policy **and payment** levers
- **Ensuring that measurement and associated policy levers proactively support the elimination of healthcare disparities**

Discussion

- What should be the goal of the Roadmap?

Draft Dimensions for Committee Consideration

- The goal
- Guiding principles that direct the actions described in the Roadmap and help to focus efforts to make practical and valuable progress towards the goal of the roadmap.
- The desired future state for measurement and associated policy (ideal state)
- Outline and timeline of the actions and roles of various stakeholders
- Opportunities and challenges to operationalizing this plan
- The path for moving from current state to the desired state (including timeline)

Critical Roadmap Dimensions Survey Themes

- Role of the committee in Roadmap (advisory, consultative, partnership)
- Definitions (disparity, equity, etc.)
- Underlying casual factors leading to disparities
- Current state of measurement and associated policy as it relates to disparities
- Key questions and considerations for policy
- Clear action steps and deliverables
- Resources (literature, examples, best practices)
- Ongoing evaluation/monitoring of Roadmap

Discussion

- Are there additional dimensions that should be added to the Roadmap?
- Are there draft dimensions that should be removed from the Roadmap?

Break

Establishing Guiding Principles

- Guiding principles will direct the actions described in the Roadmap and help to focus efforts to make practical and valuable progress towards the goal of the Roadmap
  - Disparities in health and healthcare should be identified and eliminated. (Yes - 14; No – 0)
  - The Roadmap must be transparent and the DSC will be open about its goals and plans. (Yes - 14; No – 0)
  - The DSC must have accountability and commit to follow through, progress, and monitoring of the Roadmap. (Yes - 13; No – 1)
  - All stakeholders must be engaged and work to eliminate disparities. (Yes - 11; No – 1)

Guiding Principles Survey Themes

- The Roadmap should be data driven. Success depends on if recommendations have intended effects.
- Regarding 3rd point: NQF must also be accountable, not just DSC.
- Initiatives to eliminate disparities in health care quality should be based on the clearest possible understanding of underlying causes of those disparities, and on a clear understanding of which actors are best able to modify those causal factors.
- Recommendations must be feasible to implement within current system.
- A blueprint not just a set of action steps.

Discussion

- Are there additional guiding principles that should be added to the Roadmap?
- Are there draft principles that should be removed?

Describing the Future Desired State for Measurement and Associated Policy

How do you envision measurement to proactively eliminate disparities:

- Identify disparities, determining action, and tracking progress
- Promote awareness
- Create a culture of quality improvement and recognize disparities elimination is a key quality issue
- Incentivize providers and payers to work to eliminate disparities
- Should not contribute to the worsening to maintenance of disparities
- Lessen or eliminate disparities

Describing the Future Desired State for Measurement and Associated Policy

How do you envision payment policy helping to reduce disparities?

- Recognize healthcare costs are an increasing driver of disparities
- Incentivize the elimination of disparities and reward interventions that reduce disparities
- Promote value and equity
- Reflect the different/increased need of care that certain populations may face

Describing the Future Desired State for Measurement and Associated Policy (What is the ideal?)
Survey Themes

How do you envision healthcare equity and value better integrated into quality measurement and associated policy?

- Establish a national goal to eliminate disparities
- Influence laws, regulations, and resource allocation
- Create accountability for disparities

Discussion

- How should the draft role of measurement to eliminate disparities be modified?
- How should the draft role of payment to eliminate disparities be modified?
- How should the draft role of policy to eliminate disparities be modified?
- Are there additional levers that should be added to the Roadmap?

Public and Member Comment

Lunch

Identifying Stakeholders, Their Roles, and Actions Survey Themes

Measure Developers could:

- Ensure measures can help identify disparities
- Ensure their measures do not increase disparities
- Provide information on barriers of measurement collection, input on ease of collection of measurement, feasibility assessment of new measures.

Identifying Stakeholders, Their Roles, and Actions Survey Themes

Providers and Clinicians could:

- Eliminate disparities in care within their organizations
- Implement quality improvement infrastructure
- Foster a culture of equity

Identifying Stakeholders, Their Roles, and Actions Survey Themes

Payers could:

- Incentivize the elimination of disparities among providers included in their networks
- Ensure quality incentive programs do not make disparities worse
- Eliminate disparities in their plans:
  - Implement quality improvement infrastructure
  - Foster a culture of equity

Identifying Stakeholders, Their Roles, and Actions Survey Themes

Purchasers could:

- Incentivize the elimination of disparities:
  - Include measures that identify disparities in performance programs
  - Reward reductions in disparities in pay-for-performance programs
- Ensure pay quality incentive programs do not make disparities worse.

Identifying Stakeholders, Their Roles, and Actions Survey Themes

Policymakers could:

- Allocate resources to eliminate disparities.
- Incentivize the elimination of disparities.
- Ensure pay quality incentive programs do not make disparities worse.
- Incentivize data collection and reporting.

Identifying Stakeholders, Their Roles, and Actions Survey Themes

Consumers could:

- Use publicly reported measures to select quality providers.
- Advocate for change and the elimination of disparities.

Identifying Stakeholders, Their Roles, and Actions Survey Themes

NQF could:

- Embrace value and equity in everything it does
- Keep disparities at the forefront
- Ensure measures align with improvement in health outcomes or processes
- Ensure measures achieve improvement and impact
- Promote understanding of how sets of measures link together to form a plan to achieve health equity

Discussion

- How should the draft roles and actions of each stakeholder group be modified?
- Are there additional stakeholders who should be included in the Roadmap?

Identifying Opportunities and Challenges
Survey Themes

- Expanded collection, reporting and analysis of standardized data is needed
  - Comprehensive patient data including race, ethnicity, language, sexual orientation, gender identity, and disability status are required to identify disparities and develop plans to eliminate them
  - Ensure proper data collection practices
- Measurement can have unintended consequences and worsen disparities.
- Ensure appropriate design for pay-for-reporting or pay-for-performance programs
  - Appropriate attention to risk adjustment and/or stratification
  - Consider a data collection/reporting period to allow providers an opportunity for improvement before accountability beings
  - Monitor for potential unintended consequences
  - Focus on quality improvement efforts that target safety net providers and high-minority providers, and direct supplemental resources to those providers for improving disparities and including the sharing of best practices.

Discussion

- Are there additional challenges and opportunities that should be added to the Roadmap?
- Are there challenges or opportunities listed in the draft that should be removed?

Break

Suggesting the Path from the Current State to the Desired State

- Increase education about the role measurement can play and that disparities elimination is an integral part of quality improvement
- Engage a broad network of stakeholders
- Support and improve the safety net
- Leverage new care delivery models
- Improve data collection and reporting
- Improve measures help identify disparities while ensuring existing measures do not worse disparities
- Ensure the elimination of healthcare disparities is a national priority

Discussion

- How can we move from the current state to the desired state?
- Are there additional steps that should be added to the Roadmap?
- Are there steps that should be removed?

