NATIONAL QUALITY FORUM

Meeting Summary

Disparities Standing Committee Web Meeting
October 19, 2016 2-4pm ET

The National Quality Forum (NQF) convened a committee web meeting for Task Order 24, Reducing Health and Health Care Disparities Related to Social Risk Factors on Wednesday, October 19, 2016. The purpose of this meeting was to discuss the background, scope, and objectives for the new disparities project, as well as to identify information that will assist the project team in completing a series of literature reviews that will inform the first of four reports.

Welcome and Review of Meeting Objectives

Erin O'Rourke, senior director, welcomed the Committee and meeting participants. She began by introducing Marshall Chin, Committee co-chair, who also welcomed the committee. Ms. O'Rourke reminded the Committee that NQF's work would be grounded in the National Quality Strategy and focused on improving the goals of better care, healthy people, healthy communities and smarter spending. She remarked on how NQF was building on previous disparities-related work through the years. She also restated the Committee's charge to:

- 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 Socio-Demographic Status (SDS) factors and evaluate the SDS trial period; and
- provide a cross-cutting emphasis on healthcare disparities across all of NQF's work.

Drew Anderson, senior project manager, called the roll of attendees and introduced the new team members, Tara Murphy, project manager, and Mauricio Menendez, project analyst. Erin O'Rourke followed up her opening comments by describing the specific social risk factors and selected conditions the disparities team will be investigating in their reports. She went over what specific content each report will contain and the timeline of deliverables, as well as in-person meeting dates. Marshall Chin expressed that he and Ninez Ponce, Committee co-chair, want to make sure that NQF's work builds upon where the Committee has already been, he then opened the conversation up for Committee discussion.

Review the Committee's New Scope of Work

The Committee's discussion focused on the content of the four reports and incorporating anecdotal evidence from expert informants. They expressed the need to create policy approaches in their recommendations for the final report. Committee member Romana Hasnain-Wynia agreed that maintaining the policy piece of the work is important, but we should also focus on providing real world examples. Marshall Chin and Committee member Jose Escarce reminded the Committee about the National Institute of Medicine's (NAM) task from Congress to focus the report on "adjusting for social risk factors in payment," which led to further discussion about the content of the third and fourth

reports. Committee member Lisa Iezzoni mentioned that disability was not included in the NAM reports but is still included in the Committee charge. Committee member Traci Ferguson remarked that there may not be an established payment model to really address the goal of reducing disparities. Pertaining to the question of how we build on the conceptual model. Marshall Chin discussed using the Committee's overall expertise to outline present efforts that are underway that most people may not be aware of.

Input on the Literature Review of Disparities in Health and Health Outcomes in the Target Conditions

Drew Anderson discussed the background of the literature review and asked the Committee for recommendations of key informants who can speak on effective interventions. Drew also asked the Committee to suggest specific works that could assist our literature review. Romana Hasnain-Wynia remarked that NQF should not limit their search to literature that compares two or more groups. Committee member Bob Rauner stated that NQF should not limit their search to only peer reviewed work but also include gray literature. Committee member Lisa Cooper remarked that NQF should consider the parameters of their search and limit the review to interventions that are closely tied to the healthcare system, as opposed to social services. Bob Rauner and Committee member Michelle Cabrera both suggested that NQF not consider cost within the search due to its dependent nature on the context in which it's implemented. Committee member Ronald Copeland commented that the project team should look at the Healthcare Effective Data and Information set (HEDIS) of screenings and health measures that are used across a lot of large managed care organizations.

Update on the NQF SDS Trial and Review of Accounting for Social Risk Factors in Medicare Payment Data

Erin O'Rourke shared updates from NQF's SDS trial and reminded the Committee that under this new policy, adjustment for SDS factor is no longer prohibited and that during the trial period, if SDS adjustment is determined to be appropriate, NQF will endorse one measure with specifications to compute the SDS adjusted version and the non-SDS adjusted version that is only clinically adjusted to allow for stratification. NQF received an appeal of the decision to continue endorsement of the three cost and research use measures, the three episodes based on acute myocardial infarction (AMI), heart failure, and pneumonia without SDS factors in the risk adjustment model. These appeals will be considered by the NQF board during the November 2nd meeting.

For the readmissions project, the Standing Committee reviewed 17 new and maintenance measures and 16 conditionally endorsed measures. Ultimately, the Committee recommended two for endorsement with risk adjustment, looking at payer mix and marital status as a proxy for caregiver availability. The Consensus Standards Approval Committee (CSAC) will discuss those recommendations on November 9th and 10th.

Helen Burstin, NQF Chief Scientific Officer, noted that the recommendation NQF needs from this Committee is not necessarily an up or down about whether measures should be adjusted for social risk, but whether NQF should make what was a trial period change to our policy a

permanent change. Essentially, would NQF, going forward, allow measures to be submitted adjusted for social risk?

Opportunity for Public Comment

Throughout the web meeting, public participants had the opportunity to provide comments and ask questions through the webinar chat feature or on the phone. John Shaw, president of Next Wave, shared that most of the measures reviewed in the trial period have been limited to Medicare fee-for-service population, which is not representative of all measures where risk adjustment would be considered.

Next Steps

Follow up with committee for second and third web meeting availability.

NATIONAL QUALITY FORUM

Moderator: Disparities Standing Committee
October 19, 2016
2:00 p.m. ET

Operator: This is Conference ID # 55155675

Erin O'Rourke: Good afternoon, everyone. Thank you for joining our quarterly meeting of the National Quality Forum Disparity Standing Committee.

This is Erin O'Rourke, one of the senior directors here in NQF supporting this project. We're very excited today to get to share with you a new scope of work that has been given to this committee by our colleagues at CMS. So we're excited to kick off this new project with you all and get your guidance on how you'd like to move forward.

So with that, I'd like to welcome Marshall Chin, one of our co-chairs. Marshall, did you have anything as we get started?

Marshall Chin: So just to welcome everyone and to thank everyone again for your service to this important committee.

Just maybe a little bit of a tag team moderation today that (Ninez) sends her welcome also. She's on week three of being on a jury in Los Angeles and she's hoping to join us in about an hour when the jury has its break. And at that time, I'm taking my son to a sports orthopedic appointment, so hopefully I can keep on with the cellphone reception, but we'll see what happens with that, but we'll between Erin, (Drew), (Ninez), and I will be able to help moderate the session.

Erin O'Rourke: Great. Thank you so much. Next slide. OK. So, again, just a quick reorientation as we get started. We'll be grounding our work in the National Quality Strategies. Really focusing on how we can improve the goals of better care, healthy people, healthy communities and smarter spending for all.

Next slide. Apologies, I don't know if my graphic is showing.

(Off-Mic)

Female: Oh, yes.

Erin O'Rourke: But we've shown this one to you a number of times from Ernest Moy from AHRQ showing the disparities chasm and how it interacts with the quality chasm and the challenge is in quality improvement for disadvantaged populations.

As we said before, the belief is that the best way to close the gap in disparities and quality is to focus on quality improvement for those populations who need it the most. I know when Helen showed you the slide at our orientation last year, she really said we need a – this is not a rising tide, lift all the boats approach. So we need to focus on the boats, not necessarily the tide, and we're really excited that this scope of work will build on the work that we've done last year to help us have the plan to find those boats and raise quality for everyone.

Next slide. Again, just a brief reminder how we are building on NQF disparities-related work through the years. The Disparities Standing Committee is really a culmination of a number of projects that NQF has been involved in through the years and we're excited to have the opportunity to continue some of the great work of those prior committees as well as this committee's great work from last year into this new scope of work.

Next slide. So, again, just to quickly remind of our charge, first to develop a roadmap for how measurement can be used to proactively reduce disparities as well as to review implementation of the revised NQF policy and evaluate the SDS trial period and to provide a crosscutting emphasis on healthcare disparities across of NQF work.

So with that, I'm going to turn it over to my colleague, (Drew) to do a quick roll call.

(Drew): Sure. So if you could just say "here" when I call your name. Phil Alberti?

Philip Alberti: Here.

(Drew): Susannah Bernheim?

Susannah Bernheim: Here.

(Drew): Michelle Cabrera? Juan Carrillo?

Juan Carrillo: Present. Here.

(Drew): I apologize if I messed up anybody's name.

Juan Carrillo: OK.

(Drew): Lisa Cooper?

Lisa Cooper: Here.

(Drew): Ronald Copeland?

Ronald Copeland: Here.

(Drew): Jose Escarce?

Jose Escarce: It's easy, Escarce. Yes, I'm here.

