NATIONAL QUALITY FORUM

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DISPARITIES STANDING COMMITTEE

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WEDNESDAY
JANUARY 20, 2016

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The Standing Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Marshall Chin and Ninez Ponce, Co-Chairs, presiding.

PRESENT:

MARSHALL CHIN, MD, MPH, FACP, Co-Chair
NINEZ PONCE, MPP, PhD, Co-Chair
PHILIP ALBERTI, PhD, Association of American Medical Colleges
SUSANNAH BERNHEIM, MD, MHS, Yale-New Haven Health System Center for Outcomes Research and Evaluation
MICHELLE CABRERA, SEIU California
JUAN EMILIO CARRILLO, MD, MPH, New York-Presbyterian; Weill Cornell Medical College
LISA COOPER, MD, MPH, FACP, Johns Hopkins University School of Medicine
RONALD COPELAND, MD, FACS, Kaiser Permanente
JOSE ESCARCE, MD, PhD, University of California at Los Angeles*
TRACI FERGUSON, MD, MBA, CPE, WellCare Health Plans, Inc.
KEVIN FISCELLA, MD, University of Rochester
NANCY GARRETT, PhD, Hennepin County Medical Center
ROMANA HASNAIN-WYNIA, PhD, Patient Centered Outcomes Research Institute

LISA IEZZONI, MD, MSc, Harvard Medical School
DAVID NERENZ, PhD, Henry Ford Health System
YOLANDA OGBOLU, PhD, CRNP-Neonatal, University of Maryland Baltimore, School of Nursing
ROBERT RAUNER, MD, MPH, FAAFP, Partnership for a Healthy Lincoln
EDUARDO SANCHEZ, MD, MPH, FAAFP, American Heart Association
SARAH HUDSON SCHOLLE, MPH, DrPH, National Committee for Quality Assurance
THOMAS SEQUIST, MD, MPH, Partners Healthcare System
CHRISTIE TEIGLAND, PhD, Avalere Health
MARA YOUDELMAN, JD, LLM, National Health Law Program

NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer
ELISA MUNTHALI, Vice President of Quality Measurement
JANINE AMIRAULT, Project Analyst
ERIN O'ROURKE, Senior Director
MICHAEL PHEULPIN, Project Manager

ALSO PRESENT:
DAVID HUNT, MD, FACS, Office of the National Coordinator for Health IT, HHS
CARA JAMES, Centers for Medicaid and Medicare Services (CMS)

* present by teleconference

A-G-E-N-D-A

P-R-O-C-E-E-D-I-N-G-S

9:06 a.m.

MS. O'ROURKE: Thanks so much everyone for coming today to the first meeting of the NQF Disparities Standing Committee.

We really appreciate you taking the time to volunteer your services and join us today.

I'm Erin O'Rourke. I'm one of the senior directors here at NQF supporting this committee. I'm joined by my team and I'll let them go ahead and introduce themselves.

MR. PHEULPIN: Hi, I'm Michael Pheulpin, project manager here.

MS. AMIRAULT: I'm Janine Amirault. I'm a project analyst.

MS. O'ROURKE: And we're obviously greatly supported by Helen and her work. And I don't know that she needs to formally introduce herself to you.

DR. BURSTIN: I was going to say this is I think one of the few committees I've ever encountered at my time at NQF where I could almost

run the room and hug everybody. Because you've all been part of our family and have been so involved in this issue for so long.

So, I'm Helen Burstin. I'm the chief scientific officer here at NQF. I've actually been here for nine years which I find quite extraordinary after a long tenure at AHRQ and then a long tenure at the Brigham as well and several -- I knew Tom and Marshall, both as residents.

So, delighted to have you all here with us. Disparities has been a passion of mine for a very, very long time as many of you know.

I led the first National Healthcare Disparities Report when I was at AHRQ. And just have for a long time with people like Marshall and many of the people on this committee, the former SES committee and others have really pushed the idea that we can't keep doing these one-off disparities projects, and we really needed a group that would give us that longitudinal view and really be thoughtful about an approach of how we really hardwire disparities reduction into

quality.

It is something that is always an afterthought. I'm sort of shocked after so many years it continues to be something not fully built into the way we tend to think about quality, quality measurement, value-based purchasing in particular.

So I think this is a huge opportunity for us and we are just delighted to have you with us.

And with that I'm also going to have Elisa introduce herself as she walks in the door.

MS. MUNTHALI: Hello, good morning and welcome. My name is Elisa Munthali. I'm vice president for quality measurement at NQF. Thank you so much for being on the committee.

MS. O'ROURKE: And with that I'd like to turn it to our co-chairs who have been instrumental in getting this committee off the ground. Marshall and Ninez?

CO-CHAIR CHIN: I'd like to welcome everyone. First, just a thank you that we know how

busy you all are.

I think Chris Cassel issued a press release when she saw it, but she basically described this as I think her word was a powerhouse committee. And it really is.

You're all very busy, and so we really appreciate the time that you're spending and your expertise.

The other thing is I'd like to just reiterate one of the things I said in the orientation call that I think that this is arguably the most important group right now working on disparities reduction because it's multi-stakeholder, because our audience is going to be CMS and the payers, because it involves a spectrum from selection of performance measures, use and payment, and also public reporting and payment. The levers are really here.

And I was talking to a bunch of you right before we started the meeting, and I think there's a common consensus also that the timing is right. You know, you have to get lucky and I think we are

actually lucky now where the external environment has come to the point where it's the perfect time for this committee.

And it's also the first time, as Helen said, that an NQF disparities committee has had the scope of the charge we've been given.

So I really think this is a great opportunity for our committee to make a difference, and I think we will be able to. Thank you very much.

CO-CHAIR PONCE: Good morning. I'm Ninez Ponce and this is my second NQF panel.

So, I do survey research out in California so I'm going to do a quick survey. How many for you is this the first panel?

Okay, so I will be watching out. So I'm here to watch, listen, learn. So I have to make sure I call on you.

Second -- third. Second, second. Okay. The veterans, three or more. Great.

So thank you for, as Marshall said, for volunteering. I'm very excited. I'm very

excited to co-chair this with Marshall who I've worked with in Academy Health disparities theme sessions and in competing for grad students too in the past.

But all in the service of eliminating disparities in healthcare and in health. So thank you. Welcome.

MS. O'ROURKE: Thank you. And I think with that I'll turn it to Helen to lead you through the introductions and disclosures of interest.

DR. BURSTIN: Great. So on all of our committees we have an opportunity to do our introductions. And obviously we've seen your CVs. They're quite impressive.

We don't need a full recitation of them, but what we'd love to do as you go around the table introduce yourself and indicate if you have any disclosures of interest.

And in this instance there are not measures before this committee. That's fortunately for you not part of your work. It's just very detailed.

But if you have any potential conflicts, anything regarding potential businesses, or something that you think -- the simplest way to think of this is what would you want to know about somebody else as they were going around this room that might at least give you a sense of somebody's biases or conflicts.

They're probably not true conflicts, but perhaps just biases.

And with that I will begin with Ninez to walk us around the room.

CO-CHAIR PONCE: I'm Dr. Ninez Ponce from UCLA. And I have been on the board of two community organizations, the National Health Law Program -- Mara's here -- and the California Pan-Ethnic Health Network.

I have a research study that's funded by Aetna and I think that's my disclosures.

CO-CHAIR CHIN: So, I'm Marshall Chin. I'm a practicing general internist and a health disparities researcher.

I do multi-level work which ranges from

patient-level, so we have one project right now looking at shared decision-making between clinicians and LGBTQ, racial and ethnic minority populations to clinic-level.

I do a lot of work with federally qualified health centers on quality improvement.

I do population health work. We have a major project on the South Side of Chicago looking at improving diabetes care with healthcare and community approaches.

Two possible conflicts of interest. One of my grants comes from the Merck Foundation which is philanthropy funded by the Merck Company.

This is to create a new grants program in disparities intervention.

This year I'm the president of the Society of General Internal Medicine.

I'm a member of the America's Essential Hospitals Equity Leadership Forum which is advising the Joint Commission on what they can do to reduce disparities.

I'm on the National Advisory Board of

the Institute for Medicaid Innovation which is affiliated with the Medicaid Health Plans of America.

And we have a couple of Robert Wood Johnson national program offices of disparities. And as part of that we have provided some unpaid technical assistance to the Center for Medicare and Medicaid Innovation. Those are the relevant potential conflicts.

MEMBER ALBERTI: Good morning, everyone. Philip Alberti. I'm the senior director for health equity research and policy at the Association of American Medical Colleges.

Our two main areas of work - to advocate for policies, either federal or institutional policies, that really incentivize equity as a goal of everything that an academic medical center does, quality improvement, clinical care, research.

And also to build the capacity of our member medical schools and teaching hospitals. And to build the evidence base of solutions to health and healthcare inequities.

Beyond the passion for health equity I have no disclosures of interest.

MEMBER CARRILLO: Good morning, everybody. I'm Emilio Carrillo. I am an internist, vice president for community population health at New York-Presbyterian Hospital, associate professor of medicine at the Weill Cornell Medical School and the chief medical officer for our hospital's ACO.

I've been involved with cultural competence for many, many years and in 2007 co-chaired the NQF committee that worked on the definition and framework best practices on cultural competency.

So I'm very happy to be here and I don't have any conflicts to disclose.

MEMBER NERENZ: Good morning. I'm David Nerenz. I'm director of the Center for Health Policy and Health Services Research at Henry Ford Health System in Detroit.

I've been working on issues of racial and ethnic disparities in healthcare for just about

25 years now. So I think -- I have no financial or business conflicts, but I've probably got all sorts of prior statements and projects and commitments that I guess create at least a frame of reference.

I suppose the other thing I should note. I'm also a MedPAC Commissioner and occasionally MedPAC weighs in on issues that touch either quality measurement or disparities in some way, so I have to kind of balance.

So, anything that I say here is me speaking, not a Commissioner speaking. And if we ever get to a point where those things cross we'll work it out.

MEMBER SEQUIST: Hi, I'm Tom Sequist. I am a primary care doctor at Brigham and Women's Hospital, and the chief quality and safety officer for Partners HealthCare.

In terms of -- and I'm really interested and excited about health equity.

In terms of things to disclose I'm also American Indian from the Taos Pueblo Reservation

in New Mexico. I've done a lot of consulting and advising work for the Indian Health Service over the past decade.

I also do consulting and advising work for Aetna on their plans around health equity.

And I am obviously in my administrative role at Partners a very interested stakeholder in what we do with quality measures, and pay-for-performance, and public reporting, and such.

MEMBER HASNAIN-WYNIA: Good morning, everyone. I'm Romana Hasnain-Wynia and I direct the Addressing Disparities Program at the Patient-Centered Outcomes Research Institute.

I don't believe I have any conflicts of interest because when I joined PCORI about three and a half years ago I was at Northwestern University.

I had to pretty much resign all boards and give up all the grants that I had. So I had to kind of create myself anew.

So I'm really excited to be able to be

on this panel. I did have to seek permission to do so.

I am also on the America's Essential Hospitals Advisory Panel that Marshall mentioned, working with AEH as well as the Joint Commission.

But I don't believe I have any conflicts of interest except, as Dave said, things that I've written in the past, and work that I've done in this area for the last 20 years.

MEMBER FISCELLA: I'm Kevin Fiscella. I'm a family physician health services researcher at the University of Rochester.

I'm not sure I really have any conflicts of interest.

I guess I should mention I am on the board of directors of the National Commission for Correctional Healthcare which does accredit healthcare institutions. But at this point they're sort of outside of mainstream healthcare quality, unfortunately.

MEMBER COOPER: Hi, I'm Lisa Cooper. I'm a professor of medicine at Johns Hopkins, also

a general internist, and recently appointed vice president for health equity for Johns Hopkins Health System.

And I don't think I have any conflicts of interest. My research has been pretty much funded by NIH or PCORI for the last five years.

All the boards I serve on have nothing to do with healthcare delivery, interestingly. They have to do much more with other things like how to train pastors to be more aware of dealing with social determinants of health in their congregations.

MEMBER YOUDELMAN: Good morning, I'm Mara Youdelman. I'm at the National Health Law Program here in our D.C. office and I've been working on issues related to this committee for a little over 15 years.

I don't think I have any conflicts. My only disclosure would be I'm a lawyer so don't hold that against me. I think I'm the only one on the committee. But other than that I don't think I have any conflicts at this point.

MEMBER IEZZONI: I'm Lisa Iezzoni. I'm a professor of medicine at Harvard Medical School and the director of the Mongan Institute for Health Policy.

I'm at Massachusetts General Hospital. I'm a health services researcher. I don't have any conflicts.

MS. JAMES: Good morning. I'm Cara James. I'm the director of the Office of Minority Health at the Centers for Medicare and Medicaid Services.

I'm actually not a member of the committee, I'm just extremely interested in what you guys are doing.

So obviously we are very much looking forward to the work that you're doing and what is coming forward out of it. So thank you all for your time.

MEMBER CABRERA: Good morning. My name is Michelle Cabrera and I'm with the Service Employees International Union (SEIU).

I am based out of Sacramento,

California, where I develop policies and advocate on behalf of our membership in the state.

And just for a little bit of context, SEIU is the largest union in California. I believe we're the second largest in the nation in California.

Our membership is about half long-term care workers, primarily home care workers. We do have both public as well as private sector hospital workers which run the gamut from environmental services through technicians, nurses, as well as some interns and residents, a few.

We also represent private sector workers in other fields like janitorial, security and education workers. I mean, our membership is very large in California and nationally.

I'm here on behalf of SEIU's interests nationally and you know, just wanted to say that our membership in California skews low-income individuals of color.

And so we have folks who have insurance, and who are on Medicaid, and who don't have

insurance. So our advocacy tends to be around -- concentrated in Medicaid in California as well as uninsured programs.

And we have been trying really hard to bring some of these conversations that we're having in this group to other spaces where policymakers are driving policies around payment and public programs especially. Thank you.

MEMBER TEIGLAND: Good morning. I'm Christie Teigland. I work with Avalere Health which is a consulting firm that does consulting for life sciences and health plans.

I was with Inovalon who actually owns Avalere Health, acquired Avalere Health last year. So my research team moved there.

We've been doing a lot of work over at Ford Health Plans, partly funded by health plans, big health plans like WellCare and HealthFirst over the last few years looking at the impact of socioeconomic status on the five-star quality measures.

Have done some unpaid work for the

Pharmacy Quality Alliance looking at the impact of socioeconomic status on their three medication adherence measures that they're looking to update as part of the NQF pilot.

I'll be talking a little bit about that work tomorrow, but that is unpaid work.

We also have a contract with NCQA for measure development. We're working right now on their preventable all-cause readmissions measure. So that I will disclose.

I'm on the URAC Measures Advisory Panel as well, and on a PQA Measure SDS Advisory Panel. So lots of involvement in this area.

MEMBER GARRETT: Good morning, everybody. I'm Nancy Garrett. I'm from Hennepin County Medical Center in Minneapolis.

So we're a safety net provider for the Minneapolis area and for Hennepin County in Minnesota. And we serve all the rural populations there.

I was really happy to arrive yesterday into the warmth.

(Laughter)

It's been the first time it's been above zero since Thursday for me so I was really happy.

MEMBER GARRETT: And in terms of kind of my frame of reference I've been really interested for a long time in my career about health disparities and also how we can make sure that providers that serve the most vulnerable populations have the resources that they need to try and start to close those gaps and those disparities.

And so I served on the Sociodemographic Status and Risk Adjustment Committee along with David, and Kevin, and Susannah on this group.

And I also have been doing work in Minnesota with a group called the Safety Net Coalition. And we've done some work such as passing legislation that requires our health department to stratify quality measures by relevant sociodemographic factors, and also consider risk adjustment where it makes sense, as well as look at new payment methodologies to make

sure that safety net providers can continue to serve those populations. So, I'm very excited to be on the group.

MEMBER RAUNER: Bob Rauner. I'm a family physician. In my day job I mostly work on community health projects and kind of moving into the accountable care community sphere.

I had been working up until a few months ago with a physician-led ACO that was mostly rural.

In my non-paid job I do a lot of legislative and policy work at the state level with the medical societies.

MEMBER FERGUSON: Good morning. Traci Ferguson. I'm chief medical director of medical management at WellCare Health Plans.

My only disclosure is I work for WellCare. It's a government-sponsored health plan focused on Medicaid and Medicare Advantage.

And we're in 15 Medicare Advantage states, 49 Part D states and 9 and hopefully 10 Medicaid states. And happy to be here.

MEMBER COPELAND: Good morning. I'm

Ron Copeland, senior vice president and chief diversity inclusion officer for Kaiser Permanente.

I'm a general surgeon by practice and one of the physician executives that co-lead and co-sponsor our disparities and health equity work across Kaiser Permanente.

I don't think I have any disclosures to make, but I am currently a member of the disparities committee for PCORI.

MEMBER OGBOLU: Good morning. My name is Yolanda Ogbolu. I am a nurse from University of Maryland School of Nursing. I'm also the director of the Office of Global Health there.

My research has focused on organizational cultural competency and issues of health equity which is really driven by my 25 years in clinical practice.

And I am very interested in how we translate all the wonderful research and policy work that we're doing into real, everyday clinical practice.

I am currently funded by Robert Wood

Johnson for a research study on organizational and cultural competency. And I'm also a member of the American Nurses Association. I don't think I have any conflicts.

MEMBER SCHOLLE: Good morning, everyone. I'm Sarah Hudson Scholle. I'm a vice president for research and analysis at the National Committee for Quality Assurance just a couple of blocks down the street. And I'm delighted to see a lot of friends around the table.

So, my responsibilities at NCQA are for research, but I'm also involved in some of our work on performance measurement. We have a number of measures that are relevant to this discussion.

We also have several contracts from CMS where we're looking at opportunities for measurement in the area of disparities and cultural competence.

I'd like to say thank you to Cara James and her office for that work.

We're also working on a contract to look at opportunities for risk adjustment in measures

for CMS and the Medicare Advantage program.

MEMBER BERNHEIM: Hi, I'm Susannah Bernheim. I am also a family physician. We have great representation in this room.

I'm a fellowship-trained health services researcher and I spend my days at the Yale Center for Outcomes Research and Evaluation where I'm the director for quality measurement programs.

That means that much of my time is funded by Medicare to develop outcome quality measures, and then little bits of grants and research. And when I'm doing that I'm not filling out NQF forms, I am doing research related to quality and disparities.

And I'm really excited to be here. I was a part of the previous committee and I felt like we were stuck trying to address concerns about how current measures could go wrong and hurt safety net providers, and now we're going to get to have an opportunity to talk about how these quality measures can even push further and better to improve disparities. So I'm thrilled to be here.

MEMBER SANCHEZ: I think I'm last. My name's Eduardo Sanchez. I serve as the chief medical officer for prevention at the American Heart Association.

I'm a family physician by training, but I'm a public health physician at heart and by most of the jobs I've had in my career.

I served as the local health officer in Austin-Travis County. I served as the commissioner of health.

I ran the state's health department in Texas for five years. I worked for a guy named Rick Perry. That was an interesting experience. And we can talk later. And I will tell secrets.

All my career eliminating health disparities, achieving health equity has been very much a part of what I do every single day.

And I'm hopeful that even as we have this conversation the two-sided coin of disparities on the one hand and diversity on the other is one that we keep top of mind as we work forward.

I'm so pleased to be here, so honored to be with folks who are doing the work that you all are doing.

And I don't think I have any conflicts. We are a big -- we have a big grant from the Robert Wood Johnson Foundation, a childhood obesity policy grant whose primary focus is to eliminate health disparities among children with obesity.

DR. BURSTIN: Well, thank you all. Clearly confirming everything we all thought, that this is truly a powerhouse committee. And just delighted we'll have the opportunity to work with you not just at this meeting but ongoing.

This is a standing committee. NQF moved to standing committees several years ago with the idea that, again, having committees that could stay together over time, there is a really important element of how committees kind of bond together and work together more closely.

And also these issues aren't going to just go away between meetings. There's going to be a lot more work.

We're not going to finish the roadmap as much as Marshall and Ninez would love to have us do that quickly. We'll at least get a lot of that work done.

There is a huge sense of urgency. We all share it. But we know that being together for a period of time would make this just so much easier.

So just lastly, does anybody have any questions of each other about any of your -- the work you noted that you're participating in?

MEMBER ESCARCE: Well, Helen, I was wondering if you wanted me to introduce myself on the telephone?

DR. BURSTIN: Please. Thank you so much, Jose. I forgot you were there. So quiet.

MEMBER ESCARCE: Yes, I know. It's easy to forget the telephone.

Anyway, this is Jose Escarce and I'm a faculty member at UCLA where I'm an internist and I'm also a health economist.

I do research on a number of different

things. One of them has been, for a number of years, issues related to healthcare disparities and health disparities.

And I think one of the main reasons if not the main reason that I'm on the committee is that I'm also on the Institute of Medicine committee on accounting for social factors in Medicare payment programs.

So, I am sorry I couldn't be there. I got a prized specialist appointment with a doctor that I couldn't miss because it was difficult to get and so I'm taking -- but I'll be able to be on the telephone for most of the meeting. I'm looking at the screen right now and it should work well as long as I speak up, I suppose.

DR. BURSTIN: And please let us know if you want to make a comment either through the chat, our staff can pick it up, or just call on us and we'd be delighted to call on you.

MEMBER ESCARCE: Okay.

MEMBER CABRERA: I'm sorry, I was so passionate talking about our membership that I

forgot to mention that I'm also on the board of CPEHN, the California Pan-Ethnic Health Network which I should mention. Thank you.

DR. BURSTIN: Wonderful. All right. I think it's time to get work. Erin's going to kick us off and then I'll do a little bit of it. And then thankfully Marshall and Ninez will do much of the rest.

MS. O'ROURKE: Thank you. So, next slide.

So, I wanted to just get us started by reviewing the agenda for today. You'll see we're really taking the big picture view today and we're going to focus on developing the draft roadmap.

At your seat you'll see we put together a strawperson skeleton of what the roadmap might look like.

Staff developed this based on the responses from the homework assignment we sent you right after the holidays. So thank you all for diving right back into the real world with that.

We've also enhanced it a bit from what

we were able to find in the literature. And this is really our attempt to pull together the committee's vision and to develop a plan for, as Susannah was saying, how we can use measurement to not just worsen the situation, or harm the safety net, but to push forward and to use measurement and associated policy levers to help eliminate disparities.

I don't think I need to tell this group that we're really at the cusp of a new world and pay-for-performance is hitting us as a tidal wave. And how can we really wide that wave to ensure that equity is essential to quality, and that we're using measurement and associated policy to eliminate healthcare disparities.

So, as you can see our objectives for this meeting are to develop a draft of the roadmap for how measurement and policy levers can be used to proactively eliminate disparities.

Tomorrow we'll be shifting to focus on the other two aspects of the committee charge. We'll spend the morning reviewing NQF's prior work

about risk adjustment for socioeconomic factors and the committee's role in providing input on the trial period to evaluate NQF's allowing of those variables in risk adjustment models.

And then finally we'll be taking a look at how NQF can place a greater emphasis on disparities reduction in all of our work for both measure endorsement and selection.

And with that I'll turn it back to Helen to give you all a little bit of ground-setting and provide an overview of NQF and our prior work in this area.

DR. BURSTIN: Great. So, we did a bit of this on the telephone, so just very quickly.

For those of you -- most of you know this quite well, but just a couple of key points to emphasize.

As Marshall mentioned and others, I think the fact that NQF is multi-stakeholder, this committee is multi-stakeholder enables us to kind of come together and reach consensus on some of the more difficult issues I think as exemplified by

just truly the remarkable work, and thanks to Dave and Kevin for leading our remarkable work on SES adjustment as an example.

I think there are many places that could do research evaluations of issues like that and few that could bring the breadth of stakeholder voices, science together in that way and try to move forward for the nation.

So, our goals here really are to provide that opportunity as a national forum.

We are also the gold standard for quality measurement in terms of our evaluation criteria. And we'll talk a little bit about that.

Elisa oversees all of our processes related to measure endorsement and selection so we're talk more about that tomorrow.

And really thinking about what are the big issues in healthcare quality in particular, and then in this instance how do we make sure disparities doesn't get lost in there.

These are our key activities across the board. Measure endorsement continues to be a

significant part of that work, over 600 endorsed measures currently across a wide variety of groups.

We have many other standing committees like yourself or expert panels. Almost all of them are busy evaluating individual measures. So in some ways this committee is more like our Consensus Standards Approval Committee, a level above, not in the work of evaluating measures, but helping to see the crosscutting issues, measurement science issues that arise.

Our Measures Application Partnership which some of you are aware of assists HHS and in particular CMS on selecting measures, recommending measures for specific federal programs.