Input from the Disparities Standing Committee on Meaningful Use Stage 3

- 2015 EHR Standards and Certification Criteria issued by the Office of National Coordinator (ONC) for Health Information Technology do not require collection of information about disability status.
- What input does the Disparities Standing Committee have for ONC on the Common Clinical Data Set?

Public and Member Comment

Adjourn Day 1

Welcome

Recap of Day 1

Meeting Agenda: Day 2

- Overview of the NQF Risk Adjustment for SES Project
- Update on Implementation of NQF's Trial Period for SES Adjustment
- Current Challenges and Potential Future Approaches to SDS Adjustment
- Discussion of SDS Trial Period Evaluation Plan
- Incorporating Disparities Focus into NQF Measure Endorsement and Selection

Overview of the Risk Adjustment for Socioeconomic Status (SES) and Other Demographic Factors Project

NATIONAL QUALITY FORUM

Kevin Fiscella, PhD, Tenured Professor Family Medicine, Public Health Science, Community Health and Oncology, University of Rochester

David Nerenz, MD, Director, Center for Health Policy & Health Services Research, Henry Ford Health System

Views on Adjustment for Sociodemographic Factors

SUPPORT

- **Accurate and informative quantity measurement**
- **Adjustment is necessary to avoid penalizing providers serving vulnerable populations and communities**
- **Risk adjustment allows for comparative performance**
- **A performance score alone (whether or not adjusted for SDS factors) cannot identify disparities.**
- **Hospitals caring for the disadvantaged are already being penalized.**
- **No evidence that disparities would be reduced through further negative financial incentives.**
- **Adjustment generally does not mask poor performance by provider caring for high proportions of low SES patients**
- **Lack of adjustment would continue to create a disincentive to care for the poor.**

OPPOSE

- **Some providers may deliver worse quality care to disadvantaged patients**
- **Adjustment could make meaningful differences in quality disappear**
- **Worse outcomes could be expected**

No expectation to improve

Implies or sets a different standard

- **Lack of adequate data for SDS adjustment**
- **Prefer payment approach to help safety net**

SDS Expert Panel

- To consider and address these issues, NQF convened an **SDS Expert Panel** to consider if, when, and how outcome performance measures should be adjusted for SES or related demographic factors
- The Expert Panel was composed of multiple stakeholders with a variety of experiences related to outcome measurement and disparities
- The Panel's recommendations were presented for public comment and modified in response to comments received

SDS Expert Panel: Core Principles

1. Outcome performance measurement is critical to the aims of the National Quality Strategy.
2. Disparities in health and healthcare should be identified and reduced.
3. Performance measurement should not lead to increased disparities in health and healthcare.
4. Outcomes may be influenced by patient health status, clinical, and sociodemographic factors, in addition to the quality and effectiveness of healthcare services, treatments, and interventions.

SDS Expert Panel: Core Principles (cont.)

5. When used in accountability applications, performance measures that are influenced by factors other than the care received, particularly outcomes, need to be adjusted for relevant differences in case mix to avoid incorrect inferences about performance.
6. Risk adjustment may be constrained by data limitations and data collection burden.
7. The methods, factors, and rationale for risk adjustment should be transparent.

Applicability of Recommendations

- Recommendations may apply to outcome performance measures (including resource use and patient-reported outcomes) and some process measures used for comparative performance assessment.
- Each measure must be assessed individually to determine the appropriateness of SDS adjustment.
- Recommendations may apply to any level of analysis.

Recommendations Related to NQF Criteria and Processes Related to SDS Adjustment

Recommendation 1: When there is a conceptual relationship (i.e., logical rationale or theory) between sociodemographic factors and outcomes or processes of care and empirical evidence (e.g., statistical analysis) that sociodemographic factors affect an outcome or process of care reflected in a performance measure:

- those sociodemographic factors should be included in risk adjustment of the performance score (using accepted guidelines for selecting risk factors) unless there are conceptual reasons or empirical evidence indicating that adjustment is unnecessary or inappropriate;

  AND

- the performance measure specifications must also include specifications for stratification of a clinically-adjusted version of the measure based on the sociodemographic factors used in risk adjustment.

Recommendations Related to NQF Criteria and Processes Related to SDS Adjustment

Recommendation 2: NQF should define a transition period for implementation of the recommendations related to sociodemographic adjustment. During the transition period, if a performance measure is adjusted for sociodemographic status, then it also will include specifications for a clinically-adjusted version of the measure only for purposes of comparison to the SDS-adjusted measure.

Recommendation 3: A new NQF standing committee focused on disparities should be established.

Recommendations Related to NQF Criteria and Processes Related to SDS Adjustment

Recommendation 4: The NQF criteria for endorsing performance measures used in **accountability applications** (e.g., public reporting, pay-for-performance) should be revised as follows to indicate that patient factors for risk adjustment include both clinical and sociodemographic factors. ***2b4.*** *For outcome measures and other measures when indicated (e.g., resource use, some process measures):*

- *an evidence-based risk-adjustment strategy is specified; is based on patient factors (including clinical and sociodemographic factors) that influence the measured outcome and are present at start of care;14,15 and has demonstrated adequate discrimination and calibration* ***OR*** *rationale/data support no risk adjustment.*
- *14. Risk factors that influence outcomes generally should not be specified as exclusions.*

Recommendations Related to NQF Criteria and Processes Related to SDS Adjustment

Recommendation 5: The same guidelines for selecting clinical and health status risk factors for adjustment of performance measures may be applied to sociodemographic factors, and include the following:

- Clinical/conceptual relationship with the outcome of interest
- Empirical association with the outcome of interest
- Variation in prevalence of the factor across the measured healthcare units
- Present at the start of care
- Is not an indicator or characteristic of the care provided (e.g., treatments, expertise of staff)
- Resistant to manipulation or gaming
- Accurate data that can be reliably and feasibly captured
- Contribution of unique variation in the outcome (i.e., not redundant)
- Potentially, improvement of the risk model (e.g., risk model metrics of discrimination, calibration)
- Potentially, face validity and acceptability

Recommendations Related to NQF Criteria and Processes Related to SDS Adjustment

Recommendation 6: When there is a conceptual relationship and evidence that sociodemographic factors affect an outcome or process of care reflected in a performance measure submitted to NQF for endorsement, the following information should be included in the submission:

- A detailed discussion of the rationale and decisions for selecting or not selecting sociodemographic risk factors and methods of adjustment (including a conceptual description of relationship to the outcome or process; empirical analyses; and limitations of available sociodemographic data and/or potential proxy data) should be submitted to demonstrate that adjustment incorporates relevant sociodemographic factors unless there are conceptual reasons or empirical evidence indicating that adjustment is unnecessary or inappropriate.
- In addition to identifying current and planned use of the performance measure, a discussion of the limitations and risks for misuse of the specified performance measure.