(Drew): Sorry. Traci Ferguson?

Traci Ferguson: Here.

(Drew): Kevin Fiscella?

Kevin Fiscella: Here.

(Drew): Nancy Garrett? Romana …

Romana Hasnain-Wynia: Hasnain-Wynia. I am here but I will only be on for the first hour.

(Drew): OK. Thank you. Lisa Iezzoni?

Lisa Iezzoni: It's Lisa Iezzoni, I'm here.

(Drew): Lisa. Yes. Oh, yes. That's right. David Nerenz?

David Nerenz: Here.

(Drew): Yolanda Ogbolu.

Yolanda Ogbolu: I'm here. Yolanda Ogbolu.

(Drew): Ogbolu. OK. Sorry, this is my first time hearing everybody's names out loud. So bear with me.

Bob Rauner? Eduardo Sanchez? Sarah Scholle? Thomas Sequist?

Thomas Sequist: I'm here.

(Drew): Christie Teigland? Mara Youdelman? OK.

Sarah Scholle: Hi. This is Sarah Scholle, I couldn't get through my mute button fast enough.

(Drew): OK. Thank you.

Michelle Cabrera: Hi. This is Michelle Cabrera. Same technical difficulties.

(Drew): OK. Thank you.

Female: Thank you.

(Drew): All right. The next slide, please. So as you all are familiar, we sent out an email a couple weeks ago.

We have a couple new team members we wanted to introduce. We have (Tara Murphy) and (Mauricio Mendez), which will be supporting us through this new work. And, of course, we have the usual team Helen Burstin and Erin O'Rourke.

Next slide. So as Erin mentioned earlier, the purpose of this call is really to review the background, the scope and objectives for the new disparities projects and then a part of this project where we'll go in to some of more detail later on is a series of literature reviews to identify information to help support the committee's recommendations, so we'll be asking for your input on that. And lastly, we'll be reviewing the SDS trial progress to date.

So I'm going to turn it over to Erin to go over the new scope of work.

Erin O'Rourke: OK. Thank you, (Drew). So our new scope of work is focused on reducing health and healthcare disparities related to social risk factors.

Next slide. So the objectives of this project are to provide multi-stakeholder guidance on how measurement can be used to adjust disparities in some selected conditions, namely cardiovascular disease, cancer, diabetes and chronic kidney disease, infant mortality, low birth weight, and mental illness. And the committee is asked to examine these disparities based on the social risk factors outlined in the 2016 National Academies Report, Accounting for Social Risk Factors in Medicare Payment.

Just a refresher, I know we've been building on that work throughout the year but those factors are socio-economic position, race, ethnicity, and cultural context, gender, social relationships, and community and residential context. We've also been asked to specifically examine disparities related to disabilities and to focus on rural disabilities as well. So we advocate disparities as well.

So we did want to make sure that the committee was aware that we have heard your call that we need to look at disparities broadly and not be overly focused on any one social risk factor.

Next slide. Again, so this is the framework that we'll be building off of (forward by NAM) for social risk factors.

Next slide. So as (Drew) is saying, under contract with HHS, this one year project will involve a review of the evidence describing disparities and health and healthcare outcomes in the target conditions. Review of the causes and factors associated with disparities and the target conditions, evidence of effective interventions as well as gaps in the existing work.

An environmental scan of performance measure currently use – in use or under-development to assess effective interventions and the identification of gaps in measurement and the extent to which stakeholders are employing effective interventions. The development of a conceptual framework to guide performance measures and recommendations for measure development to assess efforts to reduce disparities in health and healthcare in the target conditions.

Next slide. So we've – we're really excited to receive this work. We saw it as a natural extension of what the committee was doing last year, in particular, it's really a chance to focus in on some of the committee's goals of how we could use measurement to eliminate disparities, namely to prioritize reducing disparities, to develop valid reliable performance measures, to ensure the scientific integrity of those measures and recommend measures for use, to incentivize the reduction of disparities, and to implement quality improvement and care transformation.

So as you are aware, during our in-person meeting, the committee really spent some time thinking about the desired short-term outcomes you would like to see from this roadmap to eliminate disparities. Mainly, the committee wants to incentivize the reduction of health disparities and improvement of clinical performance of at-risk population, to incorporate equity accountability measures into payment programs, to align equity accountability measures across payers, to incentivize preventive care, primary care, and adjusting the social determinants of health, to assist safety net organizations serving vulnerable populations, and to conduct and fund demonstration projects to test payment and delivery systems to perform interventions to reduce disparities.

Next slide. Just some of the draft themes of the roadmap that the committee developed last year was to set an aspirational goal of eliminating disparities in health and healthcare as well as laying out shorter term goals to achieve this aspirational goal. The committee emphasized that equity is an essential part of quality, you want to encourage elimination of disparities across the three National Quality Strategy aims and to focus on disparities in health as well as in healthcare.

The committee noted the need to consider a broad definition of populations experiencing disparities. For example, social stratification including race, ethnicity, age, gender, sexuality, disability, and geographic location, to emphasize the role of the community and the importance of building cross sector partnerships. Really namely that measurement should extend beyond clinical settings and processes of care and to develop better connections between health and healthcare.

Next slide. The committee noted your desire to use performance measurement and policy levers attached to its use such as value-based purchasing and public reporting to reduce and eventually eliminate disparities in care. The committee noted the equity and elimination of disparities needs to be emphasized in value-based purchasing programs.

We need to capitalize on new delivery and payment models that are being laid out so that we can really leverage the system transformation that's happening right now to improve equity. There's a need to address the social determinants of health, to align reimbursements with actions to eliminate disparities and to identify the accountable entities. The committee noted a need to encourage investment in the health of underserved communities and to address underlying issues of affordability. In particular, the committee called to develop measures to improve population health.

Next slide. So, again, we wanted to just reorient everyone to what is a roadmap, that we're aiming to describe a path for achieving a goal, outline the actions needed to eliminate disparities and to highlight the stakeholders and their responsibilities.

Next slide. So, again, this is a graphic we showed you back in July. We're going to continue to refine this over the new course – the course of the work of this year, but we did want to bring it back together. This really graphically ties together what I've just run through from the committee's work-to-date outlining that disparities measurement lifecycle, of prioritizing areas for measures that can reduce disparities, developing valid, reliable performance measures, ensuring the integrity of those measures, and then identifying gaps and measurement and performance with the goals of that we need to identify disparities by stratifying data, incentivize the reduction of disparities through measurement, implement and support quality improvement strategies, and then ultimately hoping to achieve our aspirational goal of eliminating disparities in health and healthcare.

So as (Drew) was saying, this new scope of work asks the committee to issue a series of reports over the course of one year. The first report is a review of disparities in health and health outcomes for people with cardiovascular disease, cancer, diabetes, and chronic kidney disease, infant mortality, and low birth weight, so those social risk factors defined by the National Academy of Medicine as well as disability and a special emphasis on rural populations.

We'll be outlining the separate effects of each social risk factor on the target conditions as well as the intersection of race, ethnicity, and culture with socioeconomic position and residential and community context.

The second report asks the committee to identify evidence of effective interventions to reduce disparities in the target conditions, again, using the framework developed by the National Academy of Science, Engineering, and Medicine which identify practices for the care of socially at risk populations.

Next slide. The third report is identification of performance measures. So we'll be performing a scan for measures, measure concepts and/or current or emerging evidence-based practices with respect to measurement of effective interventions to reduce disparities. I will be using a conceptual framework to analyze, prioritize, and make recommendations to guide measurement of effective interventions to close and eventually eliminate disparities.

And the committee will be asked to develop a core set of measure domains and measures building off of domains and sub-domains outlined in the CMS equity plan for improving quality in Medicare.

The final report will be the committee's recommendations. So the committee will be asked to make recommendations for priority measures to be developed to assess efforts to reduce disparities for the target conditions as well as recommendations for use of measures that could eliminate disparities.

Next slide. We have a rather aggressive timeline for this project, you can see we'll be issuing the first draft report in December, a final report due in January. We'll be convening you for your second web meeting in January 2017 to get feedback on developing the next draft report on the causes of disparities in the selected conditions and evidence of effective intervention.

The draft of that report is due in February, the final report due in March. We'll be reconvening you for your first in-person meeting of the year in March 2017to get guidance for the third draft report that is due in May with a final report in June. Well then the actual reconvene this committee for your second in day person – or in-person meeting in May of 2017 where we'll be, again, getting guidance for that comprehensive report and asking you to make your recommendations.