And that work includes now Medicaid, CHIP as well as the exchanges. So a lot of these issues have already certainly come up in the context of thinking about measures for states and Medicaid in particular.

A growing body of work around measurement science. Thinking about what are those complex issues that if we could work together

to really tackle some of them we don't have to re-adjudicate them every single time a measure comes forward.

So, SES adjustment was one example of an issue like that. We are now doing some work. We've convened a panel, for example, to try to come up with some principles around attribution, another one of those kind of sticky issues that comes up at almost every single outcome measure.

And it seems like an opportunity to have a higher-level discussion and not re-adjudicate it each time.

We're doing some new work on variation, beginning to understand what causes the degree of variation we see in measurement out there. When are measures comparable, when are they not, what does alignment mean and what are our goals there.

We also have more of an effect arm, thinking about how we can convene stakeholders to try to drive improvement through some key areas.

We have a couple of action teams right now focusing on, for example, antimicrobial

stewardship and complex issues at end of life. Really thinking about what are the evidence-based practices, how do we help people move forward.

So, just a very high-level view of how quality is evolving. You guys have all seen this certainly from where you sit as well.

But I think we are increasingly seeing committees wanting to see measures come forward that really reflect the best of care, optimal care, rather than I think what was initially at the start of the quality movement very much assessing what is the expectations, the standard of care.

I think there is now a sense of trying to see what is excellence.

Certainly a significant move to outcome measures which is what drove much of the discussion on the SES panel.

And in particular now a very significant move towards thinking about how patient-reported outcome measures could become the basis of performance measurement as well.

Transitioning to electronic platforms

and e-measures is something all of you are very well aware of. And we'll talk more about that later today.

We're very pleased that David Hunt from the Office of the National Coordinator is going to come join us and talk with us about meaningful use and about how just broadly HIT can be hopefully a positive force in this area.

And he's been prepped to know your questions so he's ready to go. And he's just wonderful. He's really a safety expert I've worked with since I was at AHRQ and chief medical officer there at ONC. So that'll be great.

Addressing disparities in all we do is something we -- these are actually my core slides so I that at every single talk quite intentionally -- of how do we build it in prospectively and not have it be unfortunately the afterthought it tends to be.

With the cacophony of measures out there a lot more emphasis now on thinking about harmonization and alignment. How do we ensure

payers use the same measures. How do we ensure that the variations that happen out there are intentional as opposed to what is often done just to make the measure more expedient.

And lastly, not surprisingly, given what we're seeing in terms of value-based purchasing and the move to pay for value over volume we're seeing a lot of emphasis on looking at cost measures in particular.

NQF does bring cost measures in, but as building blocks of broader measures. We wouldn't, for example, expect a cost measure to be used in isolation, but paired with a quality measure, and have done some work over the last couple of years of thinking about how, in fact, you begin pairing cost and quality measures to get at issues of value and efficiency.

And then our clinical committees in particular have continued to work hard on thinking about how do we bring in more measures that reflect appropriateness and overuse rather than just more classic process measures.

So, you can flip through this. This is actually a slide some of you have probably seen from Ernie Moy, my good friend at AHRQ who has used this for years. And I think he developed it probably 15 years ago.

But I just think it's a great example of when we're thinking about linking disparities and quality we already know very well the "Crossing the Quality Chasm." And I think he wrote this, I think he did this slide after the Chasm Report came out.

But then thinking about what care is like for disadvantaged populations and the reasons there for that potential disparities chasm.

And then how do we then, you know, seeing how that chasm becomes enormous when those two issues are put together, and what are the opportunities there to drive improvement for patients for disparities, and eliminate disparities and improve care for those who are disadvantaged.

So, a little historical context. We

have been doing work in this area certainly since I've come in 2007, work thinking about, for example, how we might look at measures and think about which ones are especially important for disparities sensitivity, not something it has been built into. Elisa will talk about that tomorrow.

It's still hard to hardwire some of this which is where we're going to want some of your help.

In 2009 we had our framework and a set of best practices which Emilio helped with around measuring and reporting cultural competency as well as additional work looking at measurement particularly around disparities and cultural competency.

Some new measures came forward, for example, looking at time to interpreter services, cultural competency assessments for providers and the like.

And then most recently, 2014, the work around risk adjustment which a good number of you were a part of.

And you'll have a significant opportunity tomorrow to talk through what happened to that initial work, what's happening so far in terms of the trial period. And then we'll enlist your support in helping us think through what the evaluation process should be like. So, much more on that tomorrow.

MS. O'ROURKE: I can pick it up here. And again, these are slides you saw on the orientation so I won't belabor them. But as we said, the disparities committee has a three-part charge.

The first is to develop the roadmap for how we can use measurement and policy levers to eliminate disparities.

You'll be reviewing implementation of the revised NQF policy regarding risk adjustment for sociodemographic factors and providing input on evaluation of the trial period for SDS adjustment.

And finally, provide a crosscutting emphasis on healthcare disparities across all of

NQF's work.

So, I think we can skip through this fairly quickly.

The first task will be what we'll be tackling today in developing that roadmap.

The second task will be tomorrow morning when we'll be taking a look at the SDS trial period in depth.

Some action items we have for you here are to review and provide guidance related to methodologies for adjustment stratification and collection of standard sociodemographic data.

Help us think about how we can evaluate the SDS trial period, and in the future make a recommendation to the CSAC and the board of directors about continued use of SDS factors in risk adjustment approaches.

This is not something we'd be asking you to do at this meeting. That would be in the future as the trial period hits its two-year mark. But we want to take some time with you at this meeting to think about what information you would need to

make those recommendations.

And then finally, as Helen was saying, we'll conclude the meeting by asking you to help us understand better how we can hardwire disparities elimination into all of NQF's work, and particularly our endorsement and selection work.

So, some action items for you here. Provide advice and technical expertise on disparities to other committees. This could be the CSAC, the MAP, or the other standing committees.

We might ask you to make recommendations regarding the evaluation criteria to either the CSAC or the MAP Coordinating Committee.

And we ask the Disparities Committee to provide strategic direction and guidance to NQF and the field on measure development activity and enhancing the portfolio of NQF-endorsed disparities-sensitive and cultural competency measures.

So I think with that we can take any

questions on the charge or the goals of the committee. And if not, we can dive into building the roadmap.

CO-CHAIR CHIN: Okay. Great. So, first just to calibrate some of the time-lines and the overall work of the committee.

As you remember on the listserv there was the -- Kevin had put out a comment about responding to a CMS information bulletin by February.

And I love Kevin's sort of sense of urgency and wanting to have an impact. That probably was too fast for the overall committee.

This first topic of today on building a roadmap is a big topic. And so realistically, we have a three-year committee, I believe. I think each of us either has a two- or three-year term.

Two or three years is probably too long. Today is probably too short. I think probably realistically we're talking like sometime over the next year us coming up with, you know, the meat on the bones of the roadmap.

I mean, usually, like the Sociodemographic Status Report as an example that we'll talk about tomorrow, that took about a year or so.

And when you look at the report, it's a great report. I mean, it's like 80 pages or so, like 10 or so specific recommendations. Very carefully thought out. And that took place over the course of a year or so.

And so that's probably along the lines of what we're talking about here of like -- it's going to evolve over time. But in terms of our product and deliverable, and being able to confidently say we recommend to payers, CMS, or whatnot, here's our roadmap. So, it will take awhile.

So first, that means everyone can relax in terms of today, that we're not going to solve it today.

But similarly though, don't worry too that like if there's a comment that you didn't make today that you forgot or comes up later, there will

be opportunities over three months to add. This will be sort of an iterative process.

But we also need to face this challenge that puts us here. We had a planning call of like how do we begin to start with this big thing of roadmap.

And so, this was our crack at it in terms of the agenda. And in some ways probably the topics will start melding after awhile, and that's okay.

So in some ways the major purpose of today is to get at what are all some of the major issues that we need to grapple with over the ensuing months.

And basic foundational things. Like you know, we need to agree upon a goal, objectives, some of the basic type of things there.

Details, again, I wouldn't worry about too much. That's what we're going to have a year to go over. So don't worry too much about sort of the nitty-gritty. But this is going to be a start so that we can accelerate between the conference

calls and the future in-person meetings.

So, the overall message is put on your brainstorming hats, but also relax. We do have time, but we need to get started somewhere.

Okay. Do you want to start with the?

MS. O'ROURKE: Absolutely. So, just to make sure we're all on the same page we wanted to take a second and define how we're envisioning a roadmap.

We want to describe a path for achieving our goal, outline the actions needed to eliminate disparities in healthcare, highlight the stakeholders involved and their responsibilities and actions that the committee would advise them to take.

In particular I think this is a unique opportunity to capitalize on the multi-stakeholder nature of this committee and think about the stakeholders broadly, and in particular tasks perhaps some private sector synergies with getting involved in this work as well.

So, as Marshall was saying we want to

start off with some foundational work.

And this was one of the highest areas of discordance on the survey was agreeing what the goal of this roadmap should be.

Split about 50/50 on agreeing with the draft goal. More skewing towards no though.

Some key themes from the survey. I think what the committee seemed to want was more action in the goal, to be more outcome-oriented, really task people to take action on this and to ensure that we're using measurement and all of our associated levers to support elimination of disparities.

So, I think with that we can go to the next slide and I'll turn it to Marshall to facilitate some conversation about clarifying our goal.

CO-CHAIR CHIN: Okay, so we're now in brainstorming mode.

And maybe what we can do in terms of like, we have a big committee so we can maybe do like the if you want to speak put the tent vertical

thing and then go in order.

So we can start really broad here in terms of what is the goal of the roadmap. Very foundational. Romana, then we have David, Bob. So, Romana?

MEMBER HASNAIN-WYNIA: So, can we go back one slide to the elements that were?

I think one of the things that during our first call of this committee, and I think it was Eduardo who brought this up.

But I noticed that we, you know, this might just be language, but we focus on healthcare disparities and healthcare outcomes.

And I worry that we're losing the concept of health as well. Especially because we are focusing on outcomes. So, we've evolved from thinking about just processes of care to really honing in on healthcare outcomes.

But to me they're healthcare and health outcomes. And the health component actually embodies more of the community piece that steps outside of the healthcare system.

So, in terms of our own goals and the roadmap I would hate to lose sight of that, especially as we're looking into new delivery models that are kind of bringing together the healthcare system and the community. So that's just one comment that I have.

CO-CHAIR CHIN: Thanks, Romana. And I think there's actually a lot embedded in Romana's point that we'll be coming back to probably repeatedly about the scope and the targets. David?

MEMBER NERENZ: In any group like this you always run into questions about what's the scope, what's the boundary, when are we within our charge.

And we always get into the semantics, so I may as well just kick it off.

The word "associated" here. I'm wondering if you could just give us some guidance.

Because I perceive the role of NQF largely to be in the domain of quality measurement. But the word "associated" then creates connections

out.

So, for example, if we're talking about healthcare or health disparities we could conceivably have long discussions about payment issues that are really not directly related to quality measurement.

So, for example, we could debate whether Medicare payment at inner-city hospitals should be up or down, or whether health plans should get this, sort of the other form of supplemental payment.

Is that in the charge or is that out of the charge? How do we think about outer boundary here?

DR. BURSTIN: Oh, he's looking towards me. As usual, that's a great question, Dave.

I would say as long as it clearly somehow relates to quality. I mean, I think we think of measurement as a really important lever, but there are other levers.

And so I think if other levers come up I think it's fair game to discuss them. We would

certainly prioritize in terms of our work going forward the ones most clearly in our wheelhouse.

But I think it's an important discussion to have and I wouldn't want to limit the discussion. Let's start broad and then we can narrow in as needed. Does that sound reasonable to you?

CO-CHAIR CHIN: I mean, that's one of the questions that Ninez and I asked Helen at the beginning. Otherwise we wouldn't have co-chaired this.

I think part of it, and Dave and Kevin talked about this also. One of the challenges with the prior NQF disparities committees is that there was -- whether it was a real or de facto firewall between discussion of performance measurement -- this is the classic topic -- and then their use.

And one of the problems that the SES committee had was that it's hard to talk about SES risk adjustment without talking about how they would be used. So, it just didn't make any sense to have the firewall.

So, my understanding is that we do have the full flesh on things that pertain.

DR. BURSTIN: Yes, and just two more quick things to add.

This work, for good or for bad, at least for now is purely internally funded by NQF. We did not get support from the feds to do this. We thought it was important. We're doing it anyway.

But the positive side of that -- my COO wouldn't agree -- but the positive side of that means that there are no -- it's not as if a grant came saying focus on this, this and this.

This is truly generative among you and us to think about what makes the most sense for the nation. Not to sound too grandiose but truly what's the right thing to do at this time.

Secondly, since the initial work there we have also done a lot of work within NQF. And actually Elisa has led a lot of this where we have eliminated a lot of those internal walls between, for example, measure endorsement, measure selection, or implementation work.

And we really just see it as more fluid. So I think it allows to not be caught in the trap of saying this is about measurement, this is about policy, this is about -- just do what makes sense.

CO-CHAIR CHIN: Yes, Bob, we've got Traci and is that Christie down there? Oh, it's Michelle. Okay. So, Bob.

MEMBER RAUNER: Yes. And I kind of like actually the last one the best.

The thing that I think can't be forgotten is the payment side. And I suspect that -- I think I understand why the last panel stayed away from using SES because they were worried about what might happen.

But the problem is that in healthcare you always have to think of the "first, do no harm" principle. And by not using SES measures there's a lot of unintended consequences where the least well-funded healthcare providers could get dinged a lot.

And I think we can't lose sight of the payment, even though people are often afraid to

think of payment while they're also thinking about providing healthcare.

And so I really think the payment does need to be a central component of this because that what leads to our ability to have the resources to actually do something about it on the front lines.

And I think that's why you're seeing even some people saying that we should report it this way for public reporting, but this way for payment.

And I think it's -- we have to kind of keep that payment and not forget about that just because that is what really affects the front-line providers.

CO-CHAIR CHIN: Thanks, Bob. So Traci and then Michelle.

MEMBER FERGUSON: I did have a sort of issue about the associated policy levers.

And coming from the payer side how we get paid in terms of taking care of our members, Medicare and Medicaid depends on how we do on the measurement.

So we're seeing a lot of in terms of our premium associated with how we're doing on the measures.

So I think we have to broaden the scope in terms of disparities to include that payment side too.

CO-CHAIR CHIN: Michelle?

MEMBER CABRERA: So, part of what I've observed in policy discussions, particularly in Medicaid programs, is that public payers seem to be heavily influenced in this moment by what's happening on the private commercial side.

And those theories and those ideas are really driving them.

So for example, when we talk about alignment across purchasers around data, or pay-for-performance and these sorts of things.

The driving force skews toward where the experience is which is on the private side. And unfortunately, at least in our state that's not where a lot of the diversity is concentrated. And so it's not where a lot of these problems are most

pronounced, most measurable.

And so one of the things that I've really been trying to advance is this idea that there are some things that have to start with a Medicaid or safety net-centric point of view.

And it's difficult because we don't yet have a huge body of researcher experience on that side either, but that's really where the investment needs to start, I believe, and where some of this change needs to be driven from.

But it requires sort of breaking into a conversation, again, that even on the public payer side -- I'm looking at my friend from CMS here -- has been really influenced by private. So, you know, Triple Aim, et cetera.

And so I just think sort of flipping that will require giving people the roadmap, the framework, the tools to understand how to do it.

Because it just isn't coming up naturally. Equity and elimination of disparities is not coming up naturally in these conversations around value-based purchasing.

CO-CHAIR CHIN: We've got Philip, Mara, then Lisa, and then Nancy.

MEMBER ALBERTI: I appreciate all the comments and I want to first argue or agree with the broadening of the scope to really focus on the action steps that need to be taken for solutions.

And in light of that the measurement might happen within the hospital or health system. And so there's going to be some needs and actions there.

But the solutions will really be built through partnerships. So I wonder if there's a way in our goal to really call out the importance of cross-sector partnerships and actually build in that solution set.

So, even if hospitals, providers are responsible for a lessening or a narrowing of gaps, really making it clear that they will not drive solutions on their own in a vacuum or in isolation.

MEMBER YOUDELMAN: I'm supportive of expanding the goal as others have said.

I am a little bit tripped up by

"associated policy levers" because I just don't think it's a clear term at all, and can mean different things to different people.

Particularly, I work on policy issues at the federal level so it can mean one for me. And others have said payment. So, I would also just stress the need to be very clear, or as clear as we can.

So it sounds like payment is one of those specific things that has to be taken out and not sort of lumped in with associated policy levers.

But I'm wondering if there's also other associated policy levers we might want to integrate more specifically. Not a 10-point list, but at least a couple of really crystal clear ones.

And payment seems like one of them. I'm not sure about any others.

CO-CHAIR CHIN: Maybe we can do Lisa, Nancy and then we can get back to the specific question of when we're saying "associated policy levers" what do we mean.

I've heard payment is part of it and there may be others. So, Lisa, Nancy, then we'll hit that question.

MEMBER IEZZONI: Because I think that's a really great point, but I'm going to talk about something just a little bit different.

And I do so with some trepidation because I think having the goal statement that's very tight is a good thing to do.

But I cannot tell you how many times I've been put on disparities committees, and I hope I don't say something awkward. It's all about race and ethnicity.

And I think that we need to make a statement for our committee that we are thinking more broadly about populations that do experience disparities, just to make absolutely clear to the outside world that we are thinking more broadly.

And at some point during today I just want to get a commitment from everybody that we are, in fact, thinking more broadly.

Because I think that that's still -- I

saw the paper that you commissioned from my colleagues, Joe Betancourt, et al, and Joe Weissman, and it's all about race and ethnicity, and a little bit about literacy, but nothing about other populations.

So, I think it's just really going to be important to make that clear.

CO-CHAIR CHIN: What we'll do process-wise -- Lisa has an important point. So we'll hear Nancy's comment. We'll get back to Mara's point about associated policy levers.

Do a little more brainstorming. I'll feedback the themes I've heard and then we'll have to drill down on some of them. Because people have made comments. We need to think through thoughts about -- like your comment, for example, Lisa. So that's what we'll do process-wise. Nancy.

MEMBER GARRETT: So, one of the things that I reacted to in the initial statement "healthcare quality" - NQF endorses measures in all parts of the Triple Aim. So, including efficiency measures as well as patient experience. And so the

quality part, I was worried that that might be too narrow.

And so I really like Romana's idea of also healthcare itself might be too narrow. So maybe the last statements where we're supporting the elimination of health disparities would be broad enough to encompass all of those.

But it kind of depends on what we mean by quality. If we're thinking more broadly about all of those aspects, or more narrowly about what's more traditionally a quality measure.

CO-CHAIR CHIN: Thanks, Nancy. So why don't we now hit directly with Mara's questions about when there's -- yes, but we're going to hit this first -- the associated policy levers. That means different things to different people.

So, how are we defining that? What do we mean? So, if we're going to have more specific language, what are the associated policy levers?

MEMBER RAUNER: A follow-up on Lisa's comment that I agree that we need to make -- there are other disparities people often forget about.

And I think I'm the token rural guy from the rural NQF committee. There are very big differences in the urban-rural landscape. And people often forget that.

And with all due respect to CMS they keep forgetting that by paying our rural health centers through Part A how much it eliminates the ability for rural health centers to do so much in quality improvement.

And that's constantly forgotten in D.C. that rural is funded differently, it works differently and it's often missed. So.

CO-CHAIR CHIN: Eduardo?

MEMBER SANCHEZ: So, a couple of things. Thinking about associated policies, what comes to mind for me as I think about associated policies is kind of this development of accountable communities for health, and accountable health communities.

Those are still nascent. And understanding what those are, and how one might even measure quality or performance I think is

still a little bit of a question mark.

But that might be a place where there doesn't exist yet I don't think actual measures where I would see that as an associated policy.

I think it goes back to the earlier comment, and I appreciate you referencing me, that we need to think beyond just what happens in the clinical setting.

And I think that the accountable communities for health and the accountable health communities will begin making that easier to do than maybe our comfort level allows us.

And so, associated policies to me may be things around which the metrics either don't exist yet but should, or some models exist around which some hard and fast metrics could be informed by the kind of work that we will be doing.

CO-CHAIR CHIN: Nancy is that a new comment? Okay. I'm going to ask Jose to get involved. So Jose, when you're thinking about associated policy levers what would you include under that bucket?

MEMBER ESCARCE: Actually, I was going to make a comment on the other issue which has to do -- I think the very first comment was made by Romana.

And I suppose that from a conceptual perspective, or even a principle perspective it would be hard not to have the multiple goal be sort of the elimination of the tremendous disparities in health that we see.

But it seems to me, and of course I'm new to this committee so I'm going to have to get guidance from other people and from the conversation.

But it seems to me that there are so many factors involved in the generation of those health disparities that are beyond the provision of healthcare.

And my sense is that this committee and this organization is about healthcare. That is to say that the people sitting around the table and the people on the telephone both care a great deal and maybe even more so about health because, after

all, that's the ultimate goal.

But I suppose what I was thinking is it's probably important -- and again, this is a guess -- it's probably important not to over-reach.

And so, sometimes if you make an aspirational goal. So one of the things that I often see in situations like this is they have an aspirational goal.

And the aspirational goal, of course, is to eliminate disparities in health and to improve everyone's health. And that's a distant goal. It involves a number of different players that are -- and there are changes in attitudes, changes in the way government works, changes in labor markets, changes in the educational system, all sorts of changes that are way beyond the scope of this committee or this organization or the healthcare system.

But then there are also sort of goals for this particular effort as one of the components of eventually achieving that aspirational goal.

So, that's really what I was thinking

as everybody was talking. So thank you very much for giving me the opportunity to say it.

CO-CHAIR CHIN: Yes. Romana, do you want to comment?

MEMBER HASNAIN-WYNIA: So, I mean I completely appreciate what Jose said in terms of we don't want to over-reach. I understand not over-reaching.

I think one way to address this is by really being very explicit about what the aspirational goals are.

But I wouldn't -- I guess what I would say is that I wouldn't want to clump all of our aspirational goals into one bucket without kind of differentiating them. Because they get set aside then.

Versus aspirational goals that are more proximal and that depending on kind of whatever policy levers we have that we can identify, that we can get there sooner.

So, I worry about -- I mean, I've been on committees where we've identified aspirational

goals and they go nowhere because at the end of the day the end users are focusing on kind of what is the have-to-do's. So that would be my only comment.

MEMBER ESCARCE: So, I suppose I would like a clarification from you, Romana, because maybe I just didn't understand your first statement.

So, there's sort of the issue of healthcare outcomes. And I suppose -- when I think about that idea or that term I think of it as outcomes directly tied to some healthcare that I got, or that somebody got.

And you know, we can think about what those are. There are many out there.

Then there's just health. And so, when you said that you wanted to think about eliminating disparities more broadly I understood that you were saying eliminating disparities in health as opposed to eliminating disparities in the immediate health outcomes that ensue as a result of healthcare that you got.

Which was it? Because maybe what I said was irrelevant if you meant the latter.

If you meant the former then that's really what I was addressing.

MEMBER HASNAIN-WYNIA: You know, I was leaning more towards the latter, but I actually think that the latter is connected to the overall concept of health.

Part of this is just language, and you know, as when we were introducing ourselves, and when Marshall and Ninez and Helen were introducing the goals of the committee, and saying that this is an important committee in terms of what we put out there. So, language matters.

And to me if we focus on healthcare -- and I think I was taking issue with this concept of just focusing on the healthcare piece. I think we've been doing that for a very long time.

And I agree, Jose, that we do want to be mindful of not making the charge so broad that we lose sight of what it is that we're trying to do.

So yes, I would focus on those healthcare outcomes that are very strongly associated with what happens in the context of the community where we kind of live our lives.

So, that's the piece I don't want to lose sight of.

And I really believe that we're at a time right now with new delivery models where we're beginning to see those intersections coming together.

So, the language that we use, I want to be mindful about that. I want to make sure that we're explicit about it so it is not left up to interpretation.

I completely agree with you about not being so broad in the concept of health though.

CO-CHAIR CHIN: This is a fantastic discussion. I think we're getting a lot of the important points out.

Also, a lot of people want to speak. So just fill up --

CO-CHAIR PONCE: It was Lisa, Kevin,

Philip, Ron and Sarah.

CO-CHAIR CHIN: Lisa doesn't have her -- oh. Whatever Ninez said.

MEMBER COOPER: So, I actually wanted to again support Romana's point.

And one of the reasons why I think it's really important for this committee to place the emphasis on the eliminate of health disparities, not as a goal that states that that's what we are going to do, but it says that we are going to ensure that all the other things are in place that will eliminate health disparities.

And I think focusing on healthcare disparities is way too limited for us to be doing at this point in time.