Recommendations Relevant to NQF Policy

Recommendation 7: NQF should consider expanding its role to include guidance on implementation of performance measures. Possibilities to explore include:

- guidance for each measure as part of the endorsement process;
- guidance for different accountability applications (e.g., use in pay-for-performance versus pay-for-improvement; innovative approaches to quality measurement explicitly designed to reduce disparities).

Recommendation 8: NQF should make explicit the existing policy that endorsement of a performance measure is for a specific context as specified and tested for a specific patient population (e.g., diagnosis, age), data source (e.g., claims, chart abstraction), care setting (e.g., hospital, ambulatory care), and level of analysis (e.g., health plan, facility, individual clinician). Endorsement should not be extended to expanded specifications without review and usually additional testing.

Recommendations about Broader Related Policy Issues

Recommendation 9: When performance measures are used for accountability applications such as public reporting and pay-for-performance, then purchasers, policymakers, and other users of performance measures should assess the potential impact on disadvantaged patient populations and the providers/health plans serving them to identify unintended consequences and to ensure alignment with program and policy goals. Additional actions such as creating peer groups for comparison purposes could be applied.

Recommendations about Broader Related Policy Issues

Recommendation 10: NQF and others such as CMS, Office of the National Coordinator (ONC) for Health Information Technology, and the Agency for Healthcare Research and Quality (AHRQ) should develop strategies to identify a standard set of sociodemographic variables (patient and community-level) to be collected and made available for performance measurement and identifying disparities.

Update on Implementation of NQF's Trial Period for SDS Adjustment

Karen Johnson, MS

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NQF Policy Change: Trial Period

- The NQF Board approved a **two-year trial period** prior to a permanent change in NQF policy.
- Under the new policy, adjustment of measures for SDS factors is no longer prohibited.
- During the trial period, if SDS adjustment is determined to be appropriate for a given measure, NQF will endorse one measure with specifications to compute:
  - SDS-adjusted measure
  - Non-SDS version of the measure (clinically adjusted only) to allow for stratification of the measure

NQF Policy Change: Trial Period (cont.)

- Each measure must be assessed individually to determine if SDS adjustment is appropriate.
- Not all measures should be adjusted for SDS factors (e.g., central line infection would not be adjusted)
  - Need conceptual basis (logical rationale, theory) and empirical evidence
- The recommendations apply to any level of analysis including health plans, facilities, and individual clinicians.

Measures Included in the Trial Period

- **ALL measures submitted to NQF after April 15, 2015 will be considered part of the trial period**, and Standing Committees may consider whether such measures are appropriately adjusted for SDS factors as part of their evaluation.
  - Newly-submitted measures
  - Previously-endorsed measures undergoing maintenance
  - Measures with conditional endorsement (e.g., Admissions/Readmissions, Cost & Resource Use)
  - Measures undergoing ad hoc review

Infrastructure to Support the Trial Period

- Communications to external stakeholders
- Frequently Asked Questions (FAQs)
- Additions/modifications to measure submission form
- Guidance and training for developers
- Guidance for staff to facilitate Standing Committee discussion
- Evaluation plan data collection tool

NQF Standing Committee Consideration of SDS Adjustment

- Questions for Standing Committees to consider when reviewing SDS-adjusted measures:
  - Is there a conceptual relationship between the SDS factor and the measure focus?
  - Is the SDS factor present at the start of care?
  - Is there variation in prevalence of the SDS factor across measured entities?
  - Does empirical analysis (as provided by the measure developer) show that the SDS factor has a significant and unique effect on the outcome in question?
  - Is information on the SDS factor available and generally accessible for the measured patient population?

Projects Contributing to Trial Period to Date

- Cost and Resource Use (2014)
- Admissions/Readmissions (2014)
- Cardiovascular, Phase 3
- Pediatrics

Cost and Resource Use

- Three measures were endorsed with the condition that they enter the trial period:
  - #2431: Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for **Acute Myocardial Infarction** (AMI) (CMS/Yale)
  - #2436: Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for **Heart Failure** (HF) (CMS/Yale)
  - #2579: Hospital-level, risk-standardized payment associated with a 30-day episode of care for **pneumonia** (CMS/Yale)

Cost and Resource Use

- Variables initially considered (based on initial conceptual analysis and data availability)
  - Educational attainment or income (from census data using patient zip code)
  - Medicaid status (proxy for low income and insurance coverage)
  - Black or white race
- SC asked developer to broaden the conceptual model and add to the some literature review I
- Empirical analysis explored race (Black/non-Black) and Medicaid enrollment/Dual Status (as a proxy for low income)

Cost and Resource Use

- Based on the empirical analysis, the developers chose **NOT** to include the SDS variables in the model, citing the nominal impact of the SDS variables on the risk model performance and payment outcomes
- Ultimately the Committee voted to continue endorsement of the measures without inclusion of SDS factors in the risk-adjustment approach

Admissions/Readmissions

- 17 admission and readmission measures endorsed with the condition they be reviewed for the need for SDS adjustment
- The Standing Committee determined that 16 measures should enter the trial period
- The Standing Committee met in September to review the SDS factors/variables that developers plan to test

Admissions/Readmissions: Input from SC on Empirical Approach

- Tension: "robustness" of proposed factors vs. data availability and accessibility
- More than one appropriate way to accomplish risk adjustment: NQF should not be prescriptive regarding methods or SDS factors
  - Potential for inclusion: patient characteristics that are present prior to treatment and are known or suspected confounder

Admissions/Readmissions: Input from SC on Empirical Approach

- Encouraged consideration of age, gender, measure of poverty (e.g., dual eligibility status)
- Test community-level variables when patient-level data are not available or not sufficiently robust
  - Justify any decision not to include such factors
- Geographic proxy data should represent the actual SDS characteristics of the patient as accurately as possible
  - Data derived from 9-digit ZIP Code may be best
  - Data derived from 5-digit ZIP Code or county too heterogeneous
- Urged caution on the use of race as a proxy for patient SDS, as it is often difficult to assess the underlying concept that race is measuring

Cardiovascular, Phase 3

- 27 measures evaluated; 10 included risk-adjustment
- 4 of these included information on the conceptual rationale for inclusion of SDS factors
  - Variables examined included race, dual-eligibility status, and AHRQ composite index
  - These ultimately **not included** in risk-adjustment
- 6 did not include information on the conceptual rationale in the written submission, but the topic was addressed briefly during discussion of the measures

Pediatrics

- 24 measures evaluated; 11 included risk-adjustment
- Measures based on 2 instruments (PRO-PMs)
- Relatively little discussion of risk-adjustment approach
  - 1 included conceptual rationale
    - » Variables considered included age, self-reported health status, gender, education, health condition type (Complex Chronic vs. Non-Complex Chronic)
    - » Only age and self-reported health status included in final risk-adjustment
  - Remainder did not have conceptual rationale
    - » Variables considered included child gender, age, and race/ethnicity; caregiver age, race/ethnicity, English proficiency, and educational attainment
    - » Only respondent education included in final risk-adjustment

Current Challenges and Potential Future Approaches to SDS Adjustment

Karen Johnson, MS

NATIONAL QUALITY FORUM

Potential Approaches – Activities Outside NQF's Trial Period

- Pharmacy Quality Alliance/Inovalon: Medication Adherence measures
  - Christie Teigland
- National Academy of Medicine (aka IOM)
  - José J. Escarce

An Investigation of Sociodemographic Risk Adjustment of Medication Adherence Measures

NQF Disparities Committee Briefing
Christie Teigland, PhD, Vice President Advanced Analytics, Avalere
January 21, 2016

Member-Level Analysis

Main Data Source: Inovalon's MORE² Registry® 2014 Data

- Statistically de-identified administrative claims data for **764,581 members in 44 Medicare Advantage Plan contracts** that qualified for one or more of the PQA Medication Adherence measures.
- Calculated measure scores at the **member level**.