The draft comprehensive report is due in July, we'll reconvene the committee via web meeting in August where we'll be bringing you the results of the public comments that we receive on that report so that you can consider those before the report is finalized in September of 2017.

So …

(Drew): We do have (Cara) on the line.

Erin O'Rourke: Oh, we do have (Cara) on the line? Oh, with that, I did want to see if (Cara James), our federal liaison and our funder of this work has anything to share before we open for a committee discussion. We're excited to have our committee to committee to continue to work with you.

So (Dr. James), are you on the line?

(Cara James): I am. Thank you so much for the introduction and good afternoon, everyone. As you're hearing, we are very excited about the work.

We're hoping that what we have been able to really pull together is building off of the work that already has been underway and helping move us forward. And I think as we kind of think about the narrative of what we're trying to do here that there are – you know, focusing on these particular areas that we have mentioned, understanding really what is driving the disparities that we see and figuring out what are potential for lack of a better term process measures that we could use as intermediate outcomes along the way to reducing disparities and to be able to monitor that, because we're not going to be able to reduce disparities in one year or six months or three months, but it's going to take us some time and we want to be able to see what are those signals we should be working for along the way to know that we're headed in the right direction as we ultimately work towards those final outcomes of disparities reduction.

So I will stop there but I think if there's any thoughts or questions, we'd welcome those.

Marshall Chin: And this is Marshall. Before we open it up, I just want to let people know that a couple of days ago (Ninez) and I had a call with Erin and (Drew) so that they briefed us beforehand to let us give a heads up on the different issues.

And (Ninez) and I, we raised a couple of points just to clarify, but I think I'm going to point out explicitly. We want to make sure that in some ways that this work that (Cara) mentioned builds upon where the committee where has already been. So in particular, you'll see that like when Erin went through the slides, there was quite a bit of discussion about then the roadmap for it to come up-to-date and then the issues ranging from selection of proposed measures to their use. And that will be continued.

So in other words, the first two reports talk mostly about document disparities and effective solutions. Three and four then start to give issues then of linking to the conceptual model and as Erin had mentioned in that last slide on the

four reports, their use. So we're not in some ways taking a step back but we're basically continuing to build upon the work of the committee.

A second point is that, it's a point that (Ninez) emphasized too that in some ways, even though there are four reports, some of the work has be concomitant. So for example, to be able to come up with the first two reports looking at document disparities and effective interventions, there needs to be further work kicking off report three which is the conceptual model, because in some ways that helps frame what are some of the relevant aspects to look at for reports one and two as well as (Cara) is saying that a part of the goal is also to come up with some intermediary process measures to be able – better be able to assess change over time.

Some of that needs to be done upfront also. And so even though it's sequential to the reports, some of the work for the conceptual model has some – or earlier probably at a minimum by when we have our first web call – the web call in January. So some of this will be concomitant. So hopefully that will provide a little more context so that it is more tightly linked than perhaps was clear from the slides the work that we've done in the past as a committee, and then this new charge.

Erin O'Rourke: Great. Thank you, Marshall. So with that, next slide. We'd really like to take this opportunity to get your thoughts as Marshall was saying as we start to lay out the plan for achieving this new scope of work. We'd really love to get your guidance on how we could leverage your previous work to guide and build on for this new work, how we can take advantage of the changing payment and policy landscape to improve equities, how we can continue to build off of and refine the conceptual model the committee developed to guide this new work. And any strategic guidance you have for us as we really begin to dive in to these reviews and reports.

With that, I'll turn it to Marshall to moderate.

Marshall Chin: OK. So why don't we open it up and maybe we'll start with the first question about how can we leverage the committee's previous work to guide this new work?

Maybe before we do, before we march the four questions, if people have any I guess global thoughts as we are thinking about them, all that Erin and (Cara) have mentioned, just any initial reactions, any initial sort of thoughts before we go through each of the four questions?

Lisa Cooper: Well, this is Lisa Cooper, I just want to say that I am just – I'm thrilled to hear that, you know, CMS is taking such a strategic approach to the issue and because I think they, you know, by doing that they're sort of setting the tone.

And really making people sit up and pay attention because when CMS takes a close look at this and actually identifies specific interventions that they deem to be effective and things that are likely to be potentially like reimbursable, I think that you'll see like health systems paying attention to that and trying to make sure that they're looking carefully at these interventions and not sort of always thinking about disparities as sort of a sideline issue, but bringing it more to the center, you know, of like the whole sort of population health and quality improvement agenda.

Marshall Chin: Thanks, Lisa.

Romana Hasnain-Wynia: This is Romana.

Marshall Chin: Hi, Romana.

Romana Hasnain-Wynia: Hi. So, you know, this is more of a global comment as you requested. So I completely agree with what Lisa is saying.

The other thing that I think is going to be really important is, you know, we are obviously thinking about this within the context of the healthcare system and accountability of the healthcare system. But I do think with new payment models and with a rising recognition that healthcare cannot take care of everything, I think it's going to be important to maybe even think about models where there have been some important intersections of the healthcare system or systems with other parts of the community that have really worked.

So I'd like to not just focus on kind of the policy piece, but also create somewhat of a foundation of providing some real world examples where they exist to kind of really complete the story, if you will.

Marshall Chin: Thanks, Romana. I think when we talk about the second discussion question, probably this issue of what's happening in the current environment whether it's payment policy or the current thinking of where the field is going, that sort of fits in that area so that we are relevant.

Kevin Fiscella: This is Kevin. Where do the recent National Academy of Medicine reports fit in? Maybe Jose at some point can speak to that, but how will that connect with the work that we're doing on this committee?

Erin O'Rourke: This is Erin. I can start and then I'd welcome Jose, if you have thoughts or Marshall and I'm joined by Helen Burstin.

So really we want – we are charged with building off of the framework laid out by the National Academy of Medicine Committee for identifying social risk factors. And we really want to leverage some of the great work that committee has done as far as identifying what risk factors should be looked at, current data availability. We're going to share some of the recent findings later on, so we'd welcome any guidance and input from the committee about how we can best leverage that work to build on this work.

Marshall Chin: I'll add a couple of things and then maybe, Jose, you can add to this. So just to remind people, the National Academy, they were charged by Congress to come up with five different reports that overall would look at the issue of should we adjust for social risk factors in payment but the five reports cover somewhat of a broader set of topics.

So one is specifically that issue of social demographic adjustment, and so, I think clearly that work, as well as some of the work from ASPE that we'll hear about hopefully later this month will inform, besides the internal work of the Yale group on this question that we have of this trial period for the Social Demographic Risk Factor Adjustment.

Another one of reports, I think it was the second one or the second or third report out of the five was one that Erin referred to looking at, a review of best practices, best practices for caring for at-risk populations. And so, some of that gets into the issue of effective interventions and relate to our roadmap then conceptually, and so, that will be related to that work also.

So I think there's always two different ways that the (NEST) and the (NMS) work are relevant and very helpful for our committee. Jose?

Jose Escarce: Yes. So, I guess I will say a couple of things. First is of course the National Academy of Medicine was contracted by ASPE to help them in thinking through what they had been charged with doing by Congress.

Thus, the third report really laid out the social risk factors, as we call them. And the fourth one identified data sources that were available now and that could be available in the future. The fifth report which is currently being written is sort of a summary of the others with some additional material.

I just want to talk about the second one for a second because Marshall just mentioned that it was a report that identified best practices. I think it's really important to understand that the second report – I mean they were all hard. The second report was especially hard because the truth is that at least for sort of academic or, you know, rigorous evidence-based folks, there just isn't much of it.

And so, the second report is – it's understood by the committee that the second report is sort of the collection of anecdotal reports. It doesn't mean that there isn't very valuable information there and we think, you know, that there probably is. But I think it would be a mistake to sort of say that the second report did a rigorous and, you know, I'll just say in "scientific examination of best practices that are – that work on a systematic basis," that's just isn't the case because the evidence isn't there to do that.

Marshall Chin: Thank you, Jose. And so maybe Kevin, that, very helpful NAM reports but they haven't put our committee out of business, that there's still more work to be done.

Lisa Iezzoni: Hi, this is Lisa Iezzoni. And I do need to remind people as you've already done, that disability is not included in the NAM reports and it's very much included in the committee's charge. And I think especially once we start talking about interventions, the types of interventions for some types of disability are going to be quite specific.