I think it lets everyone off the hook in the healthcare system. I think our system right now is perfectly aligned, and all of the policies and payment mechanisms we have in place are aligned to get the outcomes that we get because we are focusing on processes of care that are great, and they're evidence-based, but it really doesn't

place responsibility on the care system for making efforts to partner with systems, other resources outside of the healthcare setting to achieve the ultimate goal.

And so I think by being very explicit that we're not just focusing on measurement of quality of care like within the walls of the clinic, but we're actually focusing on measures that actually extend outside of the clinic, and that we are really looking at policies and payment that will reward behaviors that extend beyond the traditional healthcare delivery behaviors I think we'll be making a very clear statement.

And it's not that we're saying that we, that the committee itself is going to assure that health disparities are eliminated, but that all these other things that need to be in place to incentivize people to do the right things will be there.

CO-CHAIR CHIN: So, what I saw was David, Emilio, Philip, Ron, Sarah, Lisa, Michelle.

MEMBER ESCARCE: And then put me in at

the end again, okay?

CO-CHAIR CHIN: And Jose. I think I caught Kevin. David. Sorry.

MEMBER FISCELLA: You know, Lisa, you said it much more clearly than I could say it so I'll just say I completely agree with the comments about expanding it to health.

And I agree it's an aspirational goal that maybe is not going to happen during my lifetime, but I think it's really important that we have it there.

In terms of the policy issues I think that's a difficult question to answer. And I'm certainly not prepared to go through all the different types of policies that could potentially impact disparities at this point.

But I think given that we're very early in the process I think we need to keep policies which represent a very potent lever for making changes on the table, particularly as newer models and newer policies are likely to come out almost daily.

And so I think as they come out and we begin to think about it I think I would certainly want those up for discussion with this committee, and not to take them off the table.

And I think at this point it may be a little bit premature to begin categorizing them. I think as we get further in we may be able to get to that.

CO-CHAIR CHIN: So, we have -- go ahead.

MEMBER YOUDELMAN: I guess I'm not trying to come up with a list of all of the policy levers, but I think for some policy lever might mean payment issues. For some it might mean delivery system or form. For some it might be the accountable health communities, accountable communities of health. There's both, right? Others.

So, I'm thinking broad topics. Instead of just putting in "associated policy levers" which to me is sort of very generic and someone reading it might not understand that we're

talking about that we are including federal and state legislation, you know, laws and regulation.

I'm looking more for broad categories I guess. Again, it's hard in a policy statement or a goal statement. Maybe it's below the goal statement. But you know, a definition of "associated policy levers" would include items such as payment mechanisms and reimbursement, new delivery systems.

I think the health systems, too, ACH -- whatever the abbreviations are. I'm going to mess it up for the next day and a half -- think about that. Because we are broadening beyond healthcare. And if we are looking at the communities we need to be thinking about what are the levers.

And it's also embedded in the ACA. If you're getting penalized for readmission of hospital discharges, well, if you're discharging someone into a community that doesn't have the supports, doesn't have the food, doesn't have the social supports, et cetera.

So I'm just trying to get a little bit beyond just associated policy levers.

But I agree, coming up with a list would be too probably exclusive, but also not worth our time to delineate it all.

CO-CHAIR CHIN: So, Emilio, Philip, Ron, Sarah, Michelle, Lisa. Then we're going to put Christie and Yolanda in the queue also. It's been more than 10 minutes since they've spoken.

MEMBER CARRILLO: I think that the book is not closed on healthcare measurement. The Commission paper from 2011 that we worked on, there's still a lot of areas of development that are on tap in terms of how we look at the portfolio of NQF measures, how do we determine those that are disparities-sensitive. How do we bring those up to the top. How do we include other areas of disparities as Lisa pointed out and Bob pointed out.

But understanding that, that the book is not closed and that we need to do quite a bit of work on the healthcare measures. I mean, there

is really momentum in many quarters around the country in moving healthcare upstream.

And with the accountable communities in terms of really identifying those social determinants of health that account for the readmissions, that account for so much of what the cost components, never mind the human suffering.

So, I think that we have to be, you know, specific about saying social determinants of health rather than associated policy lever. Be a little bit more definitive with our language.

But I definitely think that it's about health and healthcare. I mean, I think that unfortunately it's a broad topic and we need to just manage the best we can to wrap our arms around the fact that social determinants of health have everything to do with the healthcare measures in the end.

CO-CHAIR CHIN: So, we've got Philip, Ron, Sarah, Lisa, Michelle, Christie, Yolanda.

MEMBER ALBERTI: Thanks. So I remember on the call I think Helen suggested that

we should be bold.

And so from an academic medical perspective what I see is a real lack of a systems approach to the kind of work that would actually result in a closing or narrowing of inequities and disparities.

So if we think that -- measurement happens here so I'll make up a hypothetical medical center example.

So, you might have excellent measurement. You might have an excellent community benefit office. You might conduct an excellent community health needs assessment. You might have training for residents that really focuses on disparities and quality improvement, and you might have a CTSA that has a gangbusters community-engaged core.

And they're all doing amazing work on their own without any kind of collaboration, consultation discussion.

So I think if our charge is to think about how we can add strong, valid measurement to

the mix, that we also think about in terms of the policy question, right, those are all policies. There are expectations by ACGME, there are CHNA requirements. That's a policy.

So how do we frame, you know, if you measure in this way here are the different kinds of systems, the different kinds of connections that actually yield benefits to health and not just healthcare, and that require the kinds of collaborations and bringing together different policy streams, or regulatory streams to actually affect the communities that we serve in the ways that we want.

So I think we should be bold and really think about systems of action.

CO-CHAIR CHIN: Thanks, Philip. So we've got Ron, Sarah, Lisa, Michelle, Christie if she wants it, Yolanda, and Tom. And Susannah. Oh sorry, I forgot. Jose is in there.

MEMBER COPELAND: Well, I just think it's a really critical question. And I'm glad we're spending this up-front time debating this.

Because I think if we really are serious about elimination of disparities and therefore reflect on the drivers that have been researched and that we are aware of it's a continuum.

So I think it's a bit of an artificial divide to talk about healthcare disparities segregated from health disparities.

Because I think one of the things we've got to keep in mind is across this whole continuum there's this steady drumbeat of affordability, or the lack thereof, and there's contribution to people's access to care, and so forth.

And there's no way at a population level to really get to cost trends that bring the affordability and access down to levels that make sense for the populations that have been traditionally been underserved without investing in health.

And when you talk to physician colleagues and delivery system colleagues around the country and talk about what they're currently doing or not in investing in health of populations

one of the responses that I hear a lot is, well, nobody is paying me, reimbursing me for investing in health. I get reimbursed for providing care and doing that at a level that eliminates gaps and so on.

Yet we know if you invest in health then the incidence of chronic care and complicated care begins to go down.

So just pulling an example out of my head from our experience. If we limited this to healthcare disparities and let's say we're talking about the outcomes for colorectal cancer in Latino populations, just one example.

When we look at our data on the health side of that around healthcare colorectal screening to prevent cancer from showing up in the first place, and we have disparities in the screening rates, we put our efforts there.

And by lowering those gaps and increasing the screening rates the incidence of treatable colorectal cancer in that population goes down.

So, if you're really about eliminating disparities the health component has got to be part of what you're incentivizing people to do.

And so, in terms of this associated policy lever, just one example of that is in the payment world and the reimbursement world, if that's not aligned with driving health investments in addition to the right outcomes for care delivery when these chronic illnesses are there, then I think we miss a tremendous opportunity to achieve the ultimate goal of eliminating disparities.

And so I guess my advocacy would be, my bias is for -- from a systems level is recognizing that investments in health and healthcare are both critical to this work. And in the case of payment or reimbursement we've got to harmonize and realign that component in the work of the recommendations we make if we really want to have impact.

Now, that's a scary notion for the medical care delivery models because that says now you have to move on a trajectory to be accountable for social determinants. And the medical care

model is woefully inadequate to do that today.

But that recognition of inadequacy drives, incentivizes the collaboration not only among systems but with communities to create a process where a unit, a bigger defined unit is accountable for care.

So, I know that sounds pretty grandiose, but I think that's at a macro scale how this would work at a community, at a population level actually gets done.

And anything we can do with our recommendations that will incentivize and drive that, particularly, not limited to, but particularly related to payment and reimbursement which is a critical driver I think would be well aligned in moving this work to another level of performance.

CO-CHAIR CHIN: Thanks, Ron. Let me put Jose in now. Jose, we've had like six additional people. Just to take sort of the perspective that the health and social determinants of health perspective, besides your

comment, do you want to respond? Are people missing stuff?

MEMBER ESCARCE: Well, I think there's a good chance that we're talking past each other, or at least I'm talking past people. You know, I think we're talking about different things, many of us, right?

So, when I think about -- when I hear the word "disparities" in health I think that healthcare has a relatively small role to play. If you could somehow divvy it up between healthcare and other factors the role of healthcare would be relatively small.

And then when I think about disparities in health I think about segregation, I think about the food environment, I think about housing quality, I think about pollution, I think about the access to labor markets, I think about quality of education, all of those things which influence people's health either in the short run, sort of immediately if you will, or in the long run.

And so that's why I reacted the way I

did to the idea that the scope of the committee should be disparities in health. So like, reducing the seven or eight years in life expectancy between African-Americans and whites, for example.

So, everything I've heard since then and all the people who've advocated we need a broader view, that it's not just healthcare, it's really about health.

But then the comments are followed by an explanation or an elaboration that tells me that actually it's all about healthcare. So, to me everything that's been said is about healthcare.

And if the issues are providing incentives to providers, or whatever other policy levers so to speak can be pulled so that providers engage with communities and take care of people in the community, partner with organizations, figure out how people are going to be cared for in the community when they need support, social support. Those things, oh, of course I'm totally on board with that.

But I think what -- so, the reason I said I think we're talking past each other is because, like I said, when I actually hear that term I think about housing policy, education policy, job policy and policies about pollution, and transportation policies.

And that's where I said, you know, I'm not sure we should go there. But I think it's not clear in my mind that people are not as expansive as I initially thought when I heard Romana speak.

DR. BURSTIN: Just one quick comment. From some of the other work we've been doing on population health and Lisa reminded me. All of that work, we are explicitly saying health and healthcare.

Because there are elements of this that are truly about the -- to Ron's point, about the healthcare system, about payment levers, et cetera. And there are elements of this work that are broader.

So, I think there's a lot of violent agreement actually around this table. You know,

maybe one option would be to actually just not make health something to, you know, as a stretch goal, but in fact just put them both in there, but recognize that in fact the levers for both of them, as Jose just said, could sometimes be quite different.

CO-CHAIR PONCE: I also think just from a measurement and research perspective we're behind in looking at these upstream determinants that Emilio said in healthcare. And so the literature is more flush in terms of the determinants in health.

And so we might in terms of trying to unpack where do we get with these measures, do they really matter, it's also important from a measurement perspective to be all inclusive.

And you're right, Jose. In the first meeting we had we showed different definitions of equity, disparities, AHRQ which was much more inclusive. Lisa and Ron and Bob, the token rural guy.

And we also showed the WHO framework on

social determinants of care where medical care was this tiny little box compared to everything else, but still all these other domains are important I think when we start looking for and hunting for these community-level measures that would be important, that affect health, but also affect healthcare.

CO-CHAIR CHIN: Thanks, Ninez. Maybe we'll do -- so, we're up to Sarah. Then it was Lisa, Michelle, Christie if she wanted to speak, Yolanda, Tom. You put yours down, so Tom's down now. Emilio.

So at that point then I'll maybe reflect what I've heard so far just to make sure that we're capturing sort of the main points. So, up to you, Sarah.

MEMBER SCHOLLE: So, I actually think we should take a look first and try to think about how we're grounding this in health policy.

So, the National Quality Strategy says one of our goals is to improve population health. So we can tie back to that.

The second thing is we are in the midst of a huge number of efforts to try to use patient-reported outcomes as the ways to evaluate the healthcare system. So we see that in CMS' efforts to include measures that look at symptoms and functioning in a variety of conditions.

And so we're already, we're focusing on health with those measures.

And how does this relate to healthcare? Well, when we look at particular vulnerable populations then we have to think about these social determinants of what's the housing, and what's the food.

Because if we want to help people with complex needs, or serious and persistent mental illness actually participate in healthcare effectively and achieve some improvement in their life then it's a complex effort of building of those supports and working with the individuals to achieve their preferences and life goals.

So, we're already addressing health in our National Quality Strategy and in our

measurement.

And I think what we're trying to do is understand what's the right size of the connection between health and healthcare. How do we bring those together.

I think we just have to be mindful about accountability. And one of the biggest questions we had was we talk about patient-reported outcomes. We have measures in HEDIS for health plans that are looking at whether patients with depression get to remission of symptoms.

And is this a provider responsibility? Is the primary care provider responsible? Is it the mental health provider? Is it the health plan? Is it the community?

And it's really I think trying to make sure that as we think about health and health outcomes that we're actually cognizant of the challenge of where that accountability lies, and what are the opportunities that that accountable unit has to make things better.

And the larger the accountable unit,

the more resources they have and the more ways to bring to bear to try to improve it.

CO-CHAIR CHIN: Thanks, Sarah. A question for Erin. Will the whole committee eventually have copies of the minutes, or at least some of these major points? What's going to be the way to sort of feedback like all these great points to the wider group?

MS. O'ROURKE: Of course. So, we do have a transcriptionist taking a copy of the meeting. We post that and we'll share that with the committee.

I think from our perspective the next steps would be for staff to take all of your feedback, draft it up into attempting to really put the meat on the bones of the skeleton we're working off of today.

And then I think we can share that with the whole committee to iterate by email and perhaps in our future web meetings that we have throughout the year to -- maybe we'll aim by the next web meeting to provide you a filled-out draft based on

what we heard today and go from there to start iterating on what the roadmap might actually look like.

CO-CHAIR CHIN: Thanks, Erin. That makes a lot of sense that we're not going to sort of word-craft a goal today with 30 people.

But I just want to make sure -- so we'll be fed back both everyone's comments, and then the opportunity then iteratively to go through like draft language. That's probably going to be the most efficient way to do it.

So, let's see. Sarah. So then it was Lisa, Michelle, Christie, Yolanda and Emilio. And Eduardo.

MEMBER IEZZONI: When I got my hug from Helen this morning I confessed to her how old I am. And she said oh, really? I said yes. And one of the consequences of being that old is that you've kind of been there and done that.

And I'm having all these kind of deja-vu all over again kind of feelings right now.

I was really honored to serve on the

Secretary's Advisory Committee for Healthy People 2020. It met from 2008 to 2010. There were 13 of us, a slightly smaller group. But it was all about social determinants of health.

And it was also about how we measure performance in public health. And so we have been talking about health measures here. We haven't been talking about public health measures here.

I just actually went onto the website and Jonathan Fielding who I gather has resigned from his role in Los Angeles -- he retired? Yes, he was the co-chair along with Shiriki Kumanyika. Do people know who she is? So, very kind of public health focused people.

And if you go onto their website for the disability and health topic, for example, the major ways to improve health are to employ people with disabilities. Find them accessible housing. Improve transportation.

And so I'm just concerned that we are going to be recreating so many wheels. Helen's already said that there are other committees here

at NQF that are already kind of talking about these kind of things.

I think it's going to be really important for the chairs of the committee and for NQF to think about how we can really build on some of this very solid, strong prior work that has been done.

And so we don't spend what we did back at the advisory committee, you know, three different meetings coming up with our graphic, our onion, that we really need to try to build on what other people have done before.

CO-CHAIR CHIN: That's a great point, Lisa. And it's always great to have the wise person in the room to say basically well yes, we did this 30 years ago.

(Laughter)

CO-CHAIR CHIN: So that will be important I guess in terms of some of the background that we don't repeat some of it.

But I do think it is a bit different in that when we get to some of the other topics for

today like stakeholders and the leverage we have, some of this is a little more proximal.

For example, like the 2020 committee where you guys were just so, you know, you have the whole governmental expanse that was at your feet. Whereas we have a more targeted set of levers.

So that we'll keep on it. But I think we're going to be okay.

MEMBER IEZZONI: But Marshall, my point was we haven't used the word "public health measures" this morning yet.

We've been talking about measurement, but we haven't been -- we've been talking about measuring healthcare, but we haven't talked about public health care, public health.

And that committee was very into developing public health measures. So, I don't know whether that's within the purview.

CO-CHAIR CHIN: I think we'll find our happy medium as we delve more into some of these other aspects. Like what are the policy levers, what are the mechanisms.

You're right. We need to keep this in mind. I think we'll probably end up at a good place by the end of the day.

Michelle.

MEMBER CABRERA: So, just to Lisa's earlier comment about we mean when we're talking about disparities.

I mean I think, you know, in my audacious hope for the future we'll even get to a point where we're talking about intersectionalities, right? And how gender identity, and disability, and race, and ethnicity all play into various different disparities and how we can address those.

I think one of the things that's difficult for me and that I don't want to lose sight of with this group is in the staff draft there's a lot of -- in various different places they talk about mainstreaming some of these ideas.

And I want to -- in my experience when policy discussions arise around disparities it is very much a side conversation. We put things in

the department of public health so that they cease to be relevant.

And I'm saying this very crudely, but you know, the Office of Equity is over there. And we have had our California Let's Get Healthy 2020 initiative as well. So, been there done that, you know, from a Secretary or agency director's perspective.

What's troubling to me is that then when you're having the conversations with the large payers about what really matters on the ground we're not incorporating this as a top-level goal because the Triple Aim's swallowed disparities.

It's sort of like oh, it must be included in quality. But no, it's not, you know. And so there are those problems.

Another problem that I see is, and I don't want to further alienate myself from all of the doctors on the committee, but you know, when I've talked to my doctor mentors about these issues I often hear oh, but Michelle, this is all outside of the walls of the hospital, as if you know,

institutionalized racism just doesn't touch the healthcare system. You know.

And somehow it affects us in education, in public safety, in our judicial system, everywhere else but in healthcare.

And so I think if we had solved the problem of how to measure and eliminate healthcare disparities within the healthcare system it would be fine to say let's look way broader.

But we need to also focus on the micro while we're looking at the macro. And we need to also be very mindful of how -- what really is driving a lot of the payment decisions and the policy decisions. And those two things are linked.

And again, I just feel very strongly that this stuff has to be mainstreamed or else it will continue to be an off-to-the-side conversation. I'll get off my soapbox.

CO-CHAIR CHIN: Thank you, Michelle. We have 20 minutes left on this particular part of the agenda. Before we get back in the queue let

me just reflect back what I've heard so far in terms of some of the big overarching themes, a lot of them which are starting to coalesce.

One was the incorporation of health and healthcare. So, the healthcare system and then sort of the wider outside the healthcare system, social determinants of health.

And this was one of the topics that there was violent agreement about. But with a focus it sounds like on the mechanisms within healthcare to help associate with some of the social determinants, or have those types of partnerships.

There was talk about the associated policy levers. This still is a little bit not fully formed in my mind what people have come to a conclusion with. But it seemed like it was on payment. There was regulation, multi-level range from federal to state. A systems change. So Philip talked a lot about like actionable systems change.

And then within different elements of

the healthcare system other levers such as ACGME requirement for academic institutions and all.

There was a point about thinking about is it one size fits all recommendations, or do we need to have specific lenses. Is the point I think Michelle brought up about thinking about the safety net and Medicaid and is it possible to have an all-encompassing statement, or does it need to be specific things, to talk about specific types of organizations or settings.

There was an important discussion about being specific about what do we mean by disparities in terms of populations. So, race, ethnicity, is it SES, is it disability, et cetera.

It wasn't clear to me that they were necessarily part of this, but were really important points.

So for example, Sarah had a very important point she raised about accountability. And so I really was not seeing how it fit here. Maybe it does. But it's something that we need to revisit in other parts of what we're doing here,

the level of accountability.

So that's what I've heard so far. What we also have to do in theory before 11 o'clock is there's a list of eventually like dimensions that we need to go over.

So, maybe let's get other comments and then we'll maybe flip to that particular sheet to take a look at that also.

So, I think we're up to Christie if she wants to speak or not. No pressure. Yolanda. Then it was Eduardo, Traci, Susannah. And Emilio was before them so we'll get him before then. And then David. Wow. Hmm. Wait a minute.

If Christie wants to speak. Then Yolanda who hasn't spoken for like 15 minutes. And then maybe we should first show people that slide so we can get that as a topic of discussion also.

So Yolanda, you can comment.

MEMBER OGBOLU: I basically wanted to go back to the orientation meeting, in the orientation meeting. Because I think part of what's sparking this conversation is following up

on the orientation meeting where there was a discussion of disparities and coming to some consensus for this group how we wanted to define disparities.

I know for me within part of that conversation we mentioned a WHO kind of model which focuses on health equity which I think is what Jose is saying on the phone.

Medical care is only such a small component of that. And so it's so important to include how when you think about other things in that model that might not be captured so far in the conversation are issues related to culture and cultural differences.

I agree with folks when we think about the way we want to examine disparities. We need to think about all areas of social stratification - race, ethnicity, age, gender, geographic location. You know, somebody brought up the rural areas.

And so I think that's really going to call for multilevel measures. And so we need to

think about making sure we capture things at the system level which he's talking about as well as at the community level and the individual level.

And then when we think about policy levers, in terms of what Ron was bringing up and Emilio about the social determinants of health because it's so necessary to think about that. We have to think about policy levers very broadly because we could be focusing on policy around education, or transportation, or housing. And all of those things are very important as we move forward.

But all in all what I'm hearing is that I think as a group and basically reading the minutes from that meeting it looked like there was no final consensus in terms of what definition of disparities was going to be used by us as a group moving forward.

I know so many committees do spend so much time thinking about this, but it is important that we're all on the same page.

CO-CHAIR CHIN: That's a nice summary,

Yolanda. I think you captured some of the tensions of the discussion so far of this balance between us wanting to be encompassing and addressing the important factors, yet at the same time sort of combines Lisa and Jose's initial points as somebody said, I think your comment, Lisa, was like, well in our particular setting, in the particular charge we have, what's the thing that we can uniquely do that's going to make a difference.

And Jose's point about just being careful, it's almost sort of the same thing, of like with the limited resource, with the limited leverage we have where do we best put it.

And I think when we come to some of the other topics over the course of the day. Like there's going to be one on who are the different stakeholders and the different levers that we have, it'll start coming together more.

But I think your description nicely outlined the fundamental tensions that we're dealing with over the course of the day.

MEMBER ESCARCE: Marshall, if you

still have a queue could you put me in it again just one more time?

CO-CHAIR CHIN: Sure.

MEMBER ESCARCE: If you have one. I don't know if we're continuing the queue or not.

CO-CHAIR CHIN: It's a long queue, but don't worry, guys. We have a whole day to talk about this particular topic.

Before we go back into the queue Erin was going to go over the other thing we were supposed to cover in the hour which was a list of these draft dimensions for committee consideration, some of which we've talked about, but others just to get on the table so that it may influence some of the comments people make.

MS. O'ROURKE: So, this slide shows you the dimensions that we've currently included in the draft roadmap. So goal, guiding principles, the committee's vision for a desired future state, outlining the stakeholders and their actions and responsibilities and roles. Also a time-line for trying to move things forward. Opportunities and

challenges to operationalizing the plan, and the path for moving from the current state to the committee's desired future state.

However, some themes have already started percolating up in the conversation about the goal for some other areas that need to be addressed in the roadmap.

The role of the committee. Definitions in particular around disparities, equity, et cetera, building on what Yolanda was just saying.

Identifying some of these causal pathways that lead to disparities. More of an explanation of the current state of measurement and associated policy as it relates to disparities. Outlining key questions and considerations as well as key action steps and deliverables.

Resources for the field. I believe we already mentioned that. And then an ongoing monitoring of the roadmap.

CO-CHAIR CHIN: This has been such a great expansive discussion that we've touched on

a fair amount of these things. So it's great that it's coming up.

Let's go back to the queue. So, I think it was going to be Traci, Susannah, Emilio. Yes, Emilio was in there. Eduardo, David, Jose, Mara. So, Traci.

MEMBER FERGUSON: Okay. I think that when I'm thinking about the goal, and one of the things that when I was answering the survey questions is wondering what's going to be the outcome or the end product of this committee. And how will our work, our roadmap live on beyond this committee.

And how, you know, whether you're in a larger system or you're in a smaller community in terms of the grassroots, how is this going to impact and how are they going to use that to help identify even new disparities that come up that we're addressing those that we know of.

But say 5 or 10 years from now there will be more disparities. So, looking at how we can create sort of the roadmap that's going to be

present state, but also be useful in the future state so that it will be something that lives on, and could live on through the policies that we help to develop with our federal and legislative bodies.