Utilized Data on Sociodemographic Characteristics and Community Resource Availability, such as:

- Income
- Education
- Household size
- Poverty area
- Physician shortage area

Member-Level Analysis

1. The key source of data on sociodemographic characteristics was **Acxiom's Market Indices ACS data**, which is an aggregation of the American Community Survey (ACS) and data aggregated from multiple individual and household databases (e.g., public records such as government information, self-reported data, buying activity, financial behavior).

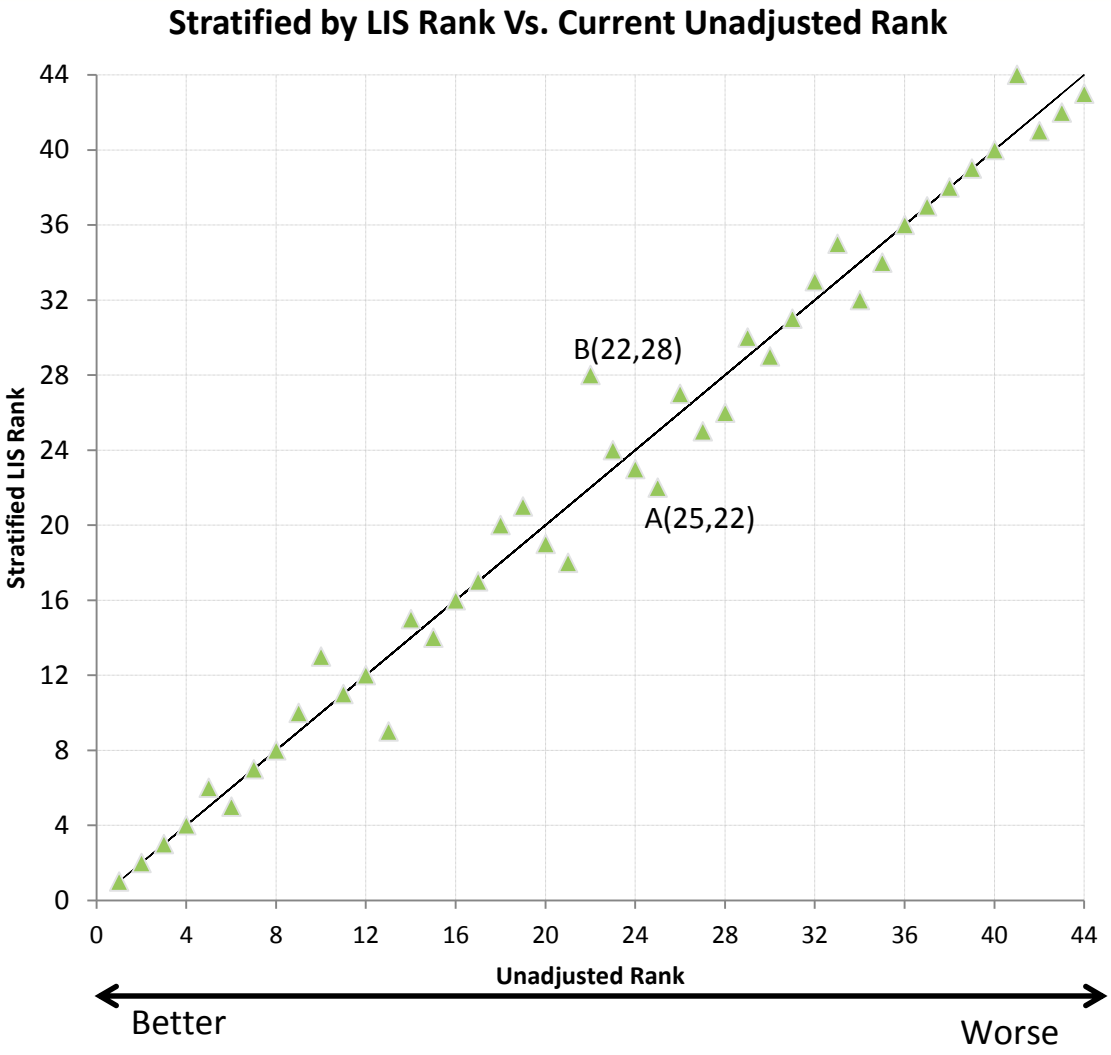
    - These sources result in roughly **30 million discrete data points based on Zip+4 areas, which include an average of eight households per neighborhood**.
    - **A wealth of research exists demonstrating the relationship of individual person characteristics and behaviors to near neighborhood characteristics.**
    - Previous studies examining sociodemographic characteristics have generally utilized data available at the **Census 5-digit ZIP code level that cover only about 40,000 discrete data points**, or **U.S. Census Bureau ACS area block group data that cover about 250,000 areas**. These sources provide information averaged across multiple disparate neighborhoods, resulting in a relatively imprecise assignment of characteristics to individuals.

2. The **area health resource file (AHRF)** was used to provide information on community-resource availability at the county level. This file contains information such as primary care and mental health professional shortage areas, number of physicians per 10,000 people, and hospital admissions per 10,000 people.

Phase 1 Pilot Testing: Low Income Subsidy (LIS) Status Stratification – Medication Adherence-Hypertension (MA-H)

As a first step, we analyzed the impact of simply stratifying measure rates by LIS status.

- Plans ranked BEST tended to stay ranked best.
- Plans ranked WORST tended to stay ranked worst.
- There was a bit more movement of plans in the middle quartiles, but the changes in rank were small for most plans.
  - For example, the biggest change observed was for Plan B, which declined from rank 22 to rank 28 (50th percentile to 60th percentile).
  - Plan B ranks higher when *not* considering the LIS status of the population they serve.
  - In contrast, Plan A's rank improved from 57th percentile to 50th percentile.



Note: Lower rank = higher adherence rate; contracts below diagonal line have better rank after stratification and contracts above diagonal line have worse rank after stratification.