Jose Escarce: So I'm glad I have the opportunity to address this for a second. We've had a couple of discussions in the committee about that issue. And some people may disagree and others may agree. But I just want to convey, the thinking of the committee was that we were charged and in fact the charge by ASPE almost describes the characteristics we were supposed to look at, but we were charged with looking at social risk factors including all the usual suspects, as well as – and this is in the law, health literacy, which is why it appears in our conceptual framework.

And after an extended discussion, the committee agreed unequivocally that disability is an important risk factor for receiving substandard care, but that it didn't fit into the basket of social risk factors as we thought we had been charged with examining. So I just want to say that so people understand why the NAM committee did not take it into account. Obviously there may be disagreements with that and that's OK. But I think understanding why we didn't take it into account is important.

Marshall Chin: Thanks, Jose. Just time check was that, Erin and (Drew) that I think it's actually a pretty important agenda item is that I think that we can use some of the time that we had devoted to the input on lit review, and so, that – we probably may need 20 minutes for that so that we can just continue with this discussion of the overall scope and the questions on the board.

Any other just general global comments before we go through some of the specific discussion questions?

Michelle Cabrera: So, Marshall, this is Michelle Cabrera with SCIU. And I'm not sure if this is the right place, so please feel free to sort of relocate my question if necessary.

But I first wanted to say thanks so much to (Dr. James) for your leadership in bringing this forward. It sounds like a really exciting project. We in

California are involved in trying very hard to move a policy agenda around this and to get some of our large purchasers in California to embrace some of these concepts linking disparities in quality.

And my sense – and, again, this may be different in other parts of the country, but my sense is that some of this work is really in the very early stages. We got our state exchange Cover California to put a requirement on qualified health plans to do data collection and then to identify disparities within their populations and agree to year-over-year improvements as part of a quality initiative. That will start taking place in 2017, but some of that work is really new.

And I think what we have experienced is that many, if not most, of the quality improvement initiatives that we're interacting with are really focused on Triple Aims and therefore do not really address disparities at all, they're focused on quality and – quality without disparities and cost is really the main factor.

And so, you know, I'm just curious about the thinking of this group about whether there really is a lot out there that we can look at pulling into this or if some of this work is new, because we are finding it a challenge even in sort of getting the decision-makers to think about the connections between quality improvement and disparities.

Marshall Chin: Thank you very much, Michelle. In fact, why don't we use your excellent points there as an entree in discussing actually the second discussion question first, because your question and Romana's gets to this issue of what's happening in the current landscape policy-wise, payment-wise, delivery system-wise.

That's what's relevant there in terms of being able to inform our effort and where we fit in. So why don't we focus on that particular question first and if anyone have any answers for Michelle or focusing on that second question about the current landscape.

Ronald Copeland: This is Ron Copeland. Can you hear me?

Marshall Chin: Yes. Go ahead, Ron.

Ronald Copeland: OK. Yes. I just want to comment on the last comment about the state of readiness, if you will. And I think what was just described is in much of the care delivery side versus the payer side that whether the concepts and uses related to disparities has been fully integrated into quality improvement agenda and practices or are they still parallel and separate.

And I think there are fair number of organizations, particularly those that oversee integrated care delivery systems where these two have been significantly integrated and the quality improvement apparatus and goal-setting in practice is aligned with recognizing disparities is a measure of disquality and therefore you can't optimize quality improvement for individual and/or populations unless these factors are taken into consideration.

So I don't know how even or uneven the current landscape is around that issue. And I would believe that many large integrated care delivery systems are further ahead on that than some of the insurers are.

Marshall Chin: Thanks, Ron.

Traci Ferguson: And this is Traci. I would agree coming from Medicare and Medicaid payer that I think one of the things when we're talking about effective interventions and how we would look to see, you know, changing the payment is that there may not be an established payment model to really address with the goal of reducing disparities.

So I guess my question is how willing, well, is the committee in – to be engaged in sort of innovative payment models that don't exist now in order to best incentivize both providers – more independent providers and payers who aren't part of an integrated care delivery system to incentivize to make those necessary changes to their systems and processes and other resources to help reduce disparities.

Philip Alberti: Hi, everyone. This is Philip. Can folks hear me?

Marshall Chin: Yes. Go ahead, Philip.

Philip Alberti: Great. Thanks. So two thoughts have occurred to me as this conversation's proceeded, so one has to do with quality improvement and disparity.

So one interesting source to tap into might be the Accreditation Council for Graduate Medical Education. There are expectations that resident trainees and fellows are learning in the course of their quality improvement education, something about healthcare disparities as part of their clinical learning environmental review visit. So I have a feeling what the answer might be in terms of where – which institutions are or aren't kind of high flyers in that space. But if we're looking for models where individuals are practicing QI in a disparities-focused way, they might have some information on exemplar institutions.

The other idea that I was thinking about as people have mentioned and is really germane to that second bullet and what we – the question that was just posed about innovative models don't exist and the dearth of literature around "effective interventions."

One of the questions that I have is how will we define effective, right? So the obvious definition would be closing or narrowing of a health or healthcare inequity, of course, as effective. But it might be very specific to a very specific population therefore not generalizable. So there's some questions there.

But at the same time an intervention that is effective in that way might be perhaps cost inefficient. And so how do we think about the many definitions of what effective approaches to measurement and interventions would we as a committee put out. And then I fear that we're even narrowing down the denominator of what's in the literature even further. So I think just thinking through how we want to approach kind of effectiveness, external validity, cost benefit might be another – an issue for us to talk about.

Marshall Chin: All excellent points, Philip. Why don't for now we hold the discussion about things like criteria for the lit reviews until the next agenda item which is going

to be that particular topic and we'll keep on like the current discussion questions.

But those are excellent points that we should come back to, Philip. What I've heard so far from Philip's earlier comments, Traci, Ron and Michelle really are these issues of – it's really starting at this issue of like the use of measures and then how do you integrate into QI and care development and payments to try to incentivize reduction in disparities.

Anything else on the second question about the changing environment right now and how things sort of fit into, our work fits into that changing environment?

Bob Rauner: Yes, this is Bob Rauner. Can you hear me?

Marshall Chin: Yes. Go ahead, Bob.

Bob Rauner: OK. Well, I think one of the things that's changing the payment environment is you're getting more interaction with the provider community which actually has better data.

And so one of the problems is that a lot of our disparity data is based on claims, like there's a healthcare (inaudible) reports just last month. And, again, they're using imputed socio-demographics from ZIP code which really isn't sufficient. A lot of the clinic level sources do have insurance status, race, ethnicity, language. But we're not publishing based on that data. Most published data is coming out of their – coming out of claims data which is really incomplete for quality. And so a lot of folks are starting to work toward that and I think that helps when we're working with our federal quality health centers and they can, of course – they know that, for example, that their cancer screening results are much better than Medicaid-covered population and the uninsured.

And so they already know this, but that kind of data doesn't get published because it's not as clean and available. And then it's going to be an issue also state-by-state though now because, you know, our state unfortunately is not an

expansion state, so we're probably going to have bigger disparities than, say, Massachusetts because of that uninsurance rate.

But I think a lot of the data can come from some of these clinical level sources because the HRs capture more patient level data than claims does, and if we can integrate that somehow. Some states are doing a great job like Oklahoma's MyHealth where they actually do bring in both data from both the claims side and the clinic level to get a much better snapshot of quality, will give us a lot better data to actually study issues. I think our literature is still incomplete right now because everybody's imputing SDS from things like ZIP code which I don't' think works.

Marshall Chin: Thanks, Bob. And Erin and (Drew), one thing we'll need to do is sort of map all these excellent points people are making back to the draft roadmap that the committee's developing and that in some ways that becomes like the, you know, issues of the roadmap to make sure that we're covering these different issues.

So, for example, your point about data, Bob, is that that point in the model about the ability to stratify data and so it gets into these implementation issues of the data systems, feasibility, support to be able to do this type of thing.

Erin O'Rourke: Yes. Absolutely. We can check that throughout the call and then I think when we have our next meeting, continue to update our conceptual model with how we would fit in all of these puzzle pieces and great points that the committee is bringing up.

Marshall Chin: Yes. That may be a nice segue into both questions one and three on the discussion question is the third one being how we build off a conceptual model, first one being how do we build off the work we've already done as a committee over the past year. So do people have any comments on either of those questions?

Susannah Bernheim: Marshall, this is Susannah. I'm not sure it fits those questions, but the thing that I was struck by as you were summarizing both input was that there is within this group a lot of varied experience and expertise around places that

are using some sort of mechanism to either eliminate or incentivize (decision) disparities that aren't necessarily in the literature.