It could be with a regulatory body. So I think in my mind I would like to see that we have a way to have our sort of the bases, but be able to influence so much and have a greater impact.

CO-CHAIR CHIN: Thanks, Traci. So I think it was Susannah, Emilio, Eduardo, David, Jose, Mara.

MEMBER BERNHEIM: Just a thought about how to get at some of the tension in the room around sort of how expansive, too expansive, out of scope.

As I was thinking about this I was thinking about what's the problem we're trying to solve and what are the levers we're using to solve it.

And so it feels to me like there's a lot of strong feeling that the problem we're trying to solve has to be defined expansively.

We don't want to just talk about

healthcare disparities, we want to talk about health disparities.

And we don't want to talk just about race, we want to talk about disabilities and gender and rurality and everything else.

I'm just hearing the committee wanting an expansive problem statement, and that maybe the place to prevent us from trying to sort of solve everything is to narrow somewhat on the levers.

I mean, Eduardo and Sarah and other people have pointed out that healthcare is getting more expansive already. So if we're staying within the realm of measures and healthcare for our levers we've still got a lot of room.

We're thinking about communities and systems and solutions. But that may help us sort of find some balance between trying to do too much without feeling like we're restricting where we are. So, just a thought about that.

CO-CHAIR CHIN: Thank you, Susannah. So, Emilio, Eduardo, David, Jose, Mara.

MEMBER CARRILLO: Thank you. I want

to reflect back on something that Sarah said a couple of cycles ago, we're talking about two dimensions of measures.

We're talking about health, traditional NQF type healthcare measures, CMS measures. And we're talking about health measures that are more linked with the social determinants of health.

I think that there's a third paradigm. I mean, there's another way of categorizing measurements that may bring in some of the accountability for healthcare that may not be there with straight out social determinants.

And that is basically healthcare access barriers. There is a whole literature on healthcare access barriers that are predominantly social determinants. And social and cultural determinants that get in the way of people accessing healthcare.

And healthcare is what brings all the levers, and pushes all the levers, and what CMS is interested in.

So, I mean we've looked at this some years ago. I mean, healthcare access barriers are a good paradigm in terms of thinking about the interaction between the social determinants in actual healthcare.

You have three dimensions. You have financial, payment, people's ability to pay for their healthcare. People's ability to buy their medications.

Secondly you have structural barriers that are intramural, extramural. You have babysitting available, someone to take care of your child. You have transportation capability. Getting to your place of healthcare.

Once you get to the healthcare site, is there signage? Can you use the center? Are you able to get in there with a wheelchair? I mean, what is the access structurally both from your home to the medical site, within the medical site to your doctor's office?

And then thirdly there are cognitive barriers which are just straight out knowledge. I

mean, knowing about what the importance of a pap test. The kinds of things that we don't normally capture with HCAHPS and other kind of measurements.

And also, communication. I mean, more of the cross-cultural communication, the kinds of things that we talk about in cultural competency.

So, there's ways to look at the social determinants as how they impact the healthcare access. Again, understanding that the major impact is in things like the housing and the ability to feed yourself, nutrition, et cetera, that are huge.

But a smaller pie of the social determinants that link directly to healthcare access and that may be then accountable through healthcare access measures.

CO-CHAIR CHIN: Thanks, Emilio, so much. Your comment sort of ties together Susannah's point about thinking about what are the levers that a quality of care organization or framework can use to improve access as well as Philip's. Because you were talking about the

systems, actionable things.

So there's going to be probably a way to put the pieces of the puzzle together. It isn't obvious right now, but I think it's going to be there.

Eduardo.

MEMBER SANCHEZ: I know we keep repeating some themes. Earlier the word "accountability" came up and I think that's a really important one for us.

And I think the mapping of who is accountable, or what is accountable is really important.

And again, I think I'm hearing that we are absolutely moving beyond the walls of the doctor's office and trying to think more broadly than that.

Earlier public health came up and I love those two words when they're strung together.

But I would say that maybe it's not about public health measures as much as it is about population health measures. Because for me public

health measures are the things that public health does to improve or address population health, and in concert with or in collaboration with others, including health systems.

And at the end of the day when we talk about healthcare and health I think that whether explicitly stated or not optimizing health is the desired outcome.

And healthcare, the healthcare piece is the structure, process and intermediary outcomes to get us there.

And if we frame it that way I think we can allow ourselves to think about how we might influence things outside of even the health system.

And I'll give you one concrete example. Very, very, very compelling evidence that indoor smoking laws make a difference.

And so knowing that does one think about an accountability framework that says accountable communities for health ought to have as part of how they might address the issue of tobacco-related disease thinking outside the individual patient

counseling opportunity to maybe address what happens at a community level.

And what import we might give that as we think about our frame to eliminate disparities that might be based on some ideas around impact and what influence a health system might have on changing policy as opposed to just addressing things inside the clinic system.

CO-CHAIR CHIN: Thanks, Eduardo. So we're up to David, Jose, Mara and then we'll go onto our next agenda item.

MEMBER NERENZ: I think this may be a friendly amendment let's say to both Susannah and Eduardo.

When I did hear people talking about health my ears were hearing public health anyway. And whether that's population, public health, that's at least what I was hearing. Now, maybe incorrectly but anyway.

I think that does create some tension that may be irresolvable. I'll be happy to declare myself as generally a fan of the narrower view of

what we measure.

And I suspect that Lisa and I could probably talk to each other for a very long time with great mutual respect and learning, but we probably wouldn't change each other's minds.

And I think there's a way to work through all that. I think Susannah suggested, and Eduardo.

My framing of it would be to say when we have any subsequent discussion about a measure I would like us then to put in that discussion what or who is the accountable entity, and to try to be very clear about that.

If there is indeed such a thing now or in the future as an accountable community, okay, let's name that and say that this measure is really reflecting what that accountable community is doing.

And then it should feed into a measurement program for accountable communities that NQF can identify.

Likewise, if hospitals are going to be

held accountable for certain things we should articulate why it makes sense to have a hospital accountable. What we are asking hospitals to do and why.

So, I think I'm happy to live with the tension of either narrower or wider view as long as in that discussion we always try to name as sharply as we can who or what is the accountable entity and why.

CO-CHAIR CHIN: Thanks, David. So we have Jose, and Mara, and then we have a little break.

MEMBER ESCARCE: Yes, so this conversation has been tremendously helpful to me in thinking more clearly, I think. And hopefully I'll be able to say what I meant all along but didn't say clearly before.

And I'm going to particularly build on what Emilio and David said because I think kind of the same idea.

So, when I think about social factors, or social determinants they can act in a number of

ways, but one of the things they can do is interfere through a number of mechanisms that Emilio talked about, others have talked about, with the ability of people to enjoy the benefits of healthcare, good healthcare, and with the ability of healthcare providers, the healthcare system to deliver that care, and to have the best possible outcomes of the care obtained.

And then, social determinants work on people's health and affect people's health in ways that are completely separate and distinct, and have nothing to do with healthcare.

Now, the line isn't always sharp, of course. But in many cases it's sharp enough that most reasonable people would say yes, this is an example of A and this is an example of B.

I think what we've been talking about is making sure that A, that is that when social factors interfere with the ability of healthcare to be provided and for people to enjoy the benefits of healthcare, that when that's an issue that providers have to be aware of, that providers ought

to try to remedy those, and ought to be incentivized to do that, and ought to be measured to the degree that they do that. I'm totally onboard, totally, you know, it's good, I'm good.

But I guess at the beginning I was interpreting this to mean, the conversation to mean, and of course I'm still not sure, but I think that most people around the table if I try to synthesize the conversation in my mind are not saying that the healthcare system ought to be measured on whether it can address all the extra healthcare pathways through the social determinants of people's health.

So that distinction between social determinants -- I think somebody said, maybe Emilio, or interacting with the ability of the healthcare system to act and people to enjoy the benefits of healthcare.

If people are comfortable with that distinction then they can be on either side of this. And some people might think everything ought to be included.

But I guess just what I would believe is that we often think about that part and not about the part where social determinants actually have on these. So, I'll stop there.

CO-CHAIR CHIN: Jose, I think the committee probably still doesn't have consensus on that.

I don't think I would disagree with the first part about like the degree social determinants of health impacts healthcare. That's part of the charge.

But I heard quite a few people talking about even with direct new payment mechanisms, so for example, Eduardo mentioned the CMS accountable goal, healthy communities came out. Or else in general the global payment, capitated payment and the relative allocation of resources to things like primary care and social determinants of health versus end-stage complications.

I've heard what people said, that's part of it also, the degree to which you incentivize the allocation of resources towards the social

determinants. So I think that's still not clear on the committee what the consensus is there.

MEMBER ESCARCE: Maybe they won't weigh on it, you know?

CO-CHAIR CHIN: What's that, Jose?

MEMBER ESCARCE: Maybe there won't be a consensus. And that's fine.

CO-CHAIR CHIN: Yes, yes. Mara, and then we'll take a break.

MEMBER YOUDELMAN: I'm trying to bring together a bunch of different thoughts.

I guess on the one hand just responding immediately was I don't think there's an either/or. I think it's a continuum.

And that there are some times when the healthcare entity or provider should have some responsibility for what's happening in the community.

If they know that they're discharging someone into a place that's not safe, or that they can't access, or they can't get services, or they can't get the healthy food they need, or whatever

it is.

So I think there's some overlap. And we can't just say it's one or the other. I think it depends. Typical lawyer answer.

I think on a second piece, at least at this stage I would like to see us go wide, go broad, go big, go long, whatever you think it is, and not constrain ourselves.

One, I think we have three years and a lot's going to be changing in three years. And even the last couple of months with the community -- I'm still -- ACH/AHC. Someone will get me to get it right soon.

We are looking broader than healthcare. And so I think that does speak at least right now to health.

And I think if this is, as Helen said, a standing committee and we should be visionary I don't want to see us limit ourselves too early.

And then building on I think what Yolanda and Michelle and Lisa said, I do think we have to go beyond race/ethnicity and make sure we

are looking at lots of different groups.

And so race, ethnicity, language, gender. Yolanda, you had some of these. Sexual orientation, gender identity, disability, age, rural. Also, immigration status. I think I said language.

But I think we have to do that, one, because all those groups are experiencing disparities, but two, I think it was Michelle who said we've got the intersectionality issues. And you can't divorce and say, well, this is because you're African-American and not because you're lesbian, or not because you have a disability.

And so I think the more we as a committee can sort of look at that and be pushing the envelope a little bit, that's important because of the depth and breadth that this committee brings.

And that might mean we need to think also about do we need to have a couple of other people added in because of who's on the committee currently. We might not cover all those populations to the extent we should.

But just also I think it is really important. We're seeing it in the civil rights community. In the Affordable Care Act we have a broad non-discrimination provision.

And it went broad. It didn't say, okay, we're going to protect people with disabilities under Section 504 of the Americans with Disabilities Act. And we're going to protect people on race and ethnicity because we have Title 6. It went broad and it looked at that all-encompassing thing.

I think we're seeing that movement. And so the more we can sort of embrace it and push it forward I think it helps us also have that visionary role and look beyond the one-year or even three-year time frame that some of us might be on the standing committee.

CO-CHAIR CHIN: Thanks very much, Mara. So, a great start. That's basically a little more than an hour that, boy, a lot covered in an hour in terms of the issues. And there's going to very interesting discussions over the next

two or three years.

Let's take a 15-minute break. So we'll restart at 11:20.

(Whereupon, the above-entitled matter went off the record at 11:04 a.m. and resumed at 11:27 a.m.)

CO-CHAIR PONCE: All right, it's close to 11:30. We're about half an hour past our scheduled time to reconvene.

But I just wanted to check if Jose is back and if there's anybody else that has joined us.

MEMBER ESCARCE: Yes, I'm here.

CO-CHAIR PONCE: Great. Is there anybody else on the phone that's joined us?

(No response)

CO-CHAIR PONCE: Oh, okay, so we're only 15 minutes. We're only 15 minutes. I overreached.

So, we have 30 minutes before lunch to get to the guiding principles which I think all of us can agree that we touched a bit on that in the

last discussion.

But in this session we're going to display some of the responses from the survey. It was not a 100 percent response rate, but a good representation.

Well, I don't know if it's a good representation. It's okay coverage. It's definitely as good as some telephone-based population surveys in terms of response rates.

(Laughter)

CO-CHAIR PONCE: So, the item disparities in health and healthcare should be identified and eliminated. Again, strong language. Should be identified and eliminated. And among the respondents there was consensus and agreement.

The second item is the roadmap must be transparent and a disparities standing committee or DSC will be open about its goals and plans.

Now, of course, we haven't at this point defined our goals and plans, but once we do that we would be transparent.

And again, among the respondents there was complete agreement that yes.

The DSC must have accountability and commit to follow-through, progress and monitoring of the roadmap.

An overwhelming agreement. One who dissented. And this is all anonymous so I don't know who was the lone person who said no, but we certainly, for those of you who didn't respond, again, this shows that there is a diversity in your thoughts about accountability and commitment here that we will engage that discussion during this time.

And the last is all stakeholders must be engaged and work to eliminate disparities. Again, it was among the respondents an overwhelming yes. This is a group that wants action to happen and we're there all along the way.

Any comments? Well, maybe even before that, just any comments on these four guiding principles? Lisa.

MEMBER IEZZONI: Marshall had said at

the end of the last session that we would go back to the issue about the populations. And I just don't want to lose that because I think that that helps with our guiding principles too.

CO-CHAIR PONCE: Okay, so noted. In terms of defining which populations --

MEMBER IEZZONI: Yes.

CO-CHAIR PONCE: -- that is under our purview. Okay. Tom.

MEMBER SEQUIST: In that third bullet, who is the DSC accountable to? When you say it must have accountability.

CO-CHAIR PONCE: So, the "who" --

MEMBER SEQUIST: Who or what.

CO-CHAIR PONCE: -- and what's the audience is the audience in terms of stakeholders and policy handle recipients of this roadmap will be discussed more after lunch. Because we have a stakeholder discussion.

But I know just in speaking to some of you during break that that's still fuzzy and you'd like that defined. And I know I will call on Helen

to help with that definition.

But my understanding is that, you know, we're the committee that defines that. So it's our charge to define that. NQF will shape some of that, but it is our charge. David.

MEMBER NERENZ: I think I'm the "No" vote on the last bullet. I just wanted to explain a little bit.

(Laughter)

MEMBER NERENZ: I'm pretty sure I am.

CO-CHAIR PONCE: But you're a respondent, so.

MEMBER NERENZ: And my objection was just to the very inclusive nature of the statement. It sort of doesn't admit of any exceptions.

And I have personally been involved in exceptions where a disparity could be identified, completely eliminated by the action of one accountable entity with multiple stakeholders having nothing to do with it. So that was really my concern.

Basically, if you take it in a certain

direction it says to ever make progress on any disparity anywhere you need multiple stakeholders around the table. I just don't believe that to be true. So it depends on how you take the words.

CO-CHAIR PONCE: Yes, noted. Some of you already raised this issue, the term "accountability." Any other issues with the way these guiding principles are phrased? Lisa.

MEMBER COOPER: I just want to reiterate what I heard David say, is that I think, you know, saying something like all stakeholders must be engaged is a bit black and white thinking.

And I think maybe saying something more like eliminating disparities requires a broad, multi-level group of stakeholders from a broad cross-section of society or something like that, rather than all stakeholders.

CO-CHAIR PONCE: Okay. Thank you. Tom.

MEMBER SEQUIST: Just on that point, I just want to make sure I'm clear.

I agree with you that if there are 400

measures that you're looking at and you're looking at disparities you could identify 1 where everyone doesn't need to be involved.

But this struck me as a more general statement that the area of disparities requires everyone to be engaged and committed to it.

If it said everyone must be working on eliminating disparities in pap smears then I would say no. Well, if you don't do pap smears, or you have nothing to do with ambulatory care I'm not sure why you should be engaged or committed.

But this is just sort of a general conceptual statement.

MEMBER NERENZ: Yes, I understood that to be the case and I just was sort of making a point with my "no" vote.

But I guess it is important because there's some maybe missing words here that we eliminated some disparities? Eliminate all disparities? What are we talking about here?

Again, the exceptions exist. You can point to places where a specific identified

disparity has been made to disappear by the actions of one entity. So a disparity has been eliminated without stakeholders.

And Tom, I understand the spirit of it, but I'm by nature a contrarian sort of person.

CO-CHAIR PONCE: Okay, noted. My take on the last statement and all stakeholders was more of an inclusivity type of statement to make sure that we're as a group, and that's why we're a diverse group, want to make sure that who you represent, or perhaps those who are not at the table, that we think about who these stakeholders would be. So I thought of it as more of an inclusivity statement. Traci.

MEMBER FERGUSON: I think that, going onto Lisa's point, that we can have the discussion within the group and we have some clarifying language around it.

But when we're writing this and taking it and other people are looking at it, whether they're federal or state, you know, legislative, that they might take that as all. So we may need

to be a little bit more clarifying.

Because we can explain it within the group, but with others, we have to I think be clear in what we're stating so that we can eliminate the ambiguity in the statement.

CO-CHAIR PONCE: Yes, yes. And Lisa has already provided the alternative language of eliminating disparities must include a broad set of stakeholders.

Okay, thanks. Next slide, please. Oh, sorry. Christie, sorry.

MEMBER TEIGLAND: So, I'm the economist in the group and a very concrete thinker. Not as much high-level policy as you all may be.

I wanted to ground us into sort of the smart goal concept. It's if you can't measure it, you can't improve it, you can't change it.

I'm not a fan of committees that have a lot of great ideas and do these big huge reports and then they go on the shelf and I don't see any concrete things happening.

So, specific, right? Measurable. A,

there are three A's - achievable, actionable, action-oriented. Realistic? We could probably argue about that. But certainly timely.

We need to see some progress. Let's not just blah blah, right? We need some smart goals, measurable goals from my perspective.

And you know, don't shoot me because I'm the economist.

CO-CHAIR PONCE: Christie, I think Jose is also an economist and I'm a health economist.

So, but that comment is a good segue to the next slide. Oh, Romana, sorry.

MEMBER HASNAIN-WYNIA: So, I just want to say that I completely agree with that.

What I really like, I think it was Susannah, Susannah's framing around identifying or defining the problem, the scope broadly, but then articulating what our goals are in terms of addressing components of the larger problem.

Because I don't think we can address everything. So I completely agree with that

statement and I really liked, Susannah, how you framed kind of the way to come about it, come about how this committee would work.

CO-CHAIR PONCE: I was going to call on Susannah if she wanted to rephrase.

All right, so the roadmap should be data-driven. So we're getting more concrete in terms of the guiding principles. I'm sorry, Mara, you were up. Oh, okay.

Success depends on if recommendations have intended effects. Again, what Christie was appealing to.

Regarding the third point, NQF must also be accountable but not just to us. The initiatives to eliminate disparities in healthcare quality should be based on the clearest possible understanding of underlying causes of those disparities -- so, conceptual frameworks matter here -- and a clear understanding of which actors are best able to modify those causal factors.

So, this guiding principle helps us think about conceptual frameworks, but makes sure

that there's some policy handles here.

Recommendations must be feasible to implement within the current system. Again, this appeal of feasibility.

And that this is a blueprint, not just a set of action steps. But I've also heard during the break let's make sure it's not a huge document that it becomes impossible to wade through.

So, any comments on these guiding principles? Eduardo.

MEMBER SANCHEZ: Given the conversation that we had earlier I would express some concern about the language in the penultimate bullet-point about within the current system.

Because that system is evolving and we really need to be thinking with Wayne Gretsky in mind to where the puck is going to be, not where it is.

CO-CHAIR PONCE: Okay, Mara and then Lisa. Okay, Lisa. I'm sorry, Lisa Cooper and then.

MEMBER COOPER: Yes, I know, there's

this Lisa thing going on here today.

So, I love the points they just made, but mine is going to sound like I'm sort of backpedaling a little bit.

Because while I like the idea of being visionary in our recommendations, I also like the idea of building in flexibility because I know that systems are going to differ in the degree to which they will be able to execute a lot of the things we're recommending.

So I think we ought to consider building in flexibility, or having like a range of things that we would expect health systems, stakeholders to be able to do.

CO-CHAIR PONCE: Lisa Iezzoni, then Bob and Michelle.

MEMBER IEZZONI: There's my little hobbyhorse that I'm on that we aren't going to always have data about some subpopulations like LGBTQ populations, people with disabilities.

And I think that our committee should be a forum for kind of highlighting that we need

to systematically collect data on some of these individuals.

But I also wanted to make a finer point that I'm not sure I'm going to make very well. And so I hope that people will bear with me on this.

If people get different care that doesn't necessarily mean that it's worse. And we need to have scientific evidence to show that that care that they're not getting is, in fact, an indicator that they are getting worse care.

And we do not have good scientific evidence about a lot of care in our healthcare system.

And there are some subpopulations, like people with disabilities, who are routinely excluded up front from every single randomized controlled trial because of concerns that they're going to confound the results.

And so, for example, a number of years ago I did a study on early stage breast cancer survivors who had physical disabilities when they developed their breast cancer.

And these women talked to me, to a woman, about how they could not decide what treatment to get because there was no scientific evidence because people like them had been routinely excluded from all the clinical trials to develop the scientific evidence.

And so I think the broader point is the point that difference doesn't necessarily mean worse all the time. Certainly it does sometimes, but not all the time.

And I think that we just need to try to figure out how we're going to deal with that one.

CO-CHAIR PONCE: Thank you. Bob?

MEMBER RAUNER: Kind of following up on some other comments. But you know, if you just drop the "within current system."

I do think it's really important that we avoid what I sometimes call the problem of the policy wonk where it's nice in theory, but really not feasible to implement, and especially not feasible to implement outside of a large dominant health system.

So like, the CMMI's current grant on accountable health communities. Great grant, but it's frankly, if you read through it, the only people who can really do it in people in large dominant health systems, and everybody else is pretty much excluded from being able to do because of the size requirements and the reporting requirements.

You know, Lincoln and Omaha, Nebraska, aren't even big enough to do it so Nebraska is pretty much out of the whole program.

So we need to make sure that what we're pointing out there, one, is feasible to implement by those of us who actually implement these kinds of things. And also make sure that these things are available outside of, you know, New York City or Geisinger.

CO-CHAIR PONCE: Thank you. Michelle?

MEMBER CABRERA: I think just building on what others have been saying, it seems to me that we're so far behind in terms of capturing the data

adequately and analyzing the data that an end of sorts is the identification of what kinds of disparities exist, even before you get to the conversations about why and what to do about them.

So, I do think that within the recommendations that needs to be captured.

On the bullet number three where it talks about a clear understanding of which actors are best able to modify those causal factors I think a couple of times today we've talked about not letting folks off the hook.

Whether it's letting, you know, the larger conversation off the hook for what are very real social determinants, really population health-related issues, but conversely not letting health systems off the hook for things that may very well be within their control or ability to change.

And again, I think a lot of it goes back to the identification of there's a problem here.

And on the issue that Lisa raised about different care is not worse, I wholeheartedly agree.

I think for me a lot of it got captured in the background materials when we talked about health equity versus equality, right?

And it's this notion that we shouldn't be striving to build a health system that is the same for everyone. Same payment, same programs, same indicators, same everything, but actually different populations have very different needs and barriers to accessing care.

And that we have to account for those, build in policies, payments and also measurement that values those differences and accounts for them.

CO-CHAIR PONCE: Thank you. Yolanda?

MEMBER OGBOLU: I was looking at bullet point one and the comment that followed that the roadmap should be data-driven.

It says success depends on whether the recommendations have intended effects.

And I also thought it would be important for us to think about unintended consequences. And I didn't see where that was represented here.

CO-CHAIR PONCE: Great. That's noted. The next slide was what did we miss and is there anything that you object to in these principles. Philip?

MEMBER ALBERTI: Just to tie in some comments that have been made both in this round and in some chat during the break.

Thinking about the different populations that we might target in terms of vulnerable populations and the kinds of recommendations we make, I think there's a real tension that we should acknowledge between standardization and generalizability, particularly in terms of the recommendations and action steps that might work in some populations, might not work in other populations. Just being overt about that.

We want to make sure that there's, you know, standard comparable data. But at the same time, if we are also in the business and if our charge includes developing implementation strategies or something to intervene that we need

to think about issues of external validity as well.

CO-CHAIR PONCE: Thank you. I have an issue with the first one in terms of being data-driven.

And I don't know if it's a guiding principle or part of the goal is, you know, if because data is imperfect and missing in many cases then shouldn't a guiding principle be to help with policies and to promote the collection of data? I mean, that's kind of more of a goal.

Let's go to the next slide in case this could be -- I think we've covered some of this, but just to, again, put this out for discussion. If there are any additional guiding principles.