Phase 2 Testing:

MA-H, MA-C, MA-D

Multivariate Analyses with Socioeconomic Factors Included

Covariates Included in All Models

Age and Disability:
Non-Disabled (Reference)
Disabled × 18–54
Disabled × 55–64
Disabled × 65–69
Disabled × 70+
Gender:
Female (reference)
Male
Race/Ethnicity:
White (Reference)
Asian
African American
Hispanic
Other
Medicaid Status:
Non-Medicaid (Reference)
Partial Benefit Medicaid
Full Benefit Medicaid

Number of Unique Medications:
1 - 5 (Reference)
6 - 7
8 - 10
11 - 12
13 - 15
16 +
Percent of Households that Own Their Home:
0% - 80% (Reference)
81%+
Percent of Population Below Poverty Level:
0% - 7% (Reference)
8% - 13%
14% - 23%
24% - 100%
Percent Households with Completed College or Higher:
0% (Reference)
1% - 18%
19% - 100%

Low Income Subsidy	Insignificant after including Medicaid status
Language	Not available for neighborhood level data and more than 50% are missing for member level data
Shortage Area	Insignificant in at least one measure and small effect in all measures

Phase 2 Pilot Testing: Odds Ratios – MA-H

- Disabled beneficiaries are significantly less likely to be adherent to medication.
- Younger disabled members are least likely to be adherent (OR 0.549).
- Likelihood of disabled members to be adherent increases with age.

Variable	Coefficient Estimate	Odds-Ratio	P-Value	Variance Inflation Factor	Population Percent	Note
Intercept	1.070		<.0001			
Age and Disability:						
Non-Disabled (Reference)						
Disabled × 18–54	-0.600	0.549	<.0001	1.078	0.048	
Disabled × 55–64	-0.307	0.736	<.0001	1.089	0.100	
Disabled × 65–69	-0.189	0.828	<.0001	1.043	0.057	
Disabled × 70+	-0.139	0.870	<.0001	1.048	0.066	
Gender:						
Female (reference)					0.567	
Male	-0.042	0.959	<.0001	1.033	0.433	
Race/Ethnicity:						
White (Reference)						
Asian						Insignificant
African American	-0.431	0.650	<.0001	1.198	0.240	
Hispanic						insignificant
Other	-0.197	0.821	<.0001	1.026	0.024	

Phase 2 Pilot Testing: Odds Ratios – MA-H

- Males are slightly less likely to be adherent compared to females.
- African Americans are least likely to be adherent to hypertension medications; Other (Mixed Race) Ethnic members are also less likely.

Variable	Coefficient Estimate	Odds-Ratio	P-Value	Variance Inflation Factor	Population Percent	Note
Intercept	1.070		<.0001			
Age and Disability:						
Non-Disabled (Reference)						
Disabled × 18–54	-0.600	0.549	<.0001	1.078	0.048	
Disabled × 55–64	-0.307	0.736	<.0001	1.089	0.100	
Disabled × 65–69	-0.189	0.828	<.0001	1.043	0.057	
Disabled × 70+	-0.139	0.870	<.0001	1.048	0.066	
Gender:						
Female (reference)					0.567	
Male	-0.042	0.959	<.0001	1.033	0.433	
Race/Ethnicity:						
White (Reference)						
Asian						Insignificant
African American	-0.431	0.650	<.0001	1.198	0.240	
Hispanic						insignificant
Other	-0.197	0.821	<.0001	1.026	0.024	

Phase 2 Pilot Testing: Odds Ratio – MA-H

- Dual eligible members are *more likely* to be adherent to medication compared to non-dual eligible Medicare beneficiaries.
- Full benefit duals are more slightly likely to be adherent than partial benefit duals.

Variable	Coefficient Estimate	Odds-Ratio	P-Value	Variance Inflation Factor	Population Percent	Note
Medicaid Status:						
Non-Medicaid (Reference)						
Partial Benefit Medicaid	0.084	1.088	<.0001	1.166	0.150	
Full Benefit Medicaid	0.089	1.093	<.0001	1.265	0.171	
Number of Unique Medications:						
1 - 5 (Reference)						
6 - 7	0.077	1.080	<.0001	1.628	0.141	
8 - 10	0.114	1.121	<.0001	1.880	0.220	
11 - 12	0.109	1.115	<.0001	1.584	0.124	
13 - 15	0.091	1.095	<.0001	1.664	0.140	
16 +	0.048	1.049	<.0001	2.000	0.216	

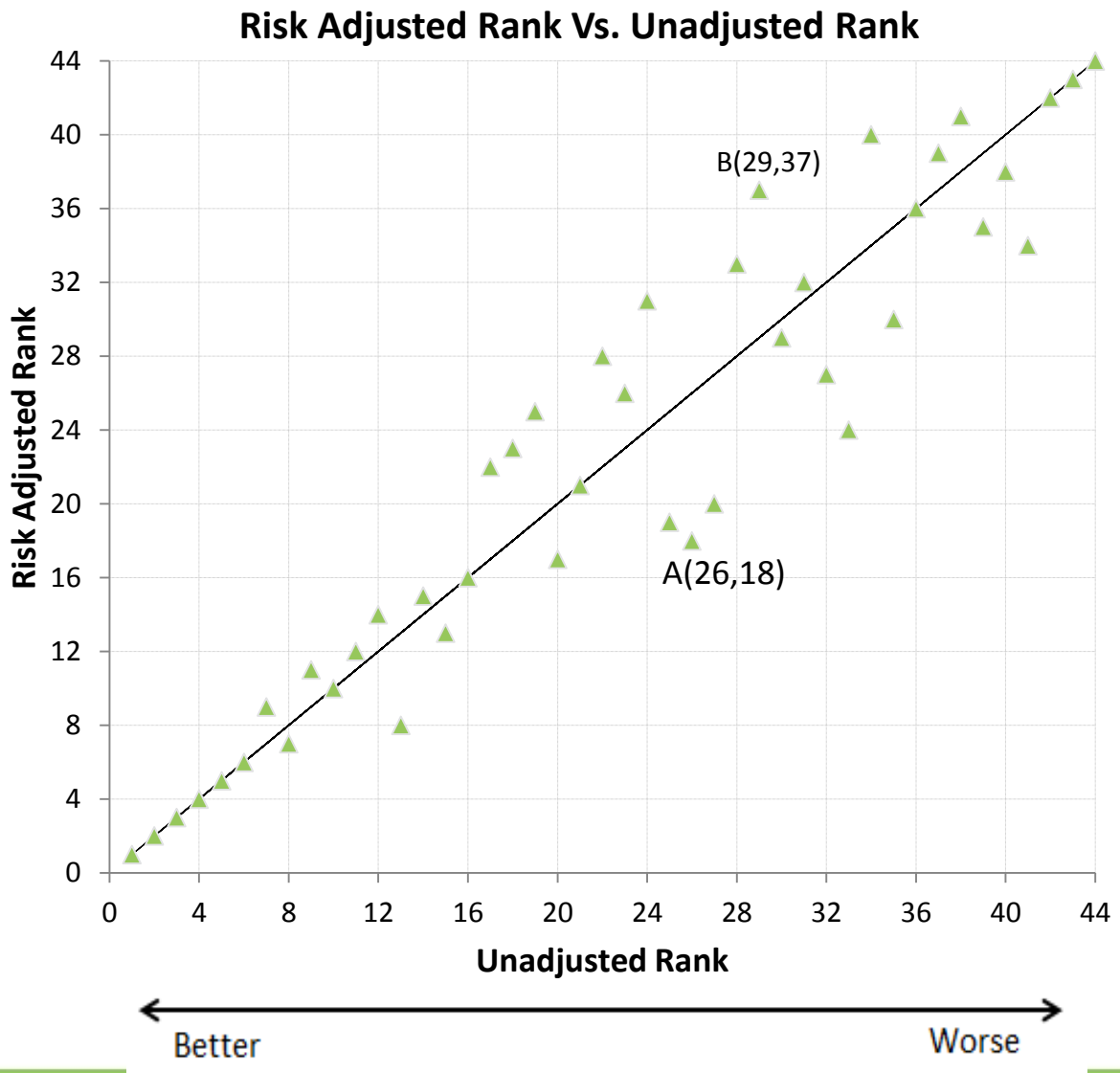
Phase 2 Pilot Testing: Odds Ratio – MA-H