Like the environment is changing really quickly, and so even if we don't know how effective all of them have been, I feel like taking advantage of the expertise of this group to catalogue broadly, you know, what's happening at ACGME, what's happening in large integrated health systems, what's happening in lots of places that might not be visible. And when I ask people about this, a lot of people don't know how much is already being done. So I think somewhere we should fit a cataloguing of that work so that it's more visible what people – the efforts that are underway.

Marshall Chin: Well, that's a great point, Susannah. And let me think a little bit about what Jose said about the second NAM report on best practices.

Your classic literature review is going to be – like a lot of them is mostly going to be research studies which are fairly defined in a narrow setting. What the NAM report did is sort of what you mentioned, Susannah, where part of it became case study issue or anecdotal because some of this is not published literature and it is sort of new and cutting edge.

As you said, like the current models people have, we're thinking about integrating disparities into quality with whole – financial side of reimbursement, I mean there very little literature on that. And so in some ways, we may – it seems like the definition of lit review one and two are more your classic types of lit reviews, when we start talking about the third and fourth reports which get into things like the conceptual model, the use of the measures and then the actual recommendations, my guess is that the committee is going to have to do a combination of the traditional type of lit review but then, as you said, draw upon things like the expertise in – of the committee, examples we know of successful organizations and similar to the NAM reports some combination of those different approaches to try to find the truth.

Romana Hasnain-Wynia: Marshall, this is Romana and I'm going to – I have to jump off in 10 minutes, but I wanted to make sure I said this.

So I agree, I think we need to go beyond, as you pointed out, you know, kind of the traditional lit review definition. You know, I would propose that we really try to focus on more of the landscape and include other sources. And the last comment I wanted to make relates to this.

So I know that there are models of, you know, using data around – with quality improvement and also looking at payment models when we're thinking about race and ethnicity. I think it's going to be really important for us to also focus on finding models where disability data are being used in hospital systems. I don't know any, but I think …

(Crosstalk)

Lisa Iezzoni: Well, there are – there are actually some in the Medicare and Medicaid duals demonstration programs.

Romana Hasnain-Wynia: Yes, but I do – Lisa, I think that it's really important that we – that we bring those up because I keep hearing that, well, you know, the general kind of sense is that, well, how are we going to do this?

And I think there's a sense within some, you know, system leaders and others that it's just really complex. But as you said, I know there are models. So within the spirit of kind of moving beyond what's in the published literature, I strongly encourage that we find those models around disability and use of disability information around quality improvement, et cetera. So I'm just really pushing for that.

Marshall Chin: Thanks. That's good points, Romana. Unfortunately, (Ninez) won't be able to join the call because the three-week trial is now close to a verdict and so they're basically doing the final deliberations now.

Back to discussion questions. Thoughts about like how we build upon our prior work over the past year building upon essential models. Any comments relevant for those two discussion questions? Well, why don't we end this part of the agenda with discussion of the fourth one which is sort of another

general question, does the committee have any strategic guidance as we begin this work?

Lisa Cooper: Well, I guess the only thing I thought of – this is Lisa Cooper, is that since we – you know, there's been a lot of discussion about branching out beyond the published literature and drawing on the experiences of people in this group. Is there – would it be – does it make sense for us to do anything where we actually specifically seek out sort of interviews or some sort of – and maybe this has already been mentioned, but – and maybe that's what the whole environmental scan is about, but sort of more in-depth like interviews with places where we know that some of these efforts are underway but that aren't necessarily represented on this committee. Would we do like a – you know, select a certain group of health systems within different categories from whom we would actually try to specifically get more in-depth information about current initiatives?

Erin O'Rourke: Lisa, this is Erin. I could jump in with that. We've built key informant interviews into our search strategies for the lit review, so we'd love any guidance from their committee on who we should be reaching out to and if you can help us make those connections to see if they'd be willing to be interviewed for this project.

Lisa Iezzoni: Yes. This is Lisa Iezzoni. I know that the Commonwealth Fund and the Kaiser Family Foundation have been very, very interested in the dual demonstration program. And so have done a bunch of white papers and have funded some small research projects about that, so maybe kind of going into the gray literature as well.

Michelle Cabrera: This is Michelle. I'd also be interested to know if there are state Medicaid directors who are thinking about, you know, weaving disparities into their quality improvement strategies. But I don't know if that goes into a different scope of work. It's just for us at least there's, you know, overrepresentation of communities of color in our MediCal population. It seems like a place where a lot of good work can happen, but it's really been baby steps.

Marshall Chin: Maybe we can morph both this question about general strategic guidance with the next general item now which is the – any advice the committee has on the lit review process for reports one and two.

But maybe before we start that, Erin and (Drew), if you can tell us a little bit more about – tell us a little bit more about sort of like just your staffing and resources and then the timeline so we get some sense of what you think is feasible and what you're potentially thinking about right now as a starting point for the work of the first two reports given the quick timeline and whatever resources you have available. Can you give us a little bit about that background?

(Drew): Sure. And I think that you all have started to talk on a lot of the issues that we were going to ask about and you've provided some guidance. So next slide, please. So we've already talked a little bit about the purpose of the lit review and that it's really to support essentially all of the reports and as the reports will be building on each other over the course of the project.

Really, the approach – so we can just skip past of this one, actually since we've touched on this. So the approach that we're taking is to, you know, do the typical review of gray literature, peer review publications, white papers and then going beyond that to, you know, news articles, websites, looking at maybe doing some key informant interviews as we've mentioned. So it'd be really helpful to identify some people who, you know, who could really speak to whatever the effective interventions out there right now.

We have a window right now from 2006 to 2016 to do the search, but we wanted to bring this to the committee on whether or not there was any systematic review or that we could build off of and maybe narrow that search down to maybe the last five years or so. So we plan to continue to move – to continue to get input from the committee as we go along.

So as we've been – we plan to share the sources that we find and continue to, you know, just kind of bounce ideas off of each other. But as far as our strategy, we plan to start broad and then just narrow it down based – using more specific mesh terms just so that we can hopefully pick up anything that,

you know, may not be labeled exactly the way that we would originally specify it.

So we plan to just kind of start broad and narrow our way down. And we've already started some searching and we've pulled back a lot of different articles. But I think it would be helpful to get the committee's guidance on, you know, where to focus the search and, you know, where – what's a good starting point.

So far as our resources to do these lit reviews, like Erin was saying, we have a very aggressive timeline. So between each report we have a couple of months to – and fortunately we have, you know, a full team, so it will take a lot of time but I think that we have enough staff and, you know, the budget and everything to do this well.

So with that, next slide. OK. So this was actually our first question is like what is the good – what's the good starting point? What's the best starting point? Is there any systematic review or areas that we should start to look at first? And, Marshall, I don't know if you have to hop off, but we can turn it over to you to facilitate if you're still on.

Marshall Chin: I'm about to start being, going en route. So maybe if, (Drew), if you and Erin can moderate this part also.

(Drew): OK. Sounds good. So, yes, so that's the first question out to the committee is are there any thoughts that come to mind on certain works that we should focus or areas that we should be searching for? At least for the first report where we're describing the disparities. I know that we're going to have to continue the discussion of where to look for effective interventions, but at least the first report, that will be available for your review in December.

Romana Hasnain-Wynia: This is Romana. I'm going to speak up one more time and then I'm going to jump off. I'm sorry.

I just wanted to say something about kind of the literature that we target. So, you know, in kind of conventional disparities, the definition of disparities and when we're looking at inclusion or exclusion criteria for papers in the

literature, you know, the conventional process has been to look for studies that have, you know, two or more groups, so there's a comparison group to show a closing of the gap or to at least, you know, with the assumption of studying a reduction in disparities which implies a closing of the gap.

I am going to strongly advocate that we look for studies that are powered to target disparity populations and condition and not limit it to having two or more comparison groups, i.e. you know, Hispanic Latino versus White, Black, African-American versus White, whatever the comparisons are, because I think we're going to end up missing out on specific interventions that are targeted and studies that are powered to specific disparity populations if we limit it with that lens in mind.

So that's just, you know, a thought that I wanted to currently put on the table. I'm sure some agree and others don't. And I'm happy to have this conversation, you know, as we continue to evolve with these reports, but I think it's incredibly important. Thank you.

Lisa Cooper: That's a great point, Romana. Thanks.

(Drew): It sounded like someone else was speaking up right before.

Bob Rauner: Yes, this is Bob Rauner. I would encourage you not to limit yourself to just peer review though, because I think a lot of the peer reviewed literature is going to be very incomplete in this area. And a lot of the folks doing innovative stuff are not the people who are that inclined to publish.