Let's go back then to Lisa's point. Populations that -- Lisa Iezzoni's point. Sorry. On the populations that are going to be part of this roadmap.

MEMBER IEZZONI: We were just talking during the breka about how AHRQ defines its priority populations. And if you look at them you've basically got everybody.

And so I think that, you know, obviously I want my priority population included. But I think we should just have a conversation about are there people who we shouldn't include among AHRQ's list. You know, if you want to start there.

CO-CHAIR PONCE: Okay. So, do we have that slide from AHRQ's list? We had it in our orientation slides, but in addition to race, ethnicity and socioeconomic status. There was rural, disability, LGBTQ. Am I missing?

MEMBER IEZZONI: There were women, there were children, there were old people. So, basically you've got everybody.

DR. BURSTIN: I've got it. Yes, it's children, chronic care, disabilities, elderly, end of life care, inner-city, low-income, minority, rural and women.

Again, having been at AHRQ when a lot of this was started the idea was more that these were the priority populations we should ensure there was research around.

So that isn't necessarily the same

lens. So I think just something for us to consider.

MEMBER IEZZONI: No, absolutely. I just thought it was a good starting point.

CO-CHAIR PONCE: Eduardo just asked if immigrant was part of that. And no. Tom?

MEMBER SEQUIST: Just so I understand, is the idea we want to detail a list of every population that this committee is interested in looking at?

Because that seems problematic. Like it seems like that -- we'll never get that list correct.

CO-CHAIR PONCE: Lisa Iezzoni.

MEMBER IEZZONI: I think we just want to make clear, Tom, and again, I'm going to very awkward and I apologize if I offend anybody here. But we have to make clear it extends beyond race and ethnicity.

MEMBER SEQUIST: Oh, I'm definitely in support of what you're saying. But I'm just trying to figure out -- so I'm 100 percent in agreement

with that.

I was just trying to figure out is the goal of what we're doing right now that we're trying to add to the goals and objectives statement every population, or that we're trying to actually specifically list out every population?

CO-CHAIR PONCE: I think the goal, this is the guiding principles. This is our kind of groupthink moving forward that we have some agreement.

And I think what Lisa Iezzoni was pointing out again is if everybody is thinking this is about race and ethnic disparities that that may not be the groupthink.

And so I think that that's what we're trying to get at. Romana?

MEMBER HASNAIN-WYNIA: So, this is something that we really struggled with with the addressing disparities program at PCORI.

It was a program targeting disparities. So, part of the challenge was at PCORI we also have a priorities population list which is pretty

inclusive like AHRQ's.

But then it really begged the question of then why the addressing disparities program if all the other programs and, you know, it's all-encompassing.

So, we ended up having a much broader lens than just race and ethnicity. We included rural, LGBTQ, individuals with disabilities and SES.

But part of our rationale was the recognition that these were populations where we knew there were disparities.

And these are not mutually exclusive. So, if you think about gender, somebody submits a proposal to us focusing on women.

We would like there to be some focus on what we target as the disparities population. So, women with disabilities, or from Hispanic backgrounds, or whatnot.

So anyway, my point being that I do think that if we cast the net very broadly we kind of lose the lens of what do we mean by disparities,

you know, populations that are at risk for experiencing disparities because that could include everybody. So there has to be some kind of a focal point.

I totally agree that it needs to be broader than race and ethnicity. And I think that there are a couple of immigrant populations, language, that we can definitely bring into the mix because we know there's strong evidence for disparities in these populations.

But I would vote for expanding it, but still having a defined population that we're addressing.

CO-CHAIR PONCE: Okay. That's really helpful. Mara and is Lisa, is that up? Okay, so we'll do Mara, Lisa, Michelle and then Yolanda.

MEMBER YOUDELMAN: So I agree, I think we need some definition and some scope. It doesn't necessarily to me have to be in the singular goal statement which would say we're addressing health and healthcare disparities at this point, or something like that.

But whether it's a principle or somewhere else we have to define what disparities means for this committee. Sort of what Yolanda just said about PCORI.

So, I do think at least for me the way I'm thinking it's race, ethnicity and language. It's disability. It's immigration. And then whether you want to say LGBTQ, or define it as sexual orientation, gender identity, something like that, I think that's the broad. And then as Bob brought up, the rural issue.

So, maybe we just need to parse through to some degree each of those and figure out if it's in or out, or if we can get to consensus.

But I do think there has to be some scope so that someone reading it who might normally think, oh, we're talking about racial disparities knows that for this group it actually was much broader than that.

CO-CHAIR PONCE: Okay, thank you. Michelle? Oh, I'm sorry. Lisa Cooper.

MEMBER COOPER: I also, I agree with

what's been said. And though I also think that there could be certain parts of the country, or certain communities for which there might be groups experiencing disparities that we haven't actually identified. Or they might not be in this list.

So, I think while we do need to be inclusive, and we do need to have a defined scope, we ought to allow for the fact that within certain settings that there might be other populations that would be of concern for the delivery system to explore to what extent that population is experiencing disparities in health or healthcare.

And then to actually use a similar framework to address that.

CO-CHAIR PONCE: Okay, thank you. Michelle and then Kevin.

MEMBER CABRERA: I can't remember, I think it might have been the Commission paper that we got in the background materials, but one of the documents talked about a framework for measurement that related to the population which had been historically advantaged, or something along those

lines.

And I think putting in place, and you know, kind of building off of this conversation, a framework that kind of builds off of that might be useful.

And I don't know because I'm literally brainstorming this, but you know, I am lesbian and I've got to tell you, the young folk in the queer movement challenge me all the time in terms of my understanding of how they are defining themselves, and how they categorize themselves, et cetera. And I'm always like I've got some learning to do.

So I just think that not only are there groups that we may be missing or not thinking of, but our understanding of these social constructs is also evolving.

And we will soon be outdated -- well, we already are, in the way that we're discussing this stuff and thinking about it.

And so for this to be a document that has relevance to the populations that we're trying to deal with and across time I think putting in

place a framework will be useful.

It will also be useful so that folks don't misunderstand the purpose of this which, you know, they could say oh, well, here's a disparity that affects, you know, a historically advantaged group. And then try to latch onto that.

CO-CHAIR PONCE: Great, thank you. Kevin.

MEMBER FISCELLA: I'm just going to raise the issue of those who are detained and incarcerated and the healthcare that they receive.

Because I think they are very much a neglected population in talking about healthcare disparities in part because the systems for oversight are quite different.

But I think that this is actually an opportune time to begin thinking differently about this group because many are reentering the community. There's opportunities for ACOs to provide more integrated care.

There's also the opioid epidemic now which is having enormous population-level effects.

But with a number of people being incarcerated as a result but not getting much treatment either behind bars or even within the community corrections programs.

So I think that this is -- and of course, those who are incarcerated do fit into many of the other priority groups. Obviously low-income, largely minority, low health literacy, et cetera.

So, I would like to put that out there just because I think that when we think about healthcare disparities we often think about mainstream institutions and not jails, prisons and juvenile detention facilities.

CO-CHAIR PONCE: Thank you. Lisa?

MEMBER COOPER: I'm sorry, this is very brief. But I just thought about the disparities that people with severe mental illness face. And so again, that's another population that gets left out of a lot of the conversations around disparities.

MEMBER IEZZONI: We listed --

MEMBER COOPER: So, they would be

included in that group? Okay.

CO-CHAIR PONCE: So Jose -- Lisa Cooper mentioned disparities of severe mental illness. And Lisa Iezzoni said that's part of the disabilities group.

Jose, are there any additional guiding principles that would be added, or are there any other populations that we may have overlooked in this discussion?

MEMBER ESCARCE: Are you asking me specifically?

CO-CHAIR PONCE: I'm just giving you a chance since you're on the phone. Since you said you were --

MEMBER ESCARCE: Yes, I'm here. Yes, yes. Sorry. No, I don't think I have anything to add to the discussion. Thank you for asking.

CO-CHAIR PONCE: I'm going to dare to suggest an approach. Oh, I won't do that yet. We have Philip. Philip, go ahead.

MEMBER ALBERTI: Just one quick thing. I think -- it seems like there's a lot of agreement

in terms of a broader definition of the populations with which we're concerned.

I'm a little hesitant though to suggest that we formally enumerate every single group that might be the only groups included.

So, I know there's some language I think the IOM uses, WHO uses in their definition of inequity and disparities that really focuses on differences between groups defined by levels of social advantage and disadvantage.

So I wonder if we want to make it clear that we're thinking about groups beyond racial and ethnic minorities.

We might give a for an example with some other groups listed, but then have some statement that allows for, just as the healthcare system evolves, differences in social advantage might change over time as well. We want to make sure that our framework is able to capture new groups that emerge going forward. So, thinking about some statement about differences by social advantage, disadvantage, et cetera.

CO-CHAIR PONCE: Well said. That was what I was going to dare to say, so well said, Philip. Thank you. Nancy.

MEMBER GARRETT: So, I wanted to suggest a term that we use a lot in our work at HCMC which is vulnerable populations.

That term kind of describes a lot of the people that we work with every day and a lot of the populations.

And I was just looking up the accountable health communities grant application RFP that's out right now. And they actually use that vulnerable populations term and then they define it.

So they say vulnerable populations include community-dwelling beneficiaries who have suffered from health or healthcare disparities as defined by race or ethnicity, religion, socioeconomic status, gender, age, mental health, disability status, sexual orientation, gender identity, and/or geographic location.

And on Lisa's point of not inventing

everything anew I wonder if that might be something we could build on as a starting point because I think it encompasses most of what people have brought up already today.

CO-CHAIR PONCE: Thoughts on that? Emilio.

MEMBER CARRILLO: Yes, I just want to reference back to Michelle's point.

The NQF 2011 Commission paper basically says that whereas some organizations consider any difference in quality to be evidence of a disparity, in this report we believe that for purposes of achieving equity in healthcare that is fair and just the choice of the reference group should always be the historically advantaged group.

And I think we should have that kind of language and leave it open for groups.

I mean, we may have an influx of Syrian refugees next year and they become a hugely traumatized and underserved group. So, it's constantly changing.

I think that in our report we should certainly point to those that we recognize, the disparities in disability, et cetera, but that we should leave it open because the nature of disparities changes every year.

CO-CHAIR PONCE: Right. There might be undiscovered vulnerabilities. Lisa Iezzoni.

MEMBER IEZZONI: Okay, this is me going back to being really, really old.

Do some of you clinicians around the table remember Eric Peterson's article in JAMA about cardiac surgery?

And he showed that white men had higher rates of cardiac surgery than black men, but they also died more. And the reason probably was that they were getting too much cardiac surgery.

And so it goes back to my point that we need to define what we mean by difference. And difference is not always better or worse.

You know, we have to be very clear that what we're looking at is care that's different in terms of its likelihood of improving health.

CO-CHAIR PONCE: Okay. So, Lisa Iezzoni's point is back to definition of what a disparity is. And that certainly should be part of our guiding principles.

The IOM has a definition that a difference is not a disparity because if an allowable factor such as need and preferences, for example. If you take away needs and preferences and it's about how the health system treats that person, if that's the cause adjusting for needs and preferences then that would be a disparity versus a difference.

So, I think we can bring in some of those. I know not everyone is a fan of the IOM definition, but there are some working definitions where we do define more what a disparity is versus what a difference is.

I've lost -- I'm going to go this way. Mara.

MEMBER YOUDELMAN: I agree we don't want an exhaustive list for the same reason we didn't want a principle saying we're going to solve

things within the current system. But I do think a minimum would be to have examples.

And I think in part it's because of who's going to read the report, or the roadmap, which also speaks to another issue which I hope we can discuss at some point which is who's the audience.

Because that helps sort of figure out how we're framing this, and how we're looking at some of the definitions, and what language is going to be used.

So, I do think we need to have some sort of an example list I guess that maybe is not exhaustive, but at least shows very clearly we are talking beyond race/ethnicity, and we're including disability, and we're including LGBTQ, or whatever the other groups are.

I'm a little concerned about vulnerable populations. I'm not saying you were suggesting necessarily adopt it, but I think some people who are experiencing disparities don't think of themselves as vulnerable populations, but are

experiencing disparities.

And so again it's the nuance of the language, and again who's going to be reading the report, and who's going to be looking at it and trying to do something with the roadmap.

So, just a bunch of different thoughts, but I wanted to get them out there.

CO-CHAIR PONCE: Great, thanks, Mara. Bob and Ron. And Lisa, sorry. See, Lisa you're -- yes, thank you. Bob, Ron, then Lisa.

MEMBER RAUNER: So, kind of going back, I've been sitting back thinking how on Earth are you guys going to try and synthesize all this.

And I actually like Mara's example of here's the broad principle. We think, for example, disparities should be taken into account as opposed to past ideas.

But then you probably are going to have to use specific examples because there's so much variation in the layers of both what you're measuring and at different steps along the way.

So for example, if you're looking from

the perspective of a federally qualified health center, if they're in a high-Hispanic area they're going to have higher burden of type 2 diabetes more likely.

Is it their fault? No, but it is going to affect everything downstream.

But the FQHC can do good things as far as process measures. They can have every bit as good of success with measurement of A1c and vaccination. So that's something in their control. They should be accountable for that.

Then you move to outcome. They can impact an income a little bit because they can control those processes and do better. But they still have that higher disease prevalence to go with.

And that's where you're seeing these ACOs, for example, where you are going to get the FQHCs being dinged and losing money because where they're accountable depends on where you're looking at, population health versus process versus outcome.

And because of all these unique factors you're going to see it's going to be hard for us to make really blanket statements on a lot of things. But using specific examples may be a way to do it.

And I think part of the timeliness is everybody's just started running into this now. If you're part of value-based purchasing it's so important right now because it's your sustainability and funding for next year is being impacted by it. So it's really urgent to get this figured out.

But on the other side the research is so incomplete. And if you read the IOM report when you get to the social risk factors section I felt like I was reading the same section over and over and over again.

It kept saying half the studies say this makes a difference, and half the studies say it doesn't make a difference. And everyone, every conclusion is written almost the exactly same way. It may influence, and that's about it.

And I think it's because the research is at such a midpoint right now. And a couple of examples, Christie and I were talking about this last night, because a lot of the SES measures are not -- the data sets are not complete enough.

And there's also sometimes differential effects. So, like our school stuff that I work on, gender disparities on child obesity are not that big, but if you look at individual ethnicities they're big and they go in opposite directions.

So if you just say white/non-white you might not see anything, but if you see Hispanic versus multiracial versus -- you're going to see diverging effects which makes things complicated.

There's such contextual issues where if you looked at Omaha versus Lincoln, Omaha is such a segregated community where you've got schools that are almost virtually 100 percent African-American whereas Lincoln, it's just more socioeconomic and so that's a big melting pot. You're going to see very different effects.

And the third thing we run into is people are often imputing measures too broadly, like on a zip code level we're using a proxy for education.

But if you look at the zip code within that zip code, and Christie could raise some issues there, that that's really inappropriate for a lot of these things. And so, some studies are inappropriately imputing things.

And so the problem is the research base, unfortunately this is really needed right now, but the research base just isn't there yet for a lot of things.

CO-CHAIR PONCE: Thanks, Bob, for being upbeat.

(Laughter)

MEMBER RAUNER: The gloom and doom guy on the committee.

CO-CHAIR PONCE: Ron and then Lisa.

MEMBER COPELAND: Well, I'll probably add to the doom and gloom.

But I mean, I think one of our

principles that was identified earlier was this notion of feasibility.

And I think when we talk about the categories of disparities, so the populations, clearly I'm a strong advocate for being as inclusive as possible in that.

But I think at the same time from the feasibility standpoint if we ask ourselves who is the primary recipient or stakeholder of the recommendations we ultimately make, and as I understand it, and so I'm asking for clarity here, if CMS and the payment folks are a big stakeholder in this outcome to inform how that's done.

We all know the categories that the federal government uses for rolling groups up as risk categories. It has no granularity to it whatsoever.

And so for clinical practices we ask our patients to identify at very granular levels that are relevant to them. And then we roll it up to report because one customer wants to see the data cut in these broad categories.

So I think in that reality from a policy standpoint, how is that informing our recommendations that will then enable a broader, more inclusive approach to identifying these disparities.

And then the second is the issue that was brought up around where the research is, but also frankly where the data collection capabilities are.

Because if you go all the way back to the IOM's report about unequal treatment, one of the clear barriers they identified is nobody is collecting demographic data to then take all of our performance data and stratify it to see where the things fall out.

And I'm not sure where the country is today on that same issue in terms of oh, we're a lot further along now. We're all collecting data. Or a bunch of folks are collecting data.

So, no matter what categories you come up with if you can't stratify the data how are you going to measure whether that actually is being

accomplished or not.

So, my point is however we think about this notion of feasibility I don't want that feasibility to say the current state is so poor that we can only do these categories.

But if we're going to make the case for a broader, inclusive set of categories we have to do that from a feasibility standpoint with some recommendations or suggestions about how the research, the data collection and the way CMS currently categorizes populations, how they catch up to be able to use this data.

CO-CHAIR PONCE: Great, thank you. I want to be mindful of the time. We're 15 minutes over. So, unfortunately Susannah, I'm going to give Lisa the last word and we can try to bring your comment up in the ensuing conversations. Lisa.

MEMBER COOPER: My word is going to be brief.

So, I just wanted to go back to the idea that Lisa Iezzoni raised about differences not necessarily all being bad.

So I just want to make sure that we incorporate within our language that some disparities can actually be when -- can be hyper disparities, for example, when the historically disadvantaged group is actually getting more of something which is not good. So, for example, c-sections or diabetic amputations.

Or, as Lisa indicated, it could be that they're getting less of something, but they shouldn't be getting it anyway.

And then the other thing I wanted to just comment on briefly is I also like the idea of using terminology that is not sort of negative, or implying that somehow people are responsible for the state that they're in.

So, I don't have the answer to that. I don't know whether "at-risk populations" also sounds just as, you know, value-laden as "vulnerable populations," but I like the idea of trying to frame the groups in a way that it doesn't sound like we're blaming those groups for being in the situation they're in.

CO-CHAIR PONCE: Thank you, that's a fine guiding principle.

All right. We're onto lunch, I believe.

CO-CHAIR CHIN: We're onto describe the desired future state for measurement and associated policy levers. We still have half an hour to go, guys.

CO-CHAIR PONCE: Oh, sorry about that.

CO-CHAIR CHIN: But I think it's actually an important discussion. What we're going to do with this one is that Erin's going to go over some of the themes from the surveys and some of the issues.

But what I'd like us to focus on is starting to get a little more targeted now, particularly with what Mara said about who is our main target audience.

And then the associated policy lever, that's sort of -- it's an issue also. We'll have time in the afternoon to flesh this out some, but I think now is the time to start narrowing a little

bit to like you know, get who is our user audience and then what are the specific policy measures that we have in mind.

So, Erin, do you want to go through then those slides?

MS. O'ROURKE: Absolutely. So, we tried to break out the future state into a couple of different levers that the group could use to eliminate disparities.

So, the role of measurement could be to identify disparities, determine action and track progress, promote awareness, create a culture of quality improvement, and recognize that disparities elimination is a key quality issue, not a sidelined issue as you were talking about this morning.

Incentivize providers and payers to work to eliminate disparities. Measurement should not contribute to either maintaining or worsening disparities.

And we could also explore innovative measurement that could lessen or eliminate

disparities. Next slide.

So, some thoughts the group had about how payment policy could reduce disparities.

Recognize that healthcare costs are an increasing driver of disparities. Incentivize the elimination of disparities and reward interventions that reduce them. Help to promote value and equity. And reflect that different increased need of care that certain populations may face. Next slide.

So, how we can start to envision equity and value better integrated into measurement and policy. Establish a national goal to eliminate disparities. Influence laws, regulations and resource allocation. And create accountability for disparities.

I think an overarching theme that we've heard from this morning is trying to identify at each level a group that's responsible and how we can measure and track progress. Next slide.

So, I think with that I can turn it back to Marshall for discussion.

CO-CHAIR CHIN: Right. So, I'm just going to modify the four questions here.

I guess I'll actually start with -- now, based upon the discussion we've had so far this morning who is our target audience? Who is our main target audience?

That may be multiple, but the danger is sort of what Lisa and maybe Jose said at the beginning about it's being a little too diffuse.

So, what is the priority target audience? This is actually going to have an effect on the discussion about what are the associated policy levers and the issues on this particular slide. So, who is our primary audience here?

DR. BURSTIN: Maybe I'll start since there aren't any cards up for a change.

First, and going back to Ron's part, without question one of the primary audiences here are those who are setting policy.

And I think in the broadest sense, you know, not to put Cara on the spot but certainly CMS has a strong role here.

The payers have a very strong role here. Congress. State legislatures. But frankly, also health systems who are looking for guidance as to what they should be doing.

So, I don't want us to think -- levers aren't always just about measurement or payment. The question is really are there some principles, is there something in this roadmap that it would actually be actionable and usable on the ground by those trying to reduce disparities. So, I would keep it, again, pretty open.

But without a doubt I think the policy levers given our current environment that we live in where I think we've probably got the strongest bang for the buck in the shortest term that I want to make sure we get on the table because they've not been on the table so far.

CO-CHAIR CHIN: Part of it too is being explicit about what is the sequence of mechanisms.

So for example, you mentioned like payers, Congress, state legislatures, health systems.

The health systems may be more downstream. So for example, why do they act? Well, partly it's money. So then the impact upon the payers is going to have a big effect on that mechanism as well as some direct effects.

But being explicit about somewhat what is our model here for.

So we've got Michelle, Bob.

MEMBER CABRERA: Yes, I obviously, I think leaving off from my earlier comments strongly agree with the policy as well as payer focuses.

I also think researchers, foundations should be heavily considered.

I just think, I wonder, and this is more a question, whether there are pieces of the framework that are meant to be practical implementation type guideposts. And that will really be different for these different audiences.

So, at the policy level, like I'm very intrigued by the Minnesota legislation on data collection. You know, very interested in how to integrate these things into different

demonstration projects that the federal and state governments are responsible for.

But counties are also units of government that can sometimes do different things.

And so I just think having it be practical, but understanding that what practical means for each of these subsets will be slightly different is important.

Most of all I think for me I just want this to be -- we had a side conversation about how the tables are so sort of different. So, they're sort of -- conversations aren't all happening at the same tables.

And in the case of disparities, sort of like there's a disparities table. And so, I want to figure out how to get this on the menu in some of the conversations and at some of the tables where broader policy discussions around quality and payment are being made.

CO-CHAIR PONCE: Mara?

MEMBER RAUNER: I'd say that I do think there are a lot of people who should be the

audience, but I do think the payers are probably the number one audience because that's the greatest opportunity to do the harm by not paying attention to these things.

Because the way things are set up, the very people delivering care, trying to reverse these disparities are the most likely to get harmed by not considering these payment adjustments. Like the ACO, for example.

If you are an FQHC some of those measures are going to be out of your control, and you are going to get dinged for it, and it is going to cost you money.

For rural healthcare providers the way critical access hospitals get reimbursed and how the Medicare Shared Savings program was set up, it's almost impossible to achieve savings based on the way that measure is calculated.

And so if the payers don't pay attention to this and don't do it right you're I think almost guaranteed to harm the very people who are most trying to reverse the disparities.

CO-CHAIR PONCE: Thanks, Bob. We have Eduardo, then it was -- oh sorry, Mara, Eduardo and then Philip.

MEMBER YOUDELMAN: I think I'm just building on what others have said which is I think that there are different audiences and we have to make sure that we're not trying to write a roadmap, or look at it as sort of one size fits all, and that there are going to have to be differentials.

So that a payer shouldn't have to wait for the policymaker to make this a mandate in order to make changes and improve things.

And likewise, the downstream, the providers shouldn't have to wait until something is paid for. There's different ways you could accomplish the goals of addressing disparities at all levels.

And so, I think that might be a challenge. And so, I don't know if that speaks to trying to delineate more explicitly we're going to hit three but not seven, I don't know.

But I do want to be careful of trying

instead to go the other direction which is roll everything up into sort of a broad recommendation that then no one sees themselves in and doesn't address.

CO-CHAIR PONCE: Thanks, Mara. So, Eduardo and Philip.

MEMBER SANCHEZ: So, some thoughts. It may be our principles and/or just thinking points.

One is I totally agree, different audiences that could be accommodated in an accountability framework and that begins thinking in a systems sort of way. Because while they're different audiences, they are connected.

And completely agree that there's upstream and downstream. And so, somehow, some way we've got to capture that.

And it's not to be all things to all people, but to acknowledge that in the statement "all stakeholders" while it's not explicitly saying every single human being, it is in a way saying -- there's a multiplicity of players and

actors that really need to be acting together in order to optimally get to where we're trying to get.

Having said that then, it seems to me that one broad way. On the public side there's the Health and Human Services agency, federal, state and local.