- Members that live in area with high level of home ownership (>80%) are more likely to be adherent.
- In contrast, members who live in high poverty areas are less likely to be adherent, the higher the prevalence of poverty, the less likely the member is to be adherent.
- Members who live in area where 19% or more of households have a member that completed college or higher degree are slightly more likely to be adherent.

Variable	Coefficient Estimate	Odds-Ratio	P-Value	Variance Inflation Factor	Population Percent
Percent of Households that Own Their Home:					
0% - 80% (Reference)					
81%+	0.072	1.074	<.0001	1.246	0.425
Percent of Population Below Poverty Level:					
0% - 7% (Reference)					
8% - 13%	-0.089	0.915	<.0001	1.700	0.213
14% - 23%	-0.127	0.880	<.0001	1.953	0.268
24% - 100%	-0.211	0.810	<.0001	2.308	0.318
Percent Households with Completed College or Higher:					
0% - 18% (Reference)					
19% - 100%	0.032	1.032	<.0001	1.151	0.513

Phase 2 Pilot Testing: MA-H

- Plans ranked BEST tended to stay ranked best and plans ranked WORST tended to stay ranked worst.
- There was most movement of plans in the 3rd and 4th (bottom) quartiles.
  - For example, the biggest change observed was for Plan B, which *declined* from rank 29 to rank 37 (66th percentile to 84th percentile).
  - In other words, we would expect Plan B to provide a higher quality of care than they actually are providing based on the population they serve!
  - In contrast, Plan A's rank *improved* from 59th percentile to 41st percentile.
  - Plan A appears as though they are providing a lower quality of care than they are once we adjust for population risk factors.



Summary

1. Stratification of medication adherence rates by LIS status does not significantly change the percentile rank for most plans.
2. Risk adjustment does not significantly change the rankings of plans rated best under current specifications or the rankings of plans rated worst—they are still among the best and worst with risk adjustment.
3. *Non-duals who are poor actually have worse outcomes than dual eligible members who are poor (but have more benefits due to dual status).*
4. This underscores the importance of adjusting for income/poverty *in addition to* dual and/or LIS status.
5. There is great consistency across the medication adherence measures:
   - Disability + Age,
   - Race/Ethnicity,
   - Dual Status,
   - Number of Medications,
   - % Home Ownership,
   - % Near Neighborhood Below Poverty Level, and
   - Education
6. Income and Education are significant predictors even after including dual status, age-disability interaction and other variables.

Accounting for Social Risk Factors in Medicare Payment Programs

José J. Escarce

January 21, 2016

IMPACT Act of 2014

- Required the Secretary of HHS to report to Congress by October 2016 on the impact of SES on quality and resource use in Medicare using measures such as poverty and rurality from existing Medicare data
- Required report to Congress by October 2019 on the impact of SES on quality and resource use in Medicare using measures (e.g., education and health literacy) from other data sources
- Required qualitative analysis of potential SES data sources