But there's a lot of white paper and policy things happening at the state level so, for example, what Oregon and Colorado doing with their regional healthcare collaboratives, what states like Arkansas and Oklahoma which are doing a really good job of combining their SIM grants and their primary care initiatives. But they may have some data that they may not have – may not be interested in publishing, but they may have some really good information and some good insight. And so I don't think we should – be careful about limiting too much to peer reviewed literature.

Yolanda Ogbolu: This is Yolanda Ogbolu. I would just second that, for example, in my community there's an increased focus on the social determinants of health, I'm using kind of new interventions and information technology platforms for community mapping, like Healthify. And I think some of that work is so early that is definitely won't be in peer reviewed literature but might be in some short-term case reports.

(Drew): Thank you.

Susannah Bernheim: This is Susannah. I just have a clarifying question then I apologize if this is clear from the slides which I'm not in front of. The first report is not about intervention, the first report is just about documentation of disparities, I think.

(Drew): Right.

Susannah Bernheim: But is that disparities in health or disparities in healthcare or are you trying to do both? Like are we looking at sort of unequal access in quality or are we looking at worse outcomes?

(Drew): Right, it's both and they're tied to the five conditions that we mentioned earlier, so health and healthcare outcomes.

David Nerenz: (Dave) here. Also, I was just thinking of a similar question. Let me just – from the amendment of Susannah's question.

(Wordsmith) distinction but as – we don't have in front of us says about disparities in people who have the conditions, how literally do we read that? For example, is the disparity in incidence of one of those conditions in the scope or is that out of the scope because in that case some of the people in the denominator don't have that condition.

Helen Burstin: Yes, David, this is Helen. It's an interesting question and we'll have to think about it. We should talk with (Cara) about it, but I do think – I guess what you're getting at is some of it that the actual incident of getting, let's say, chronic kidney disease in and of itself, may be representative of disparities prior to the incident case. Is that what you're talking about?

David Nerenz: Yes, and it's just a disparity itself. If we're talking about disparities in health, then disparities in disease incidents as normal people talk about it or people usually talk about is very important. But the exact wording on the slide suggested maybe we're not talking about that.

(Drew): Sorry about that. We'll make sure that is clearer in future – in the future.

Lisa Iezzoni: This is Lisa Iezzoni. I don't want to take up any time on the call right now, but there are some specific groups that you might want to talk to about healthcare disparities and health disparities for people with disabilities. If you want to set up a time to just call me specifically about that, I'd be happy to talk to you about it.

Helen Burstin: Definitely.

Erin O'Rourke: Thank you, Lisa.

(Drew): Thank you, yes.

Lisa Iezzoni: OK. Yes.

Philip Alberti: And hi, this is Philip, and I similarly don't want to take up too much time with this, but we did a project a few years back searching for disparities-relevant, equity-relevant research and found the mesh terms to be slightly problematic or difficult and not sensitive to all the things that were looking for. And so we developed a multi-term search that we'd be happy to share if that would facilitate the lit review for you.

(Drew): Absolutely. Thank you.

David Nerenz: Dave again. If I could just do – this is a second friendly amendment to Susannah's question on health and healthcare.

The slide implied – and I think we decided we didn't want to draw a sharp line between medical care on the one side and public health, community health, other sort of things on the other side. If that's the case, is there some sort of an outer boundary around which this literature – with which this literature is going to be limited either in the incidence part or the intervention part?

For example, poverty is associated with all sorts of health conditions and you can have interventions in the public sector having to do with economic policy changes, you can have workplace health intervention, you have all kinds of things that, essentially nothing to do with healthcare, is all of that within scope?

Erin O'Rourke: So that's actually something we've really been grappling with as to where the outer limit of the scope is.

And I think that might be something we'd love to get thoughts from you all on of how far do you want to go. What's feasible in the time that we have. We know there's a lot of interplay here. So I think any guidance the committee could have on where you would recommend we go and don't go would be most welcome.

Helen Burstin: Any comments? And maybe you guys could go on mute. Thank you. That'll make you type really fast. Other comments?

Lisa Cooper: This is Lisa. I'll just make a brief comment. I'm actually going to have to jump off quickly. I mean soon as well. I think it could be really challenging if we don't, you know, put some parameters around this.

So I would say that, you know, we might want to look at – well, in preventions that are like either based within healthcare or that have a very strong linkage to health care if they're community-based, you know, because otherwise, there is like a huge amount out there on community-based interventions, which are great. But that don't have any sort of linkage to healthcare, so that the possibility of it having some, sort of, a – I guess, I don't – I hate to say this because I think a lot of it could be, we could learn a lot from those kinds of interventions in terms of, you know, linkages with healthcare.

But if the ones that are out there haven't attempted to do that, I'm not sure that the lessons learned are going to be like a hundred percent informative to this specific literature review. So I – you know, I don't know. I guess you'd have

to see, kind of, what the scope of the information is when you get started because it could really be overwhelming.

Helen Burstin: Yes. Lisa, this is Helen. That's a really interesting question. I could see how, as you think about trying alternative payment models, some of it that might have been considered out of scope, might move towards close to seeing in scope.

So, we'll have to think about that as we go forward, but I hate to leave some potential linkages to community-based interventions off the table since in some ways as you point out, some of them are among the most effective.

Lisa Cooper: Right. So I think we just are going to have to think creatively about how to – like how inclusive to be with – or what criteria we might want to use to determine whether, you know, a particular intervention is relevant.

Helen Burstin: Yes.

Lisa Cooper: The other thing I was going to say is that, you know, there have been several recent reviews in medical care and in health affairs and things like that that we would – that I think it would be helpful for us to take a look at because some of them include – some of them are reviews of the published literature and then some of them are describing ongoing work as well.

Helen Burstin: Yes.

(Drew): So we'll try our best to identify and focus on those reviews.

Helen Burstin: And specifically, you know, if the committee members have any specific papers in mind that they think that are, kind of, seminal or ones like key review articles that would save back some time, please feel free to forward them along. We could share them on SharePoint so you would all have access to the library of articles as we find them. And you share them.

Susannah Bernheim: And Helen, I can't remember if it was this committee or the prior committee, but people contributed a lot of good articles. I think it was

actually the prior committee at the beginning of that group. We should certainly start with that stuff.

Helen Burstin: Yes. Yes. The Risk Adjustment Committee, yes, it has – it was every engaged in creating a library. So we could start with that and go from there definitely. Thanks, Susannah.

(Drew): Any other comments related to those questions? So the next question gets to what Philip brought up earlier about the effective interventions and how do we determine what is considered effective? Like what level of impact or is it a cost consideration? It's, you know, how much does it close the gap? So just kind of posing that to the committee to see what are your thoughts …

(Off-Mic)

(Drew): … consider effective?

Michelle Cabrera: This is Michelle. I mean I think given that it's a very limited, you know, pool that we're drawing from anyway, I would strongly urge us to not look at it from the standpoint of whether this is reducing cost. We've got plenty of stuff moving on that right now.

(Drew): Right.

Helen Burstin: Yes.

(Drew): Thank you. Any other thoughts?

Bob Rauner: Yes. I would agree with that recommendation because the costs are going to depend in part on the context in which it's implemented. And it's a changing landscape. So the cost could very easily change. So I agree with that not to consider cost with this space.

(Drew): So are there any other thoughts on what would be considered effective? Is it just anything that's demonstrated effectiveness and reducing it? Like just generally there's no parameters on that or what are your thoughts?

Female: I don't – I mean I don't know if this goes here, but I even would be interested in incentive around data collection since it's early, earliest stage of getting to this work. So as efforts to increase the validity of the demographic data collected would be, sort of, one bucket that I think could be really useful.

And then efforts that close the gap and actually made progress on that. But I think it's also instructive in something like this to highlight areas that – or efforts that didn't succeed.

So, again, I recall seeing in Massachusetts, they set up a pilot at one of their hospitals and they just didn't have enough of a population of communities of color to even make their pilot successful. And so, that was really informative for me at least in considering how to – how and where to develop a strategy in our case.

(Drew): So would you say this is something a little bit broader where we just look at interventions that have been used and highlight the ones that have been effective, but also talk about things that have been tried that may not have been, but are good lessons learned?

Female: I think so. But I would want to hear from others as well.

Susannah Bernheim: Well this is Susannah. This goes back to my earlier point about being sure that we somewhere in here, I think this report the second report is the right time to do it, search the kind of catalogue and inventory the effort that are ongoing. And many of those because they're ongoing, we don't know if they're effective yet. So that also supports the idea of sharing what's happening even if it hasn't been effective.