On the private side there's the health and human services providers. Some are hospital systems, but some are non-governmental organizations that are doing work in this space.

And then the notion of policymakers, payers and funders as may be distinct from that.

And while that sounds like a bunch, that could be captured in a logic framework, or in a diagram that at least is the biggest cut of trying to get to this place.

CO-CHAIR CHIN: A question first before we go onto Philip, Eduardo. So, can you flesh that out in a little more detail?

So, you mentioned like multiple players. They all interact in a system that they're all part of. So, off the top of your head

if you were going to put some meat on the bones for what you might have in mind, what comes to mind with that?

MEMBER SANCHEZ: Well, so one of the things that we've talked about is that -- so, example. Payers.

When we use the word "payers" we are lumping public and private payers. And they're not the same. And they operate under very different kinds of rules of engagement.

And in fact, sometimes on the public side it's easier to work through the policymaker part to make change, but sometimes it's easier to work on the private side to make the business case that sometimes can drive a decision quicker than it would on the policy side.

The other is that we've talked about the interconnectedness, or the desired interconnectedness maybe on the part of some of us between clinical care systems and community systems.

And there are organizations that are

part of -- oh, and public health came up. So when I think of health and human services -- and research came up.

So, when I think of health and human services agencies, there you've got NIH and others. You've got CMS which is a payer. You've got HRSA which delivers the care. You've got the CDC which is responsible for public health.

And you've got a whole bunch of other stuff. You've got SAMHSA and some others.

It begins to capture not only the complexity on the one hand, but the opportunity perhaps to effect change because these things are and can be interconnected.

And in fact, in some ways the governmental model is one that might ought to be better reflected in the non-governmental sector because those systems that I just articulated as supposedly being connected are in no way connected in many communities. That is, public health, and medical care, and FQHCs, and the mental health delivery system.

And I don't know if that helped at all, or if it made things even more muddled.

CO-CHAIR CHIN: That was very helpful, Eduardo.

I think in some ways when we were coming up with this agenda we had a fairly decentralized approach. Well, you know, half an hour on goals, half an hour on the stakeholders, et cetera.

What you have brought up that maybe was implicit but I think we haven't really built in explicitly, it's almost like the implementation science model here. So, the logic of change, or the logic of why these policy levers will have the intended effects spread out, ripple effects across these systems.

But that's something that, you're right, they are sort of interrelated actors that we need to think a little bit about how that --

MEMBER SANCHEZ: And I would also say not only the ripple effect, but unintended consequences came up.

So if you -- I don't want to suggest that

it's about robbing Peter to pay Paul, but sometimes it's certainly characterized that way.

And understanding the connections can at least help us articulate what we hope would be the positive ripple effects, and perhaps think about what might be the unintended negative consequences that we would want to address in advance and mitigate in some way.

CO-CHAIR CHIN: Right. Another thing. A fundamental that Yolanda spoke eloquently about earlier. It's almost like, it's not just the unintended negative consequences, it's whether do you proactively design the system. I mean, Bob's point.

How do you proactively design the system so you get the result you want. Philip.

MEMBER ALBERTI: So, I second and third and fourth the idea of a multilevel framework that really captures some of the upstream policy drivers and payment drivers as well as the downstream actions that systems might take.

And maybe this is off base, but I keep

trying to put these elements into kind of the generation of health equity research framework in terms of how we might go forward.

So you know, first generation, describe the inequity. Second generation, understand why it exists. Third generation, fix it.

So, in terms of this multilevel framework and those three main audiences it makes me think of, you know, that first generation, what should we be measuring? Where are the disparities? That kind of informs some of the metrics that we might develop.

Thinking about why those inequities exist, that really leads into that accountability conversation. What are the causes? Who might have some skin in this game or could be intervened?

And then that third step, the understanding the action that should be taken, that speaks to me in terms of the incentive payments, or the actual interventions on the health system side.

This might be a useful framework to kind

of begin to merge together the different levels we're talking about, the different kinds of accountability, and what we might actually target in terms of the payment structure given who's accountable and what action there's an evidence base for taking.

CO-CHAIR CHIN: Michelle.

MEMBER CABRERA: Somewhat of a non sequitur, but the unintended consequences conversation made me think also that -- and I don't know if this has a place here, but I theorize that there may be beneficial unintended consequences as well.

If the health system focused on the elimination of disparities we might actually make like way faster, better progress on overall quality. Just a thought, you know.

And that the interventions that would be needed to fix some of these things would benefit people beyond the target populations.

And so, I think trying to make that case as well might be useful if we're thinking about

audiences.

CO-CHAIR CHIN: Very good, Michelle. Susannah?

MEMBER BERNHEIM: Two quick things. One, just to follow on both Eduardo and Philip's comments.

I think, and I know it's never easy to do, but that if we could draw something. You know, if we had a figure that really talked about the connectedness of these various levers I think that would help a lot. That might take some time, you know, not today.

And then I'm going to steal this minute to go back to my principles saying which was just, I was hearing people talk about feasibility, and especially in disparities this issue of data. I mean, it plagues me every day.

And so, I'd like to suggest -- that said, I think there's a lot that could be done soon.

So, I'd like to suggest that one of our principles be that we are both prioritizing identifying actions that can be taken in the

current state because I think there's a lot that could be done that's not being done, and focusing on also identifying things that require a greater investment, infrastructure, whatever else. So, I think that should be one of our guiding principles so that we're doing both.

CO-CHAIR CHIN: That's a great point, Susannah. Jose, any points? Philip?

MEMBER ESCARCE: No. I'm sorry, it always takes me a second because the operator told me to mute my phone, of course, while I wasn't speaking because otherwise you guys could hear me breathing.

So anyway, I don't have any points to add right now.

CO-CHAIR CHIN: No problem, Jose. Philip?

MEMBER ALBERTI: A super quick point. I'm not sure if this is the right place to do it, but in terms of the roles that you have listed, you know, the different roles.

The first ones for role of payment,

healthcare costs are an increasing driver of healthcare disparities. You might also want to flip that. Healthcare disparities are an increasing driver of healthcare costs. I don't know if this is the right time to do that.

Yes, for the first bullet there. I might also argue that the converse is true and important to note.

CO-CHAIR CHIN: Good point, Philip. Should we go back to these original questions? I guess if we go back down to the four questions that we skipped over. Does anyone have any comments on any of these four?

MS. O'ROURKE: So, this slide really focuses on the role of measurement.

MEMBER YOUDELMAN: I guess one thing we might want to think about potentially adding is how to improve measurement, or maybe it's improve data collection. Getting to the point that sometimes we can't measure because we have a lack of data.

So where does that fit? I don't know if it's here or somewhere else.

CO-CHAIR CHIN: So we've got Susannah, then Kevin.

MEMBER FISCELLA: Yes, I was going to just add to align payment with needs.

We often think of measurement measuring quality on the back end, but another way measurement can do it is to measure what's the burden or need. You know, including, for example, social determinants which could be used to adjust per-member per-month payments, or some other form.

CO-CHAIR CHIN: Any other measurement suggestions? Traci, then Eduardo.

MEMBER FERGUSON: I think we should also include either alignment or partnership between those sort of groups that are working not necessarily in silos, but that they can work together.

Make some mention of that, that in order to do that we would promote the partnership of stakeholders to work together to eliminate disparities.

Not only just in the measurement

development, but also how they're using that measurement and implementing.

CO-CHAIR CHIN: You mean like alignment, or something else in terms of promotion of partnerships?

MEMBER FERGUSON: Well, if you're sort of -- in terms of incentivizing your providers and your payers so that you don't have multiple lists of measures that you have to follow. So again, trying to streamline and align the measures.

But also if it's going to take not just one stakeholder to do it, that you work together with another partner to get to that goal of eliminating the disparity in the measurement process.

CO-CHAIR CHIN: Okay. Eduardo, then Susannah.

MEMBER SANCHEZ: So, first I wondered, but I guess the work we're doing is about identifying appropriate measures, and standardizing them, and recommending them. So maybe that doesn't belong there.

But as I look at the language about incentivizing providers and payers I just wonder in the spirit of patient-centeredness and community-centeredness if we also don't need an explicit statement about engaging patients and communities to work to eliminate disparities.

CO-CHAIR CHIN: Susannah?

MEMBER BERNHEIM: Yes, in that spirit I would add two things.

One is I think along with identifying disparities, this concept of sort of identifying the experiences of communities that often have disparities. I'm saying that really poorly.

I mean there's work being done that I'm helping with a little bit to create a measure of the experience of discrimination in healthcare.

And that isn't necessarily per se identifying a disparity, but I think it's a really important thing to add. So I would say -- maybe somebody can say it better than I just did.

And the other thing is -- oh, following up on I think what you were trying to say earlier

about stakeholders is one of the other things measures can do is define the accountable organization.

Right, so measures can be built to hold systems accountable by sort of the focus of the measurement. And that's not here.

So if you say this measure is at the level of the public health system, suddenly instead of holding the hospital accountable you're holding a system accountable. So, I think measure can play into this accountability.

CO-CHAIR CHIN: I think -- let me sort of track that word. This question was on measurement. The next was on payment.

In some ways the process of care transformation is sort of in no man's land there. So your point and Eduardo's point, so somehow we need to figure that out. Yes.

Should we go to the next slide which I think is the payment one? Comments there. Michelle?

MEMBER CABRERA: My comment is that we

don't know a lot about how all this experimentation in payment and value over volume, et cetera, will really play out over the long run.

And anxiety about that is what drove us to say, well fine, if we can experiment so hard on systems and real people's lives with an end being controlling costs, or improving this quality as defined by HEDIS and CAHPS, you know, then we should put elimination of disparities on par with those other purchaser-centric goals.

And so, you know, it's part of why we did what we did. But you know, in advancing our proposal to use for P-for-P to reduce disparities.

That said, I think we are still in some pretty experimental phases and we don't know how all of this is going to play out, and what we'll really think about this in 10 or 15 or 20 years.

And so I think it's important for us to say if this is kind of the dominant approach right now, if this is the way everybody else is moving then the elimination of disparities is something that needs to be added on to quality. It's not

baked in.

And it should be on par with these other goals for the experimentation that's happening. And so it's complicated.

CO-CHAIR CHIN: I heard a couple of things there. One was the elevation of equity to a high level as things like cost and value.

Another is a cry for demonstration projects almost. Like you said, we're still in this fairly new era of things.

The other is the bullet about incentivize elimination of disparities and reward interventions that reduce disparities is a very global statement. But there's a lot embedded under that.

So, one is like the downstream effects. Unintended negative and positive impacts was one.

The other is it's almost implied, well, this is a very sort of behavioral economic model, but there's a lot of other things that go in also.

So for example, the whole example of intrinsic versus extrinsic motivation, and

thinking carefully about that besides the economic. So, I think there's a lot that's embedded in your comment.

Also saying we can't be too superficial or simplistic about this.

So I think it was Tom. Then there was I think Kevin and Emilio.

MEMBER SEQUIST: So I had three kind of brief comments.

So the first was I think we should add something in here that the first way the payment policy can help to reduce disparities is to stop exacerbating disparities.

So, I think it's really important for people to recognize that that would actually be a huge step is to stop making it worse, as opposed to designing it to make them better.

My second comment is, especially when we think about payment policy and financial incentives is that we put in here -- we're implying when we say incentivize, because of the title of the slide we're implying financially incentivize,

that we're incentivizing the elimination of disparities.

So in a P-for-P program there's two ways to do that. There's make care for the underserved population better, or there's make care worse for the majority population. And both of those will achieve your goal of eliminating the disparity.

When you put dollars behind this stuff anything can happen, right?

And so if we could put something in that statement that says elimination of disparities by improving care for the -- whatever word we decide on, underserved, vulnerable, whatever the language is.

And then the third is the third bullet just seems very generic. I'm not even sure -- I don't know what it means.

CO-CHAIR CHIN: Tom, great points. So, it was Kevin, Emilio, then Ron.

MEMBER FISCELLA: Yes, I'm not sure if I can express this clearly, but I think one factor related to healthcare disparities that doesn't get

too much attention is the concept of segregation of care, particularly within the same organization.

I can speak of my own institution which is often based on sources of pay. So, where somebody gets care is determined in part by whether they are uninsured, or have Medicaid, and who sees them, and the resources available to that patient population even within the same organization.

And I think that potentially measures, greater transparency because we know very little about this -- there's very little published data on that although we all know that it happens widely around the country -- is certainly one thing.

And potentially payment could have a role. Particularly as we move towards more global-based delivery models it doesn't make sense for, you know, one group to be getting care in a run-down clinic of the same organization, another in a much better equipped office that has more of a private practice feel to it.

CO-CHAIR CHIN: Thanks, Kevin.

Emilio, Ron, Yolanda, Eduardo and Michelle.

MEMBER CARRILLO: I want to bring back here an observations that Kevin made earlier that disparities also increase the cost, just focus on that.

An example. We have in the Bronx an ACO that noted an association with patients with emphysema, patients with asthma that their living conditions.

So, they targeted the housing instability, in this case air conditioners. And the ACO basically purchased and installed air conditioners in these housing projects in the Bronx.

And lo and behold, costs went down for this particular subset of the population.

So, I think that as part of a payment policy to just drive payers to target social determinants of health as part of their payment structure would be something that we could include in our recommendations.

CO-CHAIR CHIN: Thanks, Emilio. So, I

have a process suggestion to run by the group.

So, right now we're running way over the time limits. How about if we, as a group we talk till like 5 of just until I get a number of comments.

At 5 of we open for public comments which we need to do before lunch. We get lunch and then we have a working lunch so that at 1:15 where we are supposed to start we can eat while we continue on schedule.

Would that work for people? Okay, thanks.

So, we have Ron, Yolanda, Eduardo, Michelle.

MEMBER COPELAND: I just have maybe more of a clarification question when we talk about that second bullet. And you mentioned earlier there's lots of sub-bullets that are probably underneath that.

But given our comments earlier about the enablers, and research, and data, and so on, and what's not being done for the researchers in the room do we consider access to funds for targeted

research a form of payment?

I know this payment is really targeted toward people providing care. Does it include the research community doing targeted studies that create or enable data or evidence base that then drives solutions or not?

And the reason I just thought about that is because when I, at least in the last eight or nine years talking to a lot of the research community around the research they do and the funds they're able to secure for doing research in the disparities arena most of it has been around documenting that certain categories of disparities exist.

And when we would say well, that's all interesting. We've probably done enough of that. When do we get to researching evidence-based solutions? And they would say well, that's great, but nobody's funding that.

So, I don't know if that's changed in the last five years and that there's robust funding for solutions, testing to drive evidence-based

solutions to feed into this or not.

But if the answer is no, there's still not sufficient funding for that, is something here for the research community around -- or funding payment if you will for targeted research that will enable this body of work? Is that something for consideration or not? That's just a question.

CO-CHAIR CHIN: Yes, certainly for consideration. And actually, you raise sort of a very interesting issue of like well, there are different mechanisms you might say for that. Whether it's increasing the NIH or PCORI budget, or AHRQ budget.

I heard one talk yesterday actually where Tom works, Partners system. They have a tax of like 0.5 percent of their clinical revenue which goes for not equity, but more generally care transformation. So there's a lot of ways that could be done. So, that would be an open topic.

So, I think we had Yolanda, Eduardo, then Michelle, then is that Nancy? Yes.

MEMBER OGBOLU: So, I just wanted to

bring back the comments that were made earlier about data collection.

Having served on a task force on the policy level that was engaged in trying to develop a policy around pay-for-performance on cultural competency, just the sheer absence of data prevented that task force from really doing anything in terms of moving that idea forward.

So, data collection right now seems to be embedded, but we don't have like a clear bullet point for that. But I think it's so important that it should be something that even stands alone in one of our comments.

The other thing that I wanted to bring up, and I think it was on the previous slide. I guess it just struck me as we were moving onto this slide was ensure that measures that are created do not increase disparities.

And I think if we've had really not good measurement up to date we know that the measures that we create will probably on the surface initially look like there's an increase in

disparities. That would be my concern. Because maybe we'll have better measurement than we've had in the past.

And so that comment about ensuring that our measurements do not increase I think could be misinterpreted. So, I just wanted to bring that up.

CO-CHAIR CHIN: Thanks, Yolanda. So, Eduardo, then it was Michelle, then Nancy.

MEMBER SANCHEZ: I just wonder if we shouldn't consider more explicit language around the idea of incentives that eliminate health disparities so that more explicitly, and I did not wordsmith this so be patient and kind, payment policy, parenthetically allocation of resources that takes into consideration health impact to optimize health in targeted groups, that takes -- to consider health impact and cost effectiveness within and outside of the health system.

So, to the point that Emilio made earlier with regard to the -- I think it was an asthma intervention that was out of the health

system, I've also heard anecdotally, and perhaps you all have as well, of similar kinds of initiatives that got started and worked so well that actually utilization of health services went down. And the primary funder quit funding the program because it worked so well.

And I don't know how we capture this idea of the wrong pocket kind of idea, that when you achieve a savings by investing upstream oftentimes the savings, the payment accrues to someone who wasn't the entity that actually did it.

That's a different thing, but it's probably worth noting. That's one of those unintended consequences, right?

And then I just wonder if one of our payment policies. We have promote value and equity. Maybe it's payment for the health of populations.

So that value and equity may be part of it, but if you are explicitly paying to optimize the health for all then all of these other things sort of fall below those.

CO-CHAIR CHIN: I think one of your important points, Eduardo, is that when we have this lumped category, you know, payment reform, or payment incentives, when we get down to I guess the details in the future we'll need to think about different categories of payment.

So for example, some of this was originally written with your classic P-for-P, motivate the provider with the piecemeal work type of thing. We talked a lot about social determinants of health. And so it was a different test that you would have for a capitated or global payment type of scheme as an example.

Or Michelle raised the issue of, well you know, payment for the safety net, does that differ also.

So, there's different like flavors. So, some of the language we have to be careful about and we'll have to be more explicit about like your savings example. That's different than the type of payment issue that comes up from P-for-P.

So, we'll have to be careful when you

go to the next level of granularity as we develop this further. That's a great point.

MEMBER SANCHEZ: Yes, well, and even in the P-for-P model when you do the asthma the clinician may get credit for better clinical outcomes, but in fact it was the housing intervention that made the difference.

So, it all comes back, I think, to be able to map the relationships, kind of the systems relationship on the one hand, and figure out how one begins drawing the accountability maps that then can have payment go in the right direction to achieve the desired outcome.

And again, I don't like to focus that much on payment, but indeed, every conversation that anybody ever has, it boils down to who's going to pay me to do it.

CO-CHAIR CHIN: Good points, Eduardo. So, Michelle, then Nancy, then Bob. Then maybe we'll call it there, and then we'll have public comments, and then we'll get to lunch.

MEMBER CABRERA: Two quick things.

One, I don't know if this elaborates on the conversation that we were having with Eduardo, but I started to wonder in terms of payment policies about just managed care and you know, capitation, and then sub-delegation.

You know, data, how it sort of intersects with the world of capitating and sub-capitation is really gnarly stuff. And I can say that because I'm from California.

But you know, I know it's been a struggle in the universe of all-payer claims databases. They're not really evolved yet to deal with capitation.

And so, I'm just wondering if we have data collection problems as it is in this leap forward that we've made to spreading capitation and managed care throughout systems, and to the extent that that's part of some framework of payment reform. We might want to just sort of think about that. I don't know, I'm just opening that door.

And then the other one is investments in workforce transformation as a part of this whole

conversation around social determinants.

You know, I think kind of a component of it that we haven't talked a lot about are those front-line non-licensed community-based folks, like community health workers or navigators, who really can, you know, I think we're finding make a big difference in the quality of care that's delivered, and the relevance of care, and the appropriateness of care.

And so payment models that support that. Because again, I think there's a lot of thought, there's a lot of interest, but not a lot of actual reimbursement tied to that stuff.

CO-CHAIR CHIN: Thanks, Michelle. So, Nancy, then Bob, then we'll have public comments.

MEMBER GARRETT: So, I just wanted to reinforce the importance of that last point about that payment policy can really make a difference because it can reflect the different needs of care that certain populations may face.

And I think a lot of the comments that

have just been made kind of reinforce that too.

But how can you have payments that allow us to really pay attention to the social determinants of health, and not just the medical care part. And what does that look like. And I think this committee can play a role there.

And I think one of the really -- I think we should also think big. I mean, to me one of the really elephants in the room around payment policy is payer mix.

So, if you think about payer mix for a provider that has a lot of commercial patients, they're getting a lot more reimbursement for each of those commercial transactions that then they can use to offset much lower reimbursement for public programs, undocumented individuals as well.

Providers that have a really low commercial payer mix do not have those resources, and yet they're serving the populations that we most need to invest in to reduce disparities.

So, I mean those are the kind of global things that are really driving the resources that

are spent in our country. And I think we need to think big and think about those things too.

CO-CHAIR CHIN: Thanks, Nancy. So, Bob gets the last committee word before lunch.

MEMBER RAUNER: Yikes. So, kind of going off of I think it was Eduardo's thing about where so many times I've seen a project get two to three years of funding and it works. Then the funding goes away. Then it all falls back. We went right back to where we started. And so forgetting to embed that population-based payment.

And three states that are doing what I think are really cool things in this area who I don't think are actually in the room are Colorado, North Carolina and Oregon with their regional provider health organizations - Community Care North Carolina in North Carolina, Colorado's regional care collaboratives where they get a population-based payment in addition to the primary care.

And then that embeds that both population and primary care prevention. I'm

trying to create that in Nebraska right now.

But I think that is -- when you say who is accountable on a population basis to me that right now is I think one of the best ideas out there. But it's not that well known I think on national levels.

CO-CHAIR CHIN: Thanks, Bob, and thanks, everyone.

So, let's open it up now. Are there any public comments either here in the room or on the line?

OPERATOR: At this time if you'd like to make a comment please press *1 on your telephone. And there are no phone public comments at this time.

CO-CHAIR CHIN: Okay. So, great, everyone. So it's about 1 o'clock. So why don't we aim to get lunch and then start around 1:15 then.

MS. O'ROURKE: And one quick housekeeping note. Michael sent around an email with dinner plans. So if you could please let us know if you're interested in joining. Either let Michael know in person, or reply to the email. We

have a reservation at 7 at Catch 15 around the corner if anyone's interested in a group dinner.

(Whereupon, the above-entitled matter went off the record at 12:58 p.m. and resumed at 1:15 p.m.)

CO-CHAIR PONCE: So we have identified in our discussion about who the stakeholders are, but now -- and possibly their roles, but what exactly are they going to do? So, this is the next set of slides. Michael.

Again, this is from -- is this part of the survey theme? So, this came from the respondents. And this is a very parsimonious representation of what was written, but I think it'll help with the discussion and conversation.

And also, if anything repulses you, or if anything is glaringly left out, and of course, if you can help texturize these different bullet points so that we have more of -- concrete material to work with for our roadmap.

So, let's start with measure developers -- and I'm looking at Susannah -- what they could

do. And I see Dave is up.

MEMBER NERENZ: The second bullet point I think is written a little strongly, that measure developers often, at least in the current environment, don't have control over use. And that's often where the effect on disparities would occur.

And I think there's interesting territory for us to discuss in the intersection between the measure developers, and NQF and the purchasers about this bullet.

But I just want to caution -- I see Susannah nodding a little bit -- that it's a little much to ask measure developers on their own to do the word "ensure."

They're part of the team, but -- and maybe what we could say is what measure developers can do is to describe appropriate and inappropriate use, or context in which the use of the measure would help versus hurt on disparities. But "ensure" is a little strong.

CO-CHAIR PONCE: Okay. That's fine.

No, we also said measure developers could versus measure developers should, too. Mara.

MEMBER NERENZ: I'm not sure that "ensure" is even within the realm of "could."

MEMBER YOUDELMAN: I wonder if there's a way, and I don't know if it's the first bullet or a different bullet, to also emphasize the need to look not just at general populations, but subpopulations. And also some of the intersectionality issues.

So, some of that is going back to sort of discuss data collection. We all encourage data collection, but are you going to encourage, for example, race/ethnicity, the five big categories? Or are you going to look for disaggregated data? So, I'm not quite sure how to capture that, but it would be good to get to some of those points in this.

CO-CHAIR PONCE: I think that resonates with what Yolanda appealed to in terms of where does data come in. Is it one whole separate subsection, or maybe is it present in every piece of the roadmap?

Sarah.

MEMBER SCHOLLE: I agree that the second bullet probably needs to -- it could be revised that measure developers could identify where measures could help to shine the light on disparities.

It could identify populations or subpopulations at risk of disparities. And how to use measures in those settings, rather than -- any kind of language about "ensure" always makes me a little bit nervous because it is a -- it's a very strong word legally.