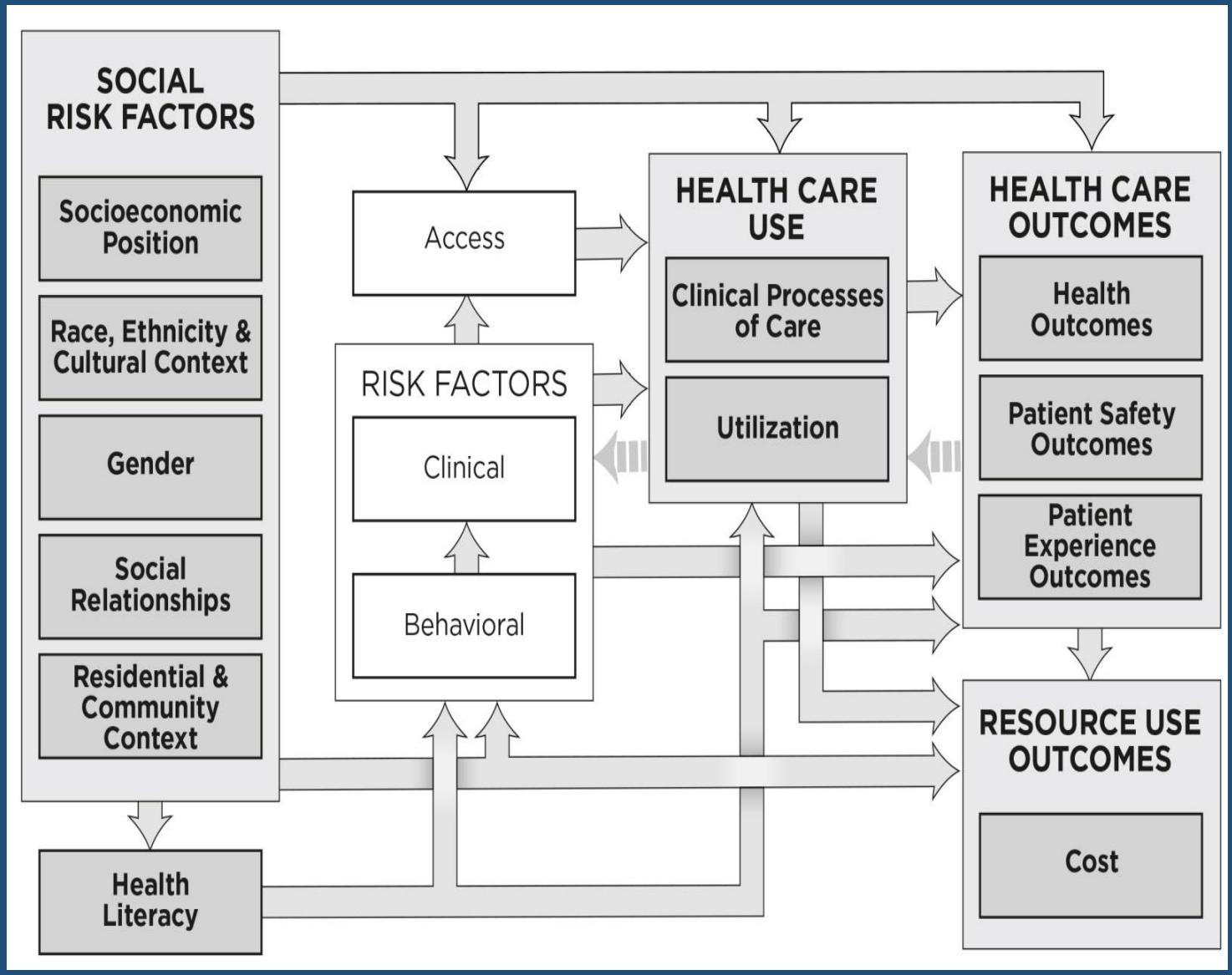
Statement of Task: Five Reports

- Report 1: Define SES for application to quality, resource use, or other measures used for Medicare payment programs and identify SES and other social factors shown to impact health outcomes of Medicare beneficiaries
- Report 2: Identify best practices of high-performing hospitals, health plans, and other providers that serve disproportionately higher shares of socioeconomically disadvantaged populations

Statement of Task: Five Reports

- Report 3: Specify criteria for determining whether an SES or other social factor should be accounted for in Medicare quality, resource use, or other measures used in Medicare payment programs; identify SES factors or other social factors that could be incorporated; and identify methods that could be used
- Report 4: For each SES or other social factor identified, recommend existing or new sources of data and/or strategies for data collection
- Report 5: Synthesize and interpret the four brief reports in one report that will include comprehensive project findings, conclusions, and recommendations

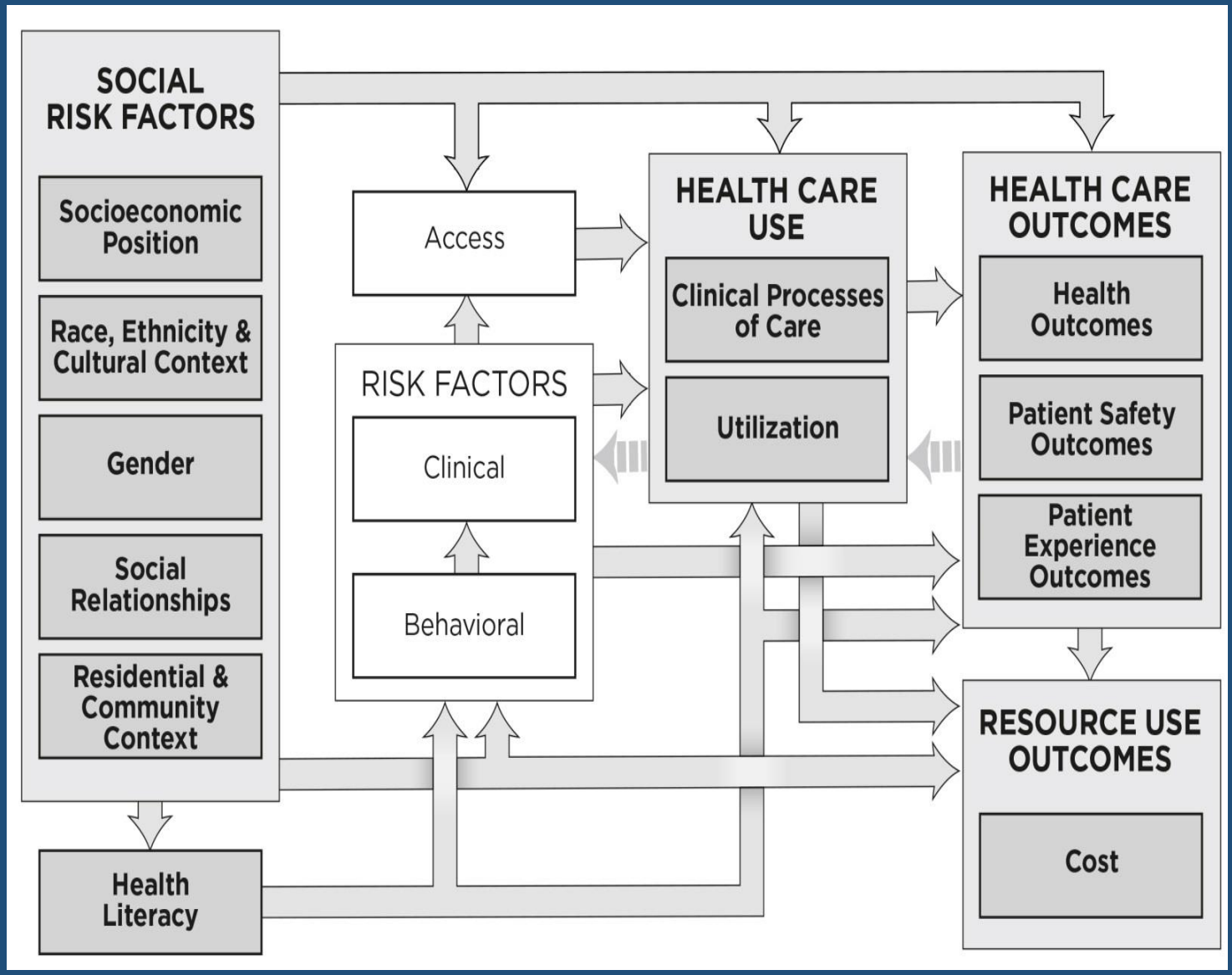
Social Risk Factor Framework



Framework: Social Risk Factors

- Socioeconomic position: An indicator of a person's position in society that captures access to material and social resources as well as relative status
- Race, ethnicity and cultural context: Race, ethnicity, language and nativity
- Gender: Social dimensions of gender (beyond biology)
- Social relationships: Marital status, living alone and social support
- Residential and community context: A set of broadly defined characteristics of residential environments that may be relevant to health
- Health literacy

Social Risk Factor Framework



Framework: Outcomes

- Health care use
  - Health care utilization
  - Clinical processes of care
- Health care outcomes
  - Health (clinical care) outcomes
  - Patient safety outcomes
  - Patient experience outcomes
- Resource use
  - Costs

Literature Retrieval

- Conducted by a professional librarian at the Academies
- Limited to studies on U.S. patients, review articles published in last 20 years and original research published in last 10 years
- Focused on social risk factors and on health care use and outcomes such as those used in Medicare value-based payment programs
- Articles were described generally without assessment of the quality of individual studies and with no attempt at data integration
- Discussion should not be mistaken for a systematic review that uses a formal system for weighing and describing evidence

Findings

- “Thus, all other things being equal, the performance of a given health care system (in terms of quality, outcomes, and cost) can undoubtedly be affected by the social composition of the population it serves.”
- “What is clear at this point in time is that health literacy and social risk factors have been shown to influence health care use, costs, and health care outcomes in Medicare beneficiaries.”