I mean you want to highlight what's out there that has been effective, but I think the NAM report suggest that we're not going to have a huge literature there and that we may serve its purpose by collecting information about all of these ongoing, you know, health system and state level initiatives.

(Drew): It's a good point. Thank you. Another question that we had here was, in the latter part of the project we'll be looking at performance measures or measures that assess the effectiveness.

Are they – do you all have any thoughts on measures that you've seen in the field or what you think we should expect when we go to look for measures that help us assess the impact? I know it's very broad since we don't have any interventions that we're talking about, but just your general sense of what measure is out there.

Lisa Cooper: So I know about one that comes to mind for me and this is just because I've had a very close family member who was, you know, in the healthcare system in the past year with cancer.

You know, I know that there is a measure – a metric for use of hospice, but I don't know that there's actually – there are actually very good measures of use of palliative care strategies. And I think that, you know, there has been documented disparities and use of hospice, but, you know, one of the issues might be that actually there are actually disparities along the entire spectrum of, you know, the – of care for cancer.

And so, I don't know that this is specific to cancer, but I think in a lot of instances, when we're looking at measures, we're not looking along the entire spectrum of care for a particular condition. So I think that in doing that, you know, I think it would be helpful for us to kind of look at measures that occur along an entire spectrum of care for specific conditions because that might actually give us some clues as to the origins of the disparities.

Helen Burstin: It makes sense. Yes.

(Drew): Yes. So as far as measures that assess like the impact of the intervention, have you – of interventions, have you been in the field, have there been anything like – do measures typically accompany these interventions to assess their impact? Have you – can you think of any examples of what that would look like? Because I imagine that they're not. They may not be in the typical

performance measure format that we think of at NQF, but how do you – how are these interventions being evaluated?

Lisa Cooper: Well I'm sorry I want to jump in just because I'm going to hang up, but I won't – I won't talk too long.

I work in the area of hypertension, so, you know – I mean, all of the interventions that we do definitely use, you know, blood pressure control in over a certain period of time as an outcome metric. And the measure is pretty much align with a lot of the typical health system performance metrics. I think the challenges might be like for certain conditions where guidelines continue to change overtime, you know, it's unclear like what providers are doing. Like what they're actually treating, whether they are following old guidelines, new guidelines, whether they're actually paying any attention to the metrics.

But I know the interventions that I've tested and I've seen a number of other ones for like depression, for example, hypertension that are addressing disparities do use outcome metrics that are, you know, pretty much aligned with what their typical health system performance metrics are.

Bob Rauner: This is Bob Rauner. We're actually in the midst of two interventions, one in private clients, one in FQHCs and we're actually using NQF measures for colon, breast, and cervical cancer, so a lot of them do use NQF-base measures.

(Drew): Great.

Helen Burstin: OK.

Ronald Copeland: The other area you might want to look at is the HEDIS set of the screenings and health measures that are used across a lot of large managed care organizations. And they then take that data for their population and then stratify it by some of the underrepresented communities to identify disparities. And so, those are processed measures like screening rates for breast cancer or for other conditions. And then some are actual achievements or in levels of quality performance regarding treatment protocols and reduction of side effects and complications and so forth.

So, you may want to just check into that and then get familiar with those measures and then as you're scouring the literature or talking with delivery systems that may not be publishing things as if they have data in their system where they stratify that data to identify disparities within their populations of care.

Helen Burstin: That's great. And I feel really lucky to have Sarah Scholle on our committee …

Marshall Chin: This is …

Helen Burstin: … so we've got a direct link into NCQA, which is great.

Marshall Chin: Yes. This is Marshall. I don't know if (Cara) is still on the line, but when I saw here at a different meeting, I had the impression that she is looking for – beside the usual process in outcome measures that we're used to, are there any innovative measures that we can think of that really are on the (intermediary) along the process by which organizations are making progress towards equity.

It's a statement I got from (briefly) in our meeting but I don't know if you're on the call (Cara) to clarify with that more about what the intent was of this particular charge.

(Drew): I think (Cara) is no longer on the line.

Helen Burstin: But we can clarify with her offline based on your question.

(Drew): Yes. We will.

Marshall Chin: Yes, so my impression was like we have conceptual roadmap as we outlined with all this different states and organizations can do as we start doing the implementation parts. Are there ways to, sort of, capture with measures some of those different steps along the way that show that organizations further along towards reducing the disparities?

Helen Burstin: Make sense.

(Drew): It make sense. All right. Does anyone have any other comments related to the lit reviews?

Yolanda Ogbolu: This is Yolanda Ogbolu. I would just say, I have some additional information that I like to share, but through email, I can send some information related to infant mortality and also cultural competency that I think is important additions to this.

(Drew): Yes. Yes, please. Yes. For everyone, if you have information you'd like to share with us, please send it to the disparitiesqualityform.org inbox.

Helen Burstin: And we'll send follow-up reminder, a little more clarity on what we love to have and I think it would be great opportunity to build that library and have it all shared.

(Drew): And, of course, we'll continue to have this conversation about effective interventions leading into the next – which will be one of the focuses of the next web meeting. So this was just to spark some initial discussion and hopefully collect some information after the meeting.

Next slide.

Erin O'Rourke: Great. OK.

(Drew): No. I was just going to say. I'll turn it over to Erin to go over updates from the field.

Erin O'Rourke: So we just wanted to – I think we've actually touched on a lot of what we were going to highlight for you today, but just updates to keep in mind as we start to build on this work that we want to make sure we're leveraging all the good work that's being done right now.

So as Marshall was saying, the IMPACT Act required – next slide, HHS to contacts with NAM on the series of reports that you can see on the next slide. And Marshall covered these already. So I don't want to belabor this.

So we did want to, just a little bit of time thinking about some of the lessons learned in the fourth report that recently came out on this data, in particular the committee identified three broad categories of data sources, new and existing data collected by CMS, data from healthcare providers and plans and alternative government data sources, such as national surveys that Non-CMS agencies and state agencies oversee and maintain.

The committee highlighted that patients are the underlying source of most data on social risk factors. But there this important role for CMS providers plans and other agencies to collect, maintain, and standardize this data. The ideal system can respond and adapt to the availability of new data and to assess advantages and disadvantages of specific sources. The committee looked at the collection burden, accuracy and clinical utility.

Next slide. So on this slide, you can see the guiding principles that the committee identified. The CMS should use in selecting data sources. Highlighting that CMS should first use data it already has. CMS should look for opportunities to use existing data collected by other government agencies to the extent that our social risk factor is relatively stable.

CMS should examine the feasibility of collecting additional data at the time of enrollment in Medicare, where social risk factors change over time and have clinical utility, requiring data collection through EHRs or other type of provider reporting may be the best approach. And for risk factors that reflects person's contacts or environment, existing data sources that can be used to develop area-level measures should be considered.

Next slide. So I did want to pull out – I thought this graphic was really helpful and particularly in the course of this committee's work to evaluate NQF's trial period, highlighting just the challenges of data availability at this time and how the – a number of factors that we'd love to have that our data on and to know how we can better incorporate them into our performance measures. But that the challenge is to actually get that data. And I know we've heard from Susannah and (Christy) and others about the work they are doing and how difficult that has been to crack.

So I think with that, I did want to just see if Jose Escarce –Dr. Escarce, if you wanted to share any thoughts, since you are serving on this committee.

Jose Escarce: Well, I don't think so. I mean, I think what you said is right on target. And probably this chart you have on the screen right now is, you know, relatively self-explanatory in terms of the different categories.

Erin O'Rourke: Excellent. Thank you. So using that as a segue, we did want to keep you updated on what's going on with NQF trial period for SDS adjustment.

Just a reminder that we had implemented this two-year period prior to a permanent change in NQF policy. We're probably about a year and a half way through, so starting to think about how we can bring an evaluation of that trial period back to this committee and that's late spring of next year.

As a reminder, under this new policy, adjustment for SDS factor is no longer prohibited and that during the trial period if adjustment is determined – if SDS adjustment is determined to be appropriate, NQF will endorse one measure with specifications to compute the SDS adjusted version and the Non-SDS adjusted version that is only clinically adjusted to allow for stratification.

Just to keep you updated on some of the latest ongoing in the trial period, particularly around the cost research used and readmissions project where there has been quite a bit of attention. NQF received an appeal of the decision to continue endorsement of the three cost and research use measures, the three episodes based on for AMI, heart failure, and pneumonia without SDS factors and the risk adjustment model. And this will be – these appeals will be considered by the NQF board during the November 2nd meeting.