And this is an enterprise where the measures are actually being developed for a purpose, and then used for that purpose by someone else, often.

CO-CHAIR PONCE: Okay, thank you. Tom. And then I don't know who was first, Nancy or Lisa. So Tom first, then Lisa and Nancy. Oh, I'm sorry. And then Lisa Cooper.

MEMBER SEQUIST: I'm a little stuck on when we're talking about measures and barriers to

measurement collection.

In my mind this is how I've been thinking about this. There's the clinical outcome that you're tracking, whatever that is.

And then there's the predictor, or the population that you're interested in, race or disability status.

And so when we're putting these bullets out here, are we talking about barriers to measurement collection of the hemoglobin A1c's, or of the patient's race or disability status? And those are two really different things.

And there's a lot of people for 50 years who have been working on that former one, about barriers to collection of the hemoglobin A1c.

And the new territory here I think is collection of the variables that define the population that we're interested in that's at risk.

And it's not clear when you read through this that -- I think that's what we're talking about, but it's not clear when you read through this that that's what we're talking about.

CO-CHAIR PONCE: I agree and that's something that we can try to be more precise about.

Again, these are just very, you know, not quite pithy because we're not there yet, but just very quick themes that we identify through your responses.

So, I'm going to zigzag, go to Lisa Iezzoni, and then Lisa Cooper, and then Nancy Garrett. Oh, and then I'll zag back to you, and then to Emilio.

MEMBER IEZZONI: Okay. I wanted to ask measure developers to make sure to talk to the community, to the people whose care they're going to be measuring.

We've got a great PCORI project right now, thank you, where we're working with people in the disability advocacy community in Massachusetts to develop measures about their care.

And it's revelatory. You know, even being a member of the disability community -- it's been revelatory to sit and listen to people with disabilities talk about the barriers that they

face, and the way that they experience those barriers. The lived experience is just going to be invaluable.

So, I think that even though that's expensive and it's time-consuming to go out into the community, that especially since we're talking about populations that historically have not had their voices heard that we should try to do that.

CO-CHAIR PONCE: Thank you. Lisa Cooper.

MEMBER COOPER: So, this may have already been said, but -- because I was having trouble hearing the first part of the conversation.

On the second bullet, I don't understand how measure developers have any influence on -- how could their measures increase disparities? I don't understand that.

I mean, the disparity is either there or it's not there. And it's like, you know, they could improve their methodology for assessing it, but I don't understand that part so I don't know where that came from.

MS. O'ROURKE: I can clarify a little bit about that. I think that theme tried to capture some of the concerns we heard about ensuring there's proper risk adjustment in the measure so that safety net providers are not unfairly penalized and issues along those lines.

CO-CHAIR PONCE: Yes, Romana.

MEMBER HASNAIN-WYNIA: So, to Lisa's point, I was wondering about that. I mean, are we talking about the measures themselves, or how those measures are implemented? Meaning, how we pay on those measures.

So, not necessarily that the measures do not increase disparities, but how we implement those measures, and our expectations around those measures don't increase disparities. I think that's the endgame.

CO-CHAIR PONCE: So, I'm just noting that clarification. Nancy Garrett.

MEMBER GARRETT: So, I think to that point a specific way -- perhaps this is just summarized too much, but I think a specific thing

that measure developers could do to ensure measures don't increase disparities is to develop methodologies for risk adjustments where -- for sociodemographic factors where it conceptually makes sense, and where there's empirical evidence that makes a difference. That's a key role that they could play.

The science, like Bob was saying, the science isn't really that advanced yet, along with the data to be available to do it very well. But measure developers can really play a role in helping advance us and developing that methodology. So I think that that's a really key role that they could play.

CO-CHAIR PONCE: Emilio?

MEMBER CARRILLO: Yes. Well, the NQF has a very well established process for measure developers in which they basically characterize measures. You know, the reliability, the validity.

And they provide to the committee the information and the committee discusses and works

with the measure developers.

I do think that there's some extra things that they could do that maybe is atypical for what the charge to measure developers by the NQF.

One is to go through the whole portfolio of measures of the NQF, several hundred, and just study to see which are disparities-sensitive. You know, what are those measures that have some sensitivity to disparity.

And secondly, we should ask the measure developers to look at areas of disparities where there are no measures, and then to find measures of disparities that have no measure, and have them think and crosswalk the literature to see what measures could be put there to address those disparities.

So, those are two unusual tasks that I would bring to the measure developers. And stay away from things like asking them to ensure this or that because they don't do that. They basically provide us with the information to have that

dialogue.

CO-CHAIR PONCE: I just want to comment on that, Emilio. So, the disparities-sensitive measures have come up.

And so those are knowable either empirically, you know, it could be you can just, perhaps -- you can look at how the gaps change with different social factors, and if the gaps widened or increased as you add some social factors, for example.

Or it could be known through what Lisa Iezzoni suggested which is talking to the vulnerable communities.

So, is that part of the identification of disparities-sensitive --

MEMBER CARRILLO: Right. For example, one set of NQF measures are the PQIs which are the prevention quality indicators that are a measure of, for example, in terms of asthma and diabetes and amputations. In a particular community with a certain denominator, how much of that presentation by those ICD-9, ICD-10 codes you

have in the EDs and inpatient facilities.

So, basically that is a disparity-sensitive measure. Because it speaks to the lack of primary care, perhaps, access to primary care.

It speaks to the housing conditions, et cetera, that can result in some of these things.

So, I think that there's a treasure trove of NQF measures like the PQIs that are important in terms of help to identify disparities and characterize disparities. So that's what I'm talking about.

DR. BURSTIN: I can give you a little more detail on what we meant by disparities sensitivity. So, some of you who are -- certainly Emilio chaired this work.

And part of the idea here was to say that of the many measures that are routinely collected, ideally, you'd love to have information on stratification and really be able to see where there are disparities.

But there are clear areas, and the areas

we ultimately honed in on where the prevalence of the given condition or the issue in different populations, the impact on what quality could do to reduce or narrow that gap.

And then finally, what's the size of the quality gap. And frankly, the size of the quality gap became the major driver.

I will tell you we did this for about 300 measures or so initially to go through the portfolio. It's very difficult, at times, for many of them to say what the quality gap is from the literature or otherwise. And it was challenging for us to build this in prospectively.

But certainly when our infectious disease committee went through the HIV measures a couple of years ago there was -- well, this is obviously a disparities-sensitive measure. To look at HIV rates, viral load, et cetera, without looking at subpopulations, doesn't make sense.

So, I guess the question is how do we build into -- and this is part of what Elisa will talk about tomorrow -- how do we build into our core

work around endorsement and measure selection something that at least kind of shines the light on measures in particular where we think there would logically be disparities, where they should always be stratified until we get to the point where we, in fact, have the data systems to more routinely do that. Does that help?

CO-CHAIR PONCE: Very helpful, very helpful, thanks. Kevin? Oh, sorry, did I miss you, Yolanda? No? Okay, Kevin.

MEMBER FISCELLA: I wonder about expanding the concept of measures. And maybe it doesn't fit in this bucket if we're talking in a narrow sense about quality measures.

But measurement of proximal drivers that often drive disparities, and even more broadly, perhaps even thinking about potential approaches and diagnostic approaches that once you've identified a disparity how do you figure out what's behind it so that you can begin targeted interventions to address that.

Because I think oftentimes, many

organizations will do a stratification. They go wow, we've got a disparity here, what do we do. And they have no idea what might be behind it.

And so I think either proximal measures that influence that, or even more broadly, an approach that may provide some guidance could increase the chances that action is going to be taken.

CO-CHAIR PONCE: Very helpful, thank you. Let's go to the next slide which I believe is what NQF -- oh no, it's not.

So, providers and clinicians could eliminate disparities in care within their organizations, implement quality improvement infrastructure, and foster a culture of equity.

Michelle.

MEMBER CABRERA: I think it's important for providers and clinicians to know what they don't know.

You know, I think a lot of this stuff is really sort of folks thinking that they're just a doctor. And you know, they try to just be as

unbiased as they possibly can.

So, I think if there's some component in here about education, or training, that's really important. And that might be more at the system level. But we have to do something to elevate the awareness within the provider community about those gaps.

And there's stuff that's really, like, very achievable if protocols can be done in different ways to account for this.

I'll give you an example. In lesbian health, depending on where people fall in the gender spectrum or whatever, you know, you go in for a routine OB/GYN appointment. Are you on birth control? No. Are you sexually active? Yes. Well, my goodness, how could you be sexually active and not on birth control. You know.

And so, there are those sorts of things that just happen. I might handle it a lot better than somebody else would. And then that's not even getting into issues of like reproductive health for transgender individuals, or gender nonconforming

individuals.

So you know, there's just stuff that's really doable, but that has to be brought into training at the practice level, not in med school. We don't have enough people going through med school right now.

CO-CHAIR PONCE: Thank you. Lisa. Lisa Cooper.

MEMBER COOPER: So, first I just want to clarify whether this is talking about individual providers and clinicians, or whether it's talking about their practices and the organizations they work in.

Because if it's talking about individual providers and clinicians, then I think there's a lot more specificity that we could provide with regard to the need to increase awareness as Michelle mentioned. So, the need to improve knowledge, attitudes and skills.

So, you know, which are we talking about? Are we talking about individual providers and clinicians, in which case they should actually

be aware of disparities, and knowledgeable about disparities affecting the populations they care for and within their own panels.

And it should start like with them so that they can then be role models for others in their organizations.

MS. O'ROURKE: Sure. So, when we drafted it it was more at the institution level, but it sounds like there is a role we need to capture for the individual as well.

CO-CHAIR PONCE: Eduardo? Eduardo, Sarah, and then Romana, and Traci, Bob, Michelle.

MEMBER SANCHEZ: I think this is more of a continuation of what Lisa said.

I think that, sure, providers and clinicians could eliminate disparities in care within their organizations. But (a) they need to understand what the disparities are, and they need to understand what contributes to the disparities.

And then they need to understand what might be some of those solutions, some of which are non-clinical and some of which are clinical, which

yet are still modifiable, and around which one can begin to build the case for accountability.

So, too often, and I've heard others discuss this, doctors will say well, I'm not responsible for what happens outside the clinic.

Well, yes you are, or else why are you doing what you do? And we could just use robots to do things if it wasn't about somehow understanding and engaging with human beings.

So, I think there's more than just eliminating. I think holding clinicians and health teams accountable for having a better understanding of not only their patients' clinical status, but the contributing factor to that clinical status up to and including the context in which they live.

CO-CHAIR PONCE: Thank you. Sarah.

MEMBER SCHOLLE: I guess I'm increasingly uncomfortable with thinking about these individual actors without laying out the logic of what are the steps that we need to take place and who's involved in each of those steps.

Because ideally, a measure developer is not going to be on their own creating measures without thinking about the providers who are going to be responsible for implementing, working with the organizations and the payers and saying, you know, what could we do to reduce disparities for this problem.

And working with consumers as well to say what is the problem, and what could we do to address it.

And how does that change our clinical workflow? How does it change the data that we collect? How does it change what we do next? Who do we partner with outside of the medical setting and the community?

And so, not to turn this around on its head, but it almost feels to me like we need the -- what's the logic model for what needs to happen?

And then which actors are involved at each step? And which ones hold primary accountability for which piece?

So, the measure developers need to make

sure that they're developing reliable, valid measures that reflect the priorities of these multiple stakeholders, and that could be useful in multiple purposes of improving clinical care and actually guiding care, as well as improving it. And then also helping to monitor the outputs for the whole healthcare system.

So, to me it feels like we're -- by talking about each individual actor without trying to think about the overall process that we would think is important for reducing disparities, that we're assigning -- "ensure," "ensure," "eliminate" to people that don't really have full accountability or opportunity.

CO-CHAIR PONCE: That's noted. And even in our planning calls we were -- should this go first? We were negotiating which part should go first.

And so, first of all, not everything is going to be baked in a day. And that there are -- as we've heard around the room there are different thinkers here.

And so the logic model process -- there's some that might be even more visual. In fact, Helen suggested maybe we can have, you know, we can put some logic blocks up for a graphic. And that's certainly something we could do perhaps later or tomorrow.

But this is, again, a way of getting back to you as a group, some of the initial thoughts on what are our guidelines. What are some of the key objectives of the roadmap?

And then who are the stakeholders and possibly -- what is the possibilities, you know, what's the realm?

So this is not fully baked and it's going to change, I imagine it's going to change once we start to have this appeal for the logic model and the interactions. But I think it's a point that I've noted and we can get back to.

I think I'll go to Romana, then Traci.

MEMBER HASNAIN-WYNIA: So, this is a question for Helen, and kind of reflecting I think on Michelle and Lisa's comments, and then just this

general discussion.

But I'm curious about the work that happened, I'm losing track of time, maybe three or four, maybe longer, four years ago, the cultural competency.

Because I thought some of that report focused on kind of big picture, and then identifying who the actors are.

And I'm wondering whether we can actually, you know, bring that into this discussion, maybe use that as a starting point. And then we can refine where we need to, based on current times and changes in policy. I just wanted to hear your thoughts.

DR. BURSTIN: I think it's a great idea. It was actually probably more like five years ago, but that's okay. It's just what happens.

I think it's a great idea. For those of you who don't know, we put out a set of preferred practices of how to address cultural competency issues with lots of good definitional work, et

cetera. Lots of -- several of you were on that group.

So we should bring it back. It's not clear it got used. Perhaps in a way it was a little bit before its time. Some health plans used it. Some other groups used it. But I think it's a great idea. We'll pull that back in.

The paper by Joe Betancourt that Lisa -- yes. Yes.

And actually, just one quick reflection on that because Lisa raised the question about that paper earlier.

That paper was specifically part of this work funded by the Robert Wood Johnson Foundation. They specifically requested that it be on race and ethnicity only.

So again, the lens there was funding. So, in this instance, keep in mind that paper was written with that lens. But again, I think we're trying to think broader than that.

CO-CHAIR PONCE: Okay. So, in the spirit of not thinking in terms of buckets and

silos, can we just go to the next slide? And you can -- no, I can still call on you. So, Traci and Lisa. You could comment back on the providers and clinicians, or comment on the payers.

Because I'm just mindful of time. We have payers, and then we have purchasers, then we have policymakers, and we have NQF to cover. Traci.

MEMBER FERGUSON: So, I was going to mention the cultural competency, but I also think that it would be good to get a summary sort of statement that addresses all of the stakeholders and how they work and collaborate together. And then we can go and bring out more details.

But in terms of we can do the payers and the clinicians, giving some more meat and more guidelines or something that they can incorporate into their day-to-day.

Because if you say in terms of -- to foster a culture of equity, what does that mean to me when I'm like in the hospital, I'm rounding on patients? Is it a checklist? Is it a needs

assessment that I'm doing on my patients because I know that they have certain cultural needs? So, being able to give them something very tangible that I think will be helpful.

And also with the payers and with enforcing, I think, looking at that work with cultural competency to make sure that they're addressing all of the issues with their members.

CO-CHAIR PONCE: Thank you. Lisa Iezzoni.

MEMBER IEZZONI: This is going to be really kind of controversial, but I'm going to raise it anyway.

And that is the law. Because there are certain laws that govern things like interpreter services. There are certain things that govern things like accessibility.

One of the things that we find for people with disabilities is that physicians actually do not understand their legal obligations.

There was a great paper published a

couple of years ago in the Annals of Internal Medicine by Tara Lagu who's a general internist out in Springfield, Massachusetts, where she got together a bunch of residents who worked for free for her, and she got the IRB to agree to let her do a secret shopper type of telephone interview where she presented a case vignette to various -- whoever answered the phone at a specialist's office, trying to get an appointment for a patient who was described in a certain way. But the patient could not self-transfer.

Twenty-two percent of the physicians offices refused to schedule this patient for a visit. And what was interesting is that the interviewers, the secret shopper interviewers asked the person who answered the phone why.

And the person just said oh, you know, we don't have the equipment, we don't have the personnel. They clearly really did not understand in any way, shape, or form what their legal obligations were.

And the reason I know this is

controversial is that people always feel that you don't want to use the stick, you want to use a carrot.

But in fact, especially around disability, the threat of the stick has unfortunately had to be what's motivated some changes like making healthcare systems accessible.

So, I think that just providing information to people about what their legal obligations are. And again, there are legal obligations beyond those relating to disability that are at play in some of what we're talking about here.

CO-CHAIR PONCE: Thank you. Mara.

MEMBER YOUDELMAN: You said it in a different way than I was going to say it, but I think at least for the last bullet, to me, doesn't go far enough because we could implement quality improvement and foster a culture of equity without getting where we need to go.

And so again, it sort of is the scope. But we need to pay for interpreters. We need to

pay for the equipment. We need to pay for additional time if it takes longer to treat certain populations, or give them the catch-up care they need because they've been uninsured.

So, this sort of doesn't identify the payment structures, but also just other types of payment, and funding, and resources, and staff time that are needed to make sure that we're not just measuring, but we're addressing.

CO-CHAIR PONCE: Noted, thank you. Eduardo?

MEMBER SANCHEZ: So, in addition to payers being -- that they could incentivize the elimination, I might suggest that payers could expand eligible services and service provider networks outside of traditional clinical services networks.

So, the example of paying for a housing intervention would be a very clear example of that.

Diabetes Prevention Project, right now, some health plans are not getting that diagnosing pre-diabetes and then sending people is

actually treatment. So, that doesn't even fall under this category.

And the community guide might serve as a basis for what sorts of things might ought to get paid for, and what sorts of networks might be created that are different than they are now.

All in the name of eliminating health disparities.

CO-CHAIR PONCE: Thank you. It's really appreciated when there's also -- resources are made -- suggestions are made for that.

So, Traci is that up again? But can I go to Bob?

MEMBER RAUNER: I was going to expand on Lisa's -- and there's other issues, not just disabilities. And language is a big one.

So what happens in our community is a lot of people use that scheduling as a way to basically screen people out.

And I hate to say it, not that this is okay, but it's an economic decision. If your overhead is $50 and Medicaid pays you $35 you're

losing $15 per patient.

Now, if I also have to pay for the interpreter and that's another $50, now I've lost $65 per patient.

And the problem is that the law does not come with any mandate from the payer to cover any of it. And so that's where you get -- sometimes the providers are stuck in the middle. And these are the safety net providers who are at least able to fund that extra $50. And it makes their bottom line even worse. And now they can't attract staff.

And so, part of the problem is that the law is not consistent with the payer. And it's not that the primary care providers are unaware of these disparities. Oftentimes, they're fully aware of it, but they have other issues they have to deal with.

And I want to go back to Lisa saying a lot of times they're aware of the disparity, but sometimes they're overly cynical about their ability to do something about it, some because they don't understand how powerful motivational

intervening really can be.

Or again, you go back to the payer where I know if I could get them to a dietitian we could help them out. But again, the dietitian isn't covered by the payer either. So now I'm stuck again.

And so sometimes it's a cynicism that develops over time because the law, and the payment, and what you need to do aren't fitting together. And that's why they're getting so cynical.

CO-CHAIR PONCE: Sarah.

MEMBER SCHOLLE: Some of those limitations are based on the financing. Because Medicare doesn't pay for some of those services, right? And there are rules about what Medicaid can do and what you can do with federal dollars.

And so that's why the changes in the payment systems, that these alternative payment systems could actually revolutionize how we think about it because it would give the health plans and their provider networks a lot more flexibility

about how they use the money.

And so, I think that's a policy change, right?

CO-CHAIR PONCE: Lisa Cooper.

MEMBER COOPER: I wonder if what I'm hearing is that we really need to get a lot more specific about what we mean. Or at least to provide some real, concrete examples of things that we feel are like kind of just critical to any payer who is purporting to eliminate disparities, that there are just certain types of services, or types of workforce workers, or programs that really ought to be in their portfolio of things that they cover.

CO-CHAIR PONCE: Emilio.

MEMBER CARRILLO: To get back to Sarah talking about alternative payment systems. That's where the puck is going.

I mean, right now, it's undeniable. So we have to be thinking in those terms, in the value-based system.

And it's amazing what can happen in this value-based system. This example about the air

conditioners, that was an ACO. The ACO saw the value of buying air conditioners.

And in terms of cultural competency, I know we're saying well, we had all this cultural competency, it went nowhere.

I mean, now the value of cultural competency measures can inform the need for community health workers who are bilingual/bicultural in a certain setting that will save money by keeping the patient out of the ED and the inpatient.

And that's measurable. And we're starting to look at those kind of things in New York with the District program.

So, I think that it's important that we get these social determinants measured. Not to say that they're going to do anything, but rather that by having measures that are there that people can apply, then in the whole marketing and the whole business case that's made, those measures that are there can serve to inform payment models.

CO-CHAIR PONCE: Yolanda, then Traci.

MEMBER OGBOLU: I just wanted to kind of build on some of that thinking about how specific do we need to get.

One of the things that I've been thinking about is technology. As Ron and I were talking about earlier, how can we get payment for e-visits consistently, particularly for patients that are in rural populations that can't afford the transportation to get to the healthcare services and could be taken of by e-services.

So that's another area where health is going, moving forward, thinking about how technology can be used.

CO-CHAIR PONCE: Thank you. Traci and then Kevin.

MEMBER FERGUSON: When you're talking about the payers in terms of government-sponsored programs, whether it's Medicare or Medicaid, being able to allow, whether it is through policy, written legislation, that they will be able to pay for these services that are outside the normal benefit that address these social determinants of

health.

I think that's where you may be able to sort of implement the changes on the payer side, but it will have to come with changes in the policy.

Because right now, we have to use community-based organizations, non-profit organizations to help fund the ramp, to help do all the other things that we can't pay for as a Medicaid provider.

CO-CHAIR PONCE: That's a good point. Kevin?

MEMBER FISCELLA: Yes. At the risk of being an echo chamber, I would just say that pay for critical resources needed to address disparities.

I mean, I agree with Emilio. Certainly in New York State, the issue of paying for resources to address social determinants of health has already arrived. We're already trying to figure out how to do that. And I think that should be out in front.

Because it's -- certainly implementing

quality improvement infrastructure is important, but ultimately, one is going to need to have the resources to be able to address many of the different barriers that we've heard about.

CO-CHAIR PONCE: So, would foster a culture of equity and social determinants be kind of the top line over the implement quality improvement infrastructure? Yes, okay.

Let's go to the next slide. Oh I'm sorry, Marshall.

CO-CHAIR CHIN: You know, I think Lisa's point about like being in specific care is important.

But I think actually this is -- if I had to say, this is the most important slide of today because probably our most important audience is actually going to be CMS. It's going to be all the other ones too, but CMS, they're the big guy. And so we, over time, need to spend more time on this slide.

I'll give an example. Like in the SharePoint materials, I have a paper on reverse

acceptance where I tried to do a piece about what are like six things that the payers can do along those lines.

The six being like requiring the reporting of stratified performance data. A second one being how do you direct -- they can do more things to direct resources to do the type of care transformation and preventive in primary care necessary to reduce disparities.

So, you gave some examples. I think e-consults, for example. But you've got much more aggressive shared savings programs so that there's more skin in the game, so that more of the money goes to these things which right now aren't being paid for.

A third is specifically paying for reducing disparities. So there's a whole variety of issues there in terms of thresholds, and -- improvement, et cetera.

A fourth being across payers aligning the equity and accountability measures so you don't have 200 different measures, but you know, the

private and public payers are working from a parsimonious set of equity measures.

A fifth was -- I think it was Michelle's point about thinking carefully about what are the special issues for the safety net.

So these are things like tomorrow's discussion about risk-adjusting for SDS comes into play. Or what do you do with the reduction in DSH payments right now, where right now the expansion of Medicaid is not being concomitant. For example, the residents are being killed, you know, as an example.

And the sixth would be like demo projects, and then I have a list of example demo projects that need to be done. There's a lot of methodological issues that we still don't know about.

But I think this is going to be critical because that's the biggest lever we have here. That's the thing that's really going to change things. Because if the money changes, then all the rest of it's going to flow. We have to fill in gaps

there, but unless we get this part right we really have missed the opportunity.

CO-CHAIR PONCE: Susannah.

MEMBER BERNHEIM: I agree with your framing. I was just going to add to your list the data. So both the providers being game to collect data, and absorb data, and use data, but the payers setting standards for data collection, just to add.

MEMBER YOUDELMAN: And this also just may speak to the need to delineate public payers and private payers. There might be some that apply to different sectors. And so it's just a thought as we continue to do this.

Not necessarily having two categories, but I think there are some levers that the public programs have, but on the other hand the private payer should also be doing some of this because they have leverage in different ways and sometimes similar ways.

CO-CHAIR PONCE: That's noted. So, Bob's card is up. Philip's was up, but no longer. Okay, Bob.

MEMBER RAUNER: One other thing with payers is the availability of their data and how they use it.