Challenges: Input from NQF's Stakeholders

- Limited availability of patient-level data
  - 9-digit ZIP Code/census block data not easily accessible
- Concerns about factors selected/analyzed to date
  - Available proxies may not be adequate
    - » Dual-eligibility status
  - Inclusion of race questioned
- Call for a more prescriptive approach
  - Should NQF establish guidelines for which SDS factors should be considered?

Discussion: DSC Guidance

- Does the Disparities Standing Committee have recommendations about the use of variables that are currently available?
- Should NQF take a more prescriptive approach to variable selection?
- How can NQF help to encourage the development of innovative approaches to SDS adjustment?

Discussion of the SDS Trial Period Evaluation Plan

Karen Johnson, MS

NATIONAL QUALITY FORUM

Limitations to the Trial Period

- There are important constraints to what can be achieved and learned in NQF's trial period. Important limitations to note include:
  - NQF does not develop performance measures or implement them in accountability applications or improvement programs.
  - NQF only controls what is required for submission, criteria for evaluation, and what is ultimately endorsed.
  - NQF does not have additional funding for special research studies that would be of interest.
  - Current data limitations for SDS variables during the trial period could result in a weaker or non-significant association with an outcome than would be seen with a more specific or reliable variable of SDS.
  - Measure developers have a range of expertise, capacity, and readiness to obtain and work with SDS data.

Evaluation of Trial Period

- To evaluate the success of the trial period – and the appropriateness of the change in policy to allow SDS adjustment – NQF will focus on a number of indicators, including but not limited to:
  - Which measures had a conceptual rationale for inclusion of SDS factors?
  - What variables and data were available/analyzed?
  - If data not available, what was the pathway forward?
  - Number/types of measures submitted with SDS adjustment, and the outcome of those evaluations?
  - If SDS factors included, were specifications for stratification also included?
- In addition, NQF will solicit feedback from stakeholders on the impact of the trial period

Evaluation of Trial Period (cont.)

- Longer-term questions for evaluating the impact of SDS adjustment may include:
  - The availability of data on SDS variables, and the quality of that data
  - How healthcare entities react to SDS-adjusted scores and stratified data for improvement
  - How purchasers and payers use SDS-adjusted scores in accountability programs
  - Whether SDS adjustment has any impact on disparities
- While these questions are largely out of NQF's control, NQF will work with stakeholders and the Disparities Standing Committee to explore ways of gaining insight into these longer-term issues

Discussion

The Disparities Standing Committee will make recommendations to CSAC and the Board about the trial period.

- What would lead the Disparities Standing Committee to recommend reinstating the prohibition on consideration of SDS factors in risk adjustment?
- What information does the Standing Committee need to make its recommendation?
- Are there additional questions we should expect to be able to answer? If so, what additional data should we collect?

Public and Member Comment

Lunch

Incorporating Disparities Focus into NQF Measure Endorsement and Selection

Elisa Munthali, MPH

NATIONAL QUALITY FORUM

Activities in Multiple Measurement Areas

- **Performance Measure Endorsement**
  - 600+ NQF-endorsed measures across multiple clinical areas
  - 11 empaneled standing expert committees
- **Measure Applications Partnership (MAP)**
  - Advises HHS on selecting measures for 20+ federal programs, Medicaid, and health exchanges
- **National Quality Partners**
  - Convenes stakeholders around critical health and healthcare topics
  - Spurs action on patient safety, early elective deliveries, and other issues
- **Other Activities**
  - Convenes private and public sector leaders to reach consensus on complex issues in healthcare performance measurement

Current Considerations of Disparities in NQF's Work

NQF Measure Evaluation Criteria for Endorsement

NQF endorses measures for accountability applications (public reporting, payment programs, accreditation, etc.) as well as quality improvement.

- Standardized evaluation criteria
- Criteria have evolved over time in response to stakeholder feedback
- The quality measurement enterprise is constantly growing and evolving – greater experience, lessons learned, expanding demands for measures – the criteria evolve to reflect the ongoing needs of stakeholders

Major Endorsement Criteria Hierarchy and Rationale

- **Importance to measure and report**: Goal is to measure those aspects with greatest potential of driving improvements; if not important, the other criteria are less meaningful (***must-pass***)
  - Includes disparities
- **Reliability and Validity-scientific acceptability of measure properties** : Goal is to make valid conclusions about quality; if not reliable and valid, there is risk of improper interpretation (***must-pass***)
- **Feasibility**: Goal is to, ideally, cause as little burden as possible; if not feasible, consider alternative approaches
- **Usability and Use**: Goal is to use for decisions related to accountability and improvement; if not useful, probably do not care if feasible
- Comparison to related or competing measures

Measure Selection: MAP

- MAP is a multistakeholder partnership that guides the U.S. Department of Health and Human Services (HHS) on the selection of performance measures for federal health programs.
- One of MAP's key initiatives is to convene stakeholders for an intensive annual review of the quality measures being considered by HHS for 20-plus federal public reporting, payment, and other programs.
  - This is known as the pre-rulemaking process

Focus on Disparities in the MAP Measure Selection Criteria

- MAP uses the Measure Selection Criteria (MSC) to guide its annual review of measures for federal programs:
  - Identify characteristics that are associated with ideal measure sets used for public reporting and payment programs.
  - Provide general guidance on measure selection decisions and to complement program-specific statutory and regulatory requirements.
  - Evaluating the relative strengths and weaknesses of a program measure set, and how the addition of an individual measure would contribute to the set.

MSC #6. Program measure set includes considerations for healthcare disparities and cultural competency

Demonstrated by a program measure set that promotes equitable access and treatment by considering healthcare disparities. Factors include addressing race, ethnicity, socioeconomic status, language, gender, sexual orientation, age, or geographical considerations (e.g., urban vs. rural). Program measure set also can address populations at risk for healthcare disparities (e.g., people with behavioral/mental illness).

- Sub-criterion 6.1 Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)
- Sub-criterion 6.2 Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack), and that facilitate stratification of results to better understand differences among vulnerable populations

Discussion

- How can NQF increase the focus on disparities elimination in its measure endorsement and selection work?

Public and Member Comment

Next Steps

Next Steps
Committee Timeline

- Quarterly Conference Calls
  - Tuesday, April 26, 2016 from 2:00-4:00 pm ET
  - Thursday, July 21, 2016 from 12:00-2:00 pm ET
  - Wednesday, October 19, 2016 from 2:00-4:00 pm ET

Project Contact Info

- Email: Disparities@qualityforum.org
- NQF Phone: 202-783-1300
- Project page:

http://www.qualityforum.org/Disparities_Project.aspx

- SharePoint site:

http://share.qualityforum.org/Projects/Disparities/SitePages/Home.aspx

Adjourn