For the readmissions project, the standing committee reviewed 17 new in maintenance measures and 16 conditionally endorsed measures. Ultimately, the committee ended up recommending two for endorsement with SDS factors and the risk adjustment model, looking at payer mix and marital status as a proxy for caregiver availability, so there has been some work in that space and some measures are being recommended for endorsement with these

adjustments. The CSAC will discuss those recommendations on November 9th and 10th.

And, again, did want to get some discussions from the committee. Really, thinking about the latest report from NAM and the challenges they highlighted in data availability that's been an ongoing theme we've heard throughout our trial period. I think there has been a desire from the field to see more measures coming through with these adjustments, but what we've heard from our developers is just how difficult it is to get this data. And does the committee have any guidance on how we should consider these findings around data availability as we begin the evaluation of the trial period and what this committee would like to see when we come back to you next year with what we found due to the trial period.

Marshall Chin: One thing, Erin, can you guys talk a little bit about the ASPE report and how that will fit into what we do?

Helen Burstin: Yes, Marshall. This is Helen. We're still awaiting the ASPE (Impact) report due in October. So we'll have to check that coming to an end in 11 days. So we'll touch-base with those folks again and see that we would definitely bring that in, bring that to this group.

We even talked about potentially pulling that in, see if we can have (Cara) join for example, perhaps give a webinar for the members of this committee just so you can consider that as we move forward and bring that, you know, the ultimate recommendations to you about the trial period.

The one thing I will say is I think in some ways, the SDS risk adjustment panels sets the bar quite high in requiring both the conceptual basis and empiric analyses. So, you know, if there are concerns about negative consequences of allowing these adjusted variables, (Drew), that’s part of what we want to be able to consider, but to date, we've not seen, for example, you know, a huge rush to adjust many measures inappropriately. I think there's been sort of a careful approach. So we'll bring all that forward and certainly all the external pieces like the new NAM report and the (Impact) report, we'll bring forward as well.

Marshall Chin: Thanks.

Philip Alberti: Hi. This is Philip. One question, I did have a chance to look at the NAM report this morning before the call. And so they do mention some and they were in the chart that you had up there earlier, Erin, some variables that in the short term are actually viable for adjustments like nativity, marital status, some index of neighborhood deprivation.

And at least in some of the proposals or the – you know, the measures that have come up under the current trial period, I haven't seen adjustment for those variables. So I wonder if there's an opportunity as we consider the evaluation of the trial period to think about the data points that NAM suggested actually are available in the near-term, the short-term, or even now. And urge measure developers to actually utilize some of those data points in their proposals.

Erin O'Rourke: Thank you. That's a …

Helen Burstin: Yes. Fair point.

Erin O'Rourke: That's a great point.

David Nerenz: Dave here. Maybe one obvious point hardly we're stating though is given the difficulty of getting rich and robust sets of data with which to adjust, one conclusion could be that during this two years, we're just not going to learn very much about adjustment because developers haven't had that much opportunity to do interesting and creative things. And it's not their fault necessarily. It's having to do with the data sets they work with and what those data sets contain. But I guess that would have to be one conclusion, is that the two-year period is not going to be very informative or conclusive given the challenges of getting data with which to try different models.

Helen Burstin: Yes, absolutely, Dave. This is Helen. So I think there are going to be two elements on it and we outlined this I think when we're doing the initial report, there are some short-term things we can certainly assess in terms of the measures as they're coming through are processed and thinking about how

many got adjusted, not adjusted, how many had, for example, a conceptual basis but then the empiric basis was not there.

I think all those data together are really what we're going to have bring to you, I guess it's in May, as the trial period ends to be able to help make an assessment. And, again, the recommendation we're going to want from this committee is not necessarily an up or down about whether measures should be adjusted for social risk but whether NQF should make what was a trial period change to our policy a permanent change. Would we, going forward, allow measures to be submitted adjusted for social risk?

So it's not going to be so much an assessment of whether the adjustment for social risk was, you know, resulted – had positive or negative impact more so, based on what we've seen, does it seem reasonable for NQF potentially just allow social risk factors to be submitted as we have been doing or does the committee believe it's time to stop that?

So that's the kind of information we'll be able to bring forward to you but not anything on the actual impact. I think you're right of what happens with adjustment or lack thereof.

David Nerenz: Right. Makes sense. And this may be premature to bring it up and but since I was thinking about it, I'm thinking ahead into the framing of how the question gets put whether it's to us in May or ultimately to the board.

You know, one nuance is it seemed to me that Mary Naylor in particular on the board was clear that at the time of the vote and this was what now, July 2014 that it, in fact, was a change and then after a two-year period, the change may or may not become permanent but indeed a change happened. Then my question is, what's the status of either inertia or burden of proof when we get to next May or the board shortly thereafter?

So, for example, if we say, “Look, two years have gone by, this revised policy has been in place. And we say, you know, a lot of things we'd like to learn we haven't learned. But basically, nothing bad has happened, nothing awful has happened, therefore let's let the change become permanent.”

Now, I'll say personally, I'd be happy with that but there – another way to say is, you know, this change was kind of flimsy and, you know, we – unless we see that something remarkably good has happened then we're going to flip back to the old policy. And I personally would not like that. But it's just a matter of where does the state of inertia lie and, you know, which side of this discussion carries the greater person to prove when we get to the next May?

Helen Burstin: You know, I think it's a fair question, Dave, and one I think we'll bring back to the committee. I mean, my personal take, I'm listening to these discussions across many committees including the recent discussion of readmission committee just last week, was a sense that this isn't over. I mean I think over time as the risk factors get better and more available like the NAM report suggests, this will still be an open question. So, you know, from that perspective that might lean you towards your first option of saying leave it open, allow the science and the data to continue to improve and allow us to continue to look at these factors. But, again, that's the kind of information we'll try to bring to you in May.

And in particular, I think, you know, the number of times committees have said, "Yes, there's a clear conceptual basis but the empiric data isn't there" might suggest that we should allow additional time for the empiric data work to proceed.

Susannah Bernheim: Helen, this is Susannah. You were asking about sort of what information this group might want to weigh in on what happens. And it would be interesting to hear from committee members. I mean, I don't know if you have the opportunity to do that, about their experience with anything. The burden of reevaluating these, the quality of the analyses that were brought in front of them, you know, their concerns, I think that would help us see from the committee members' perspective who are there looking at the application. And you could do the same for the developers, try to get some assessment sort of what this adds to the worth of the developer.

Helen Burstin: Yes. Yes, absolutely. And then some ways also has it really just become sort of part of the fiber of thinking about risk. And I think we could certainly

query our committees that had been most engagement over the last year and get their sense of it as well.

Susannah Bernheim: Good suggestion.

Erin O'Rourke: Thank you. Any other thoughts before we move on to public and member comment? So hearing none, operator, could you open the lines for public comment?

Operator: Thank you. At this time, if you'd like to make a comment, please press star then the number one on your telephone keypad.

You do have a comment from (John Shaw).

(John Shaw): Hi. Thanks for the opportunity to comment. Just in keeping with the previous discussion, one thing that we've seen in the measures that have been part of the trial period, just about all of them have been limited to Medicare fee-for-service population, which is actually not even the majority subset of everything.

In addition, when we've looked at applying disparity measures in an all-payer database, we found that there was the least impact within the Medicare fee-for-service population. So just because we look inside the subpart of population where there's the least impact doesn't mean it doesn't exist for everybody else. So I think that should be a point of consideration in the trial evaluation.

Helen Burstin: Great. Thanks, (John).

Operator: And there are no further comments at this time.

Erin O'Rourke: OK. Thank you. I just want to make sure that we didn't get any through the web platform.

So hearing none, thank you all again for all of your input on this new scope of work as prepare to get started it's been invaluable. You obviously have a lot of work to accomplish in a short period. So we'll be following up shortly with

Doodle Poll to get your availability to schedule the next series of web and in-person meetings. I will also be in touch via email to remind you of the ask for any articles, any key informants you'd like to put us in touch with, any recommendation to where we can look for the – in particular the first lit review but even thinking ahead to second and third for the scan for effective interventions and measures and potential gaps.

So, again, thank you so much for your time today. And we'll in touch shortly.

Helen Burstin: Great. Thanks, everybody.

Erin O'Rourke: Thank you.

(Drew): Thank you.

Male: Thanks, everybody.

Operator: Ladies and gentlemen, this does conclude today's conference call. You may now disconnect.

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