And so a lot of times they have the data but they won't give it to us to use. Or they won't use it in a transparent way.

And I'll pick on UnitedHealthcare's Premium Physician designation which is about the most statistically invalid way of ranking people I've seen.

And so, some of them either aren't making it available, or when they do they're using it in a very bad way. And so, trying to figure out how we can get access.

Like in Nebraska, we have a dominant Blues plan. They could provide probably some of the most up-to-date disparities data around claims if they would make it available to people.

So we could see county-level disparities on colon cancer screening because they're the dominant payer. But getting that somehow is a challenge for us.

So, if we could find ways for payers to free at least some of the data. And again, an all-payer claims database I think was mentioned earlier. Boy, we would love to have that.

CO-CHAIR PONCE: Next slide. This is about purchasers. Emilio, did you -- or did you want to comment back on payers? Okay. Well, as Marshall said, that possibly was one of the most important slides of the day. So you can comment on payers.

MEMBER CARRILLO: Yes, just a point that payers use predictive models that have 99 percent nothing to do with social determinants of health. They're all based on administrative data sets, totally flawed.

HCC, which is what CMS uses, is all based on administrative data. It's all based on previous admissions, sort of a variation of the Charlson Comorbidity Index, with no social determinants of health.

I think that there should be some recommendation that CMS and others explore

expanding predictive model tools to include those major, most impactful social determinants.

CO-CHAIR PONCE: And I think some of that we'll cover tomorrow with David and Kevin talking about SDS and risk adjustment, what the possibilities are.

MEMBER BERNHEIM: Can I just differentiate? Because the HCCs were designed -- I think what you're talking about is how they pay, right? So, determining how much you get paid based only on comorbidities, and not on social needs, which is very different than using those same tools in quality measures. I just wanted to differentiate those two issues.

CO-CHAIR PONCE: Thank you. Christie.

MEMBER TEIGLAND: Just to piggyback on that. There is a new proposal that CMS has put out for comment to adjust the payment model, the HCC payment model, to put it into six categories. And they're basically groups by age and disability percentages.

So they're taking a teeny little step, but now is the time to impact that because once they make a huge change like that, it just drives everybody's systems crazy and it takes years to adjust to that.

So, age and disability is important, but there are so many things that are missing. So again, there's some urgency.

CO-CHAIR PONCE: Did I see David? No. Go ahead, David.

MEMBER NERENZ: Well, it's just on this slide. What's the difference between payer and purchaser?

DR. BURSTIN: It's a bit of a distinction without a difference. I mean, I think some people think of themselves as those who purchase care on consumer's behalf, like a business group or a corporation.

And payers are oftentimes the insurers, although CMS and many are both payers and purchasers.

So, I think in this instance the

purchasers are slightly different because they are thinking through the business lens, or a slightly different orientation.

But many of the issues are identical.

MEMBER NERENZ: Okay. Well, just purely clarification for our discussion because I was not necessarily -- and we use the terms back and forth all the time.

MEMBER RAUNER: It's actually a pretty important distinction though because in the commercial space, more and more big purchasers are becoming self-insured and taking a very active role in what is and is not covered.

And so one of our plans, for example, even though they may want to do things along medical home, unless the businesses are also onboard, you're dead on arrival.

And so, because so many large entities are becoming self-insured, they also have to be educated on why to go this route because they're just not seeing it.

And you're essentially deferring to the

HR director at such-and-such industries which may not understand all these things that the insurer might know.

DR. BURSTIN: Just one more quick comment. Bob's point also reminds me, I mean, I think the other issue about purchasers -- you mentioned in your comments earlier about SEIU.

You know, oftentimes employers may have very diverse populations they're trying to insure. And so there may be really important issues that they can be an important lever since they're thinking about the health of their population who may be populations very much at risk.

Did I just steal what you were going to say?

MEMBER COOPER: Yes, you did. I was going to just say that. Because I think workplace programs or employers could play a really important role in helping to eliminate disparities by the decisions they make about coverage and about even just what they do with their own workforce populations.

How they incentivize those people to be healthy, and to use resources that are available to them.

CO-CHAIR PONCE: Michelle, and then Christie, and Eduardo.

MEMBER CABRERA: On this topic I just was wondering, I don't know what level of specificity we need to get at, but in California, our health exchange or marketplace has a lot of overlap with the populations that we typically see in Medicaid, you know, in terms of race, ethnicity. It's not quite as overrepresented with people of color.

You know, one of the things that I've found is whereas the state Medicaid agency is trying very hard to follow whatever CMS wants to do, and CMS hasn't yet gotten there, let's just stipulate, the exchange has some flexibility to be a real bridge between what's happening on the private and commercial side, and what's happening on the public program side.

And in this moment might be a little

more flexible, a little more open and amiable. In California, that's come hand in hand with a policy decision that was made during its establishment for it to be an active purchaser, which I think is an important distinction.

But in that vein, you know, we're really pushing on them to take some, what seemed like, modest steps in this direction, but important ones and ones that we think could have a ripple through other, maybe bigger and more challenging programs like Medicaid.

So, we have a proposal, for example, to do year over year improvements in certain disparities, and to pay qualified health plans for that.

So, I don't know if we need to get to the point of calling out exchanges, but I thought it was worth maybe referencing.

CO-CHAIR PONCE: Thank you. Christie, then Eduardo. Christie? You're agreeing. Eduardo?

MEMBER SANCHEZ: Not to broaden the

scope too much, but in the name of a systems approach and a systems perspective those employers who are self-insured are not only purchasers, but they're also parts of community.

And if we had those accountability maps that talk about policy opportunities, then players outside of how we've discussed this could be involved in the policy conversations in a different way than maybe we've thought about.

And while we might not have the measure for it, it seems to me that the work that we are going to be doing not only creates the opportunity for a framework around which there are measures and a quality improvement framework, but by shining a light on it it might lead others to think about how they might do things differently.

And again, those employers who are self-insured are not only payers, but they are in communities and might have a community social responsibility initiative that can be tapped into.

CO-CHAIR PONCE: Thank you. Yes, it's great to get another example of multiple roles,

multiple levels and the need for the connectivity and connections.

We have actually a few more stakeholders. Keep going, is that okay? Marshall's giving me some of his time. Okay, policymakers. Mara.

MEMBER YOUDELMAN: I'm not quite on the policymaker, but I think I'm taking it a step back. Or again, this might be a definitional issue. I don't know why I'm stuck on definitions today.

But I want to make sure that we also incorporate somehow that we're not exempting or leaving behind, like, the Federal Employee Health Benefit Program for the federal employees, and thinking of TRICARE, and VA, and some of the other levers.

So, we've mentioned Medicaid and Medicare. I just want to make sure we're looking sort of on a more global basis because I think there are purchasers, there are payers, there are clinicians in those, et cetera, that we need to make sure we're doing it because some people migrate

between the systems.

And even within the systems there's going to be different issues, and levers, and disparities, and payment issues.

The policymakers are very important, too.

CO-CHAIR PONCE: Thank you. Philip, and then Kevin.

MEMBER ALBERTI: Yes, I'm not sure how we could achieve this, but I think it would be important to think about how policymakers could coordinate their efforts in a way that actually assists with those efforts.

So, as a simple example that isn't related to measurement, public health departments have a five-year community health needs assessment cycle. Hospitals have a three-year community health needs.

So they're absolutely not mutually reinforcing activities that are coordinated. They're more expensive, they're less efficient.

So we are doing this work. We're going

to hear from somebody from ONC soon that's thinking about how to gather some of these data.

There are other kinds of policy opportunities that we should be thinking about how we can make sure at the highest levels of policymakers they're really coordinating these efforts to orient them toward success.

CO-CHAIR PONCE: Thank you. Kevin.

MEMBER FISCELLA: I'm not quite sure where this fits and even completely where to put this in, but I do think we need to think about the growing cost-shifting that's occurring in healthcare.

Whether that's through increased deductibles, greater coinsurance, copays for various medications, I think there's not much doubt that this is a trend that's going to continue as the cost of the medications and other things grow.

And clearly cost, probably as much as anything, represents a key driver of disparities, particularly for those who are socioeconomically disadvantaged.

And it certainly has to do with policies on the part of purchasers and those who are insuring populations.

But I think we need to make a note of that, and think about if there are ways we can both capture that, perhaps through measurement, as well as think about policies that might mitigate those effects.

CO-CHAIR PONCE: I think that permeates through all the different players. David?

MEMBER NERENZ: There might be something we could add here in the very big picture sense, and I'll use the term social contract to describe it.

A lot of our discussion so far today has talked about shifts in thinking, and evolution in thinking, and progress in thinking. But some of that thinking is way out ahead of formal policy.

So, for example -- but I'm very serious about that. The insurance companies are set up to do very specific things, and improving health

populations of communities is not on that list of things.

Hospitals are licensed to do certain things, and changing the smoking rate in the community is not one of those things.

So, a lot of the institutions we have are driven by concepts and elements of the social contract might be 50 years old, might be 100 years old.

And I think truly moving in these directions is going to take some very high-level discussion at the policy level, meaning the political level, where the voices of the community come together and say well, wait a minute, we used to want hospitals to do X, now we want hospitals to do X and Y, or Y instead of X, or something.

And all these other actions are going to be very hard to implement without some movement at this level.

CO-CHAIR PONCE: Traci.

MEMBER FERGUSON: Yes, I think there's greater ability to influence either the payers, the

clinicians, and even the institutions. Not so much the policymakers when you're talking about regulatory bodies and whether it's federal or state.

And that how are we, or how can we make them accountable to address this, to take this on as their role.

And I think that's what's going to be the key in order to make these changes. Because it's going to be a huge change for some. And so I think how can we as a committee, as NQF, make it a point that this should be part of their role and responsibility.

CO-CHAIR PONCE: Mara.

MEMBER YOUDELMAN: A couple of thoughts building on I think what you said, Bob, what others just said and some other new things maybe.

Where do the regulatory entities, the educational entities, the boards requiring continuing education, all of that sort of stuff fit?

I'm not quite sure they're represented here yet. You could call them policymakers if they're setting the curriculum or doing continuing education, but then we need to be very clear that we are explicitly including them, or it needs to be a separate category.

Because a couple of folks have talked, we have to shift the paradigm of what is being taught in the schools, what's being required in continuing education, what's being monitored, what's being -- all of that.

So, that's I think a piece that's currently missing unless it's defined differently.

Bob was also sort of looking ahead at the consumer piece which worries me about particularly some of the populations we're talking about, expecting them to use publicly reported measures when they're not in language, when they're not at a low literacy level, things like that, I think is a challenge.

So, I'm not sort of changing consumers, but maybe broadening it that we need to be thinking

of consumer assistance and health literacy issues.

So, some of this is at the policy level that we need to fund consumer assistance, and health literacy efforts, and educational efforts to help consumers understand what they need to be looking for when they're making these choices.

And so, if you're talking about the marketplaces it's the navigators and the certified application counselors who are helping people pick plans. And so if they don't understand how to use quality measures they can't help the consumers they're picking plans for understand that.

And we also know that many consumers are picking plans -- or doctors based on oh, my friend goes to this doctor, whatever.

So, I think there's a resource level as well as the sort of educational front. For the consumers it has to come at the policy level. They're intertwined.

But to be able to have the resources not just to eliminate disparities, but to help educate consumers, consumer assistance, and look at ways

to sort of do enforcement as well if some of these requirements aren't being done.

And so, if we just sort of address the up front, we create measures, or we maybe fund interpreters, but there's no implementation and enforcement at the back end or accountability, I think maybe, Dave, that was what you were saying earlier. If we don't fund that it's hard to do that too.

So it's just looking at sort of a broader picture of what we mean by funding resources and some of the consumer assistance pieces.

CO-CHAIR PONCE: Great. Consumers is the next slide, but I want to make sure that we hear from Michelle, Bob, and Sarah. Is it on the policymakers slide?

MEMBER CABRERA: Yes, on policy. So, I'm just -- and it's a little bit of a crossover with some of the purchaser/payer stuff as well. But I'm just thinking, like, I don't know if there's anything that can be done about like NCQA and how,

you know, CAHPS and HEDIS seem to in my universe when I'm in policy conversations everybody is sort of teaching to those tests.

And it's driving policy which is driving practice at the provider level. And whenever you bring up anything that's sort of not captured in that universe of measurement it's sort of like, yes, we're already overwhelmed and we're trying to align our purchasers, you know. And what they mean is we're aligning to what's happening in the private sector.

And so that is sort of like a huge frustration. It's how do we develop the case for this. Because I think from the -- we have to realize that the policymakers, the people setting state-level policy and federal policy are purchasers.

And so this whole wave that's hit us around cost containment is really attractive to them because they have state and federal budgets. So that stuff is going to continue to really be a big driver.

And that is why I think at the federal level the -- sorry, I know this is a little bit scattered, but the National Health Quality Report and the Disparities Report that were merged, that was a really great thing because when they merged them they started illustrating in the quality report that the disparities were not really accounted for there.

But that's just like a baby step, you know. That movement needs to happen in the larger policy conversations.

And again, to the extent that any of this which we haven't mentioned might actually in the short run increase costs for purchasers, and public purchasers especially, there's a possibility, you know, this is not going to be attractive or aligned with their own self-interest around containing costs.

And so I think there's an obvious lot that policymakers can do, but we all need to get real about what their motivations are.

And yes, you know, I think in theory

everybody seems very sympathetic, but it's just not rising to the level of other priorities. And that's where you see where it really falls on the priorities. And the downstream effect is people teaching to the test.

And so, to the extent that we want to change those things, again, I have no idea what this would look like in the NCQA context. You know, I'm sure people here do. But I just think we all have to think through some of that if we're going to get smarter about how to insert this into those conversations.

CO-CHAIR PONCE: I think that's what the roadmap hopes to put some teeth in and be more concrete. Doing nothing is also not cost control too, so that's the message.

So, let's go with Sarah, then Bob, then Yolanda. Do you mind if we move to consumers? I mean, you can talk about policymakers.

MEMBER SCHOLLE: Because my comments are a little different.

And just to say we would love to have

something new and exciting to address disparities, but it depends on demand from the people that pay for HEDIS, or that require HEDIS. And that's CMS and employers and state Medicaid programs.

And it also depends on a more active investment in capturing all the data we need to actually stratify all of our measures by race/ethnicity.

Right now we can't do that. In fact, we've put it on our -- we wanted to put our business plan for this year, and we had to pull it off because of the concerns about who is going to fund it. Because we depend on that funding as a non-profit. We really depend on people saying yes, we're going to do it.

So, that investment in resources is to support each step of the way is important.

And it has to be something that's valued by the providers on the ground and the health plans along the way. And that's where involving consumers to say how important it is would be valuable.

As we think about this roadmap one of the things, David's comment that well, you know, we've got this whole infrastructure of hospitals and provider organizations that have been doing one thing. And our roadmap is going to say yes, that's good, but we want you to do something else, or we want you to take a broader frame. So there really is a change management component to the work that we're proposing.

And in some ways there's a whole lot of audiences that are going to be tremendously disappointed if we only focused on what people could do today.

And then there's another audience that's going to be really disappointed if we focused only on what could be possible in the future.

And I wonder if some scenario planning would be helpful just to put a little bit more specificity around this.

So, when I think about it the accountable health communities is my future,

right? I think for this work.

And if we said here's what that should look like. And it's got to be more investment than what CMMI is offering those communities. It's just ridiculous what they expect for that itty bitty bit of investment.

And then what could hospitals, or health plans, or providers do today that really isn't that different and is kind of critical to providing good quality care to your patients.

So, if we could think about those two sides. This is what you could do today without really that much more investment. You've got your EHRs. You've got this. Make this part of your workflow.

It's really not going to be that much different and probably more valuable than those 100, 2,000, whatever it is, clicks you have to do anyway today.

But I think if we don't say this is what accountable health communities mean, this is what the payment structure, this is what the measures

are.

CO-CHAIR PONCE: Thank you. Helen, did you want to interject?

DR. BURSTIN: That's really good comments. Just one quick point after the earlier point that was made about how you also have to encourage policymakers to focus on these issues. It was Traci's point.

I have to tell you, I spend a fair amount of time on the Hill talking to policymakers as they're trying to work through some of these complex technical issues.

Disparities never, ever comes up unless I raise it. It is not an issue on their radar at all.

And in fact, most of these discussions are driven by Medicare, even though Medicaid is now a large payer. And I hear there is an effort to follow -- a pretty significant policy effort on Medicaid to follow.

So, I think there's an opportunity here to think about how we sort of infuse that in there.

But I'll tell you, the only issue that caught their attention was the SES adjustment issue because it was real for hospitals around Medicare.

But somehow -- adding something to that policymaker slide about somehow even getting disparities reduction on their radar screen when all they're thinking about is Medicare is just going to be a heavy lift. And it's really very broad, I think the full broad context that we talked about earlier.

CO-CHAIR PONCE: Thank you. So, Yolanda's next, Bob, then Ron. Oh, did you want to respond to this? On this point, then.

MEMBER COPELAND: About how a provider --

DR. BURSTIN: I think it's a great question, Ron. It just isn't how they think. They look at the global numbers and it just -- and I'd be curious what other people think who spend a lot of time in those discussions.

But it has almost never, ever come up, except for the context where the providers felt

like they were getting hurt. And then it came forward. But otherwise it was never part of the discussion.

But I think it's something we need to think about as part of this roadmap is how do you get their attention on those issues, because it's certainly not front and center.

And maybe that could be somewhat Congress-dependent, but it doesn't feel like that, certainly over the last decade.

CO-CHAIR PONCE: Yolanda?

MEMBER OGBOLU: Yes, I was just going to -- I've had the opportunity to work in policy a lot. And so when I looked at the policymakers slide what struck me was everything was allocate funds, provide incentives. And those are typically things that people just look at and say we can't do that. We have no money.

Most of my work has been on the state level. They just don't have money in the budget to do that. So, all of those things would be looked at and people would say no, we can't do that.

And so I think we have to think out of the box in terms of what other things we could do that wouldn't incur additional cost in addition to still asking for those things that we might not get.

In our state one of the things we've been able to do is stimulate collaboration among kind of key stakeholders. Kind of continue the discussion beyond workgroups like this by having policymakers establish workgroups, or task forces.

And the social networking that continues after those groups disperse really kind of takes on a life of its own, and it does help to continue to work towards eliminating disparities.

It sometimes is difficult to measure that kind of social networking that continues to kind of move our agenda forward.

But just thinking out of the box beyond something that could easily be said we can't do that, we don't have money to do that. I think we'll have to come up with some innovative ideas as we move forward.

CO-CHAIR PONCE: Thank you. Bob and

then Christie.

MEMBER RAUNER: I'm actually going to take us back to David's comments, but try to bring it to where we are now.

I think one of the biggest things that policymakers forget is it's hard to get people to do things that are against their economic self-interest.

And we keep turning to hospitals and insurers, neither of which have an interest in doing this. It is against both of their economic self-interest to improve the health of the public.

Hospitals make money taking care of sick people, not healthy people. Insurers make a percentage of a pie. As the pie gets smaller they lose money. That's one of the overriding things that people often forget.

And the ACO actually doesn't fix that. People think it does, but it doesn't really because when that hospital doesn't provide that MRI and gets half of the savings back -- they used to get all of that money. Now they only get half of it.

So, hospitals don't necessarily get the ACO thing for good reason.

And again, back to the same thing with the insurance plans. If the pie gets smaller and they're limited to 15 percent of that pie, as health gets better and costs go down they make less money. So it's against their economic self-interest to do this stuff.

And that's always going to be an undercurrent. And policy leaders need to be honest about that and introduce that elephant.

The real person in a role is the consumer, actually. But who are those consumers? Sometimes it's individuals because of out-of-pocket, but trying to corral consumers and get them to understand this is hard outside of maybe Consumer Reports.

The government is a big purchaser, but now you're trying to educate politicians and I won't go there.

Self-insured plans, that's usually the HR director. So we have to educate HR directors,

maybe Chamber of Commerce, or the X business group on health might be the way.

But the other fourth group, it's important that we have the union near. Because honestly unions are some of the biggest ones.

So in Nebraska, for example, the number two or three employer in every community in Nebraska is the teachers union. And they are probably -- they have potentially the biggest impact in the state, but this isn't even on their radar screen though unfortunately.

So, I'm glad we have a union here because you guys can play a huge role. But to be somewhat cynical, sometimes they're actually fighting changes for their own economic self-interest as well.

And so the consumer is really important in the end. And the problem with disparities is those are the people who either (a) have no money, or (b) and don't vote and that's why they just get left out. So, sorry for being gloom and doom again.

CO-CHAIR PONCE: No, but you addressed consumers. Philip? Philip, Mara, then Emilio.

MEMBER ALBERTI: I'm going to take that doom and gloom and turn it into something maybe optimistic and positive.

So, Lisa Cooper and I recently worked on a project together where we talked to community residents about what doctors could do about social determinants, what medical students should be learning, and there was real diversity of opinion.

Many folks had nothing. I can't hold a doctor accountable for what happens in my community. I can't imagine their doing anything but spending more time with us and maybe asking some questions, but I don't really see where that rubber hits the road.

We talked earlier about audiences, and who our intended audiences are, and we didn't say consumers. We didn't say the public.

And then we wonder how do we change the minds of policymakers. And the answer is up there, right? Advocate for change and the elimination of

disparities and vote, as we just heard from Bob.

So, I wonder if there's a way to rethink or add the consumers, the general population in some way as an important audience of ours in order to communicate the importance of this work, to address some of the beliefs on the ground in communities, and to maybe help them develop the capacity for and advocacy skills to make the case to the policymakers without whose support we won't be able to really push it all that far.

CO-CHAIR PONCE: Thank you. Mara, then Emilio.

MEMBER YOUDELMAN: Well, that's a little bit of what I was trying to get to earlier. So I think it's more than just the consumers, it's the advocates and it's the assisters for enrollment purposes.

Because that's a better leverage because, Bob, as you said earlier, getting the actual consumers to go out and change things is going to be challenging.

I think in the other piece, and this is

the thinking out of the box, it's budgets. I mean, if we keep in the same budget cycles that we are when you go to Congress it's maybe five years. And you don't see some of the savings farther out.

When you talk about the insurers it's one year, or maybe a little bit longer than that. And they're worried about their churn and so they spend it on intervention this year. And then their consumer goes off and goes to another plan and they don't benefit from any of the savings.

So, we talk a lot about pay-for-performance, but how do we pay for disparities reduction?

And it's not just paying for the interventions like the interpreter, or the accessible waiting rooms and things like that, but is there a way to change the framing? And I don't know, I'm not a financial person.

But to think about how do we pay for the benefits. Like you said, you have less people in your hospital beds. Well, Maryland is actually trying to do that where they're compensating the

hospitals for making the changes, and the hospitals aren't losing money because they have less people in their beds.

But how do we think more globally about that so that when we do see reductions in disparities people are actually getting more as opposed to less.

And how do we think about that in sort of the payment structures, and delivery reform, and everything else right now. And I think that's one of the challenges.

But everywhere it's what's my budget this year, next year, three years. It's not 5 years, 10 years, even 20 years which some of these are going to take to address.

CO-CHAIR PONCE: Emilio.

MEMBER CARRILLO: Well, to address the doom and gloom, Bob, and some of the points that you're making, Mara, really it's all about cost.

And until we have stratification of race, ethnicity, preferred language for healthcare, until we have those things stratified

into the CMS core measures, into the HEDIS, into HCAHPS we're not going to be able to make that cost case successfully.

I mean, readmissions. The hospitals are terrified about the readmission penalties. It's real money and hospitals work on small margins.

So, things like work in the value-based dimension about controlling readmissions where there's so much of the social determinants at play, from the language, to the culture, to the air conditioners. I mean, there's so much of that in that.

So, I think that getting stratification of core measures, of HCAHPS, of all of these measures I think would be a step forward.

CO-CHAIR PONCE: Great. Thank you. Christie, were you?

MEMBER TEIGLAND: So, I just want to talk a little bit about the whole importance of continuity of care, and how especially with the ACA and the health insurance exchanges we're seeing

that broken.

There's a huge, huge churn in the ACA population and it's probably from Medicaid to ACA. We've been looking a little bit at the members, the ACA enrollees who enroll outside of open enrollment. There's a list this long of reasons you can enroll, and they're hardship reasons, so these are vulnerable, disadvantaged people.

But they don't stay in that ACA plan. So they cost a ton of money when they get there. They don't have the time to fully assess them to get their risk scores up. And the risk scores don't account for any of these socioeconomic characteristics. This person just lost their home, whatever.

And so the ACA plans that actually take those members, and they have to take those members, are losing money because it's all based on this formula that's risk scores compared to expected costs and did you actually save money.

Well, they don't. They actually spend way more money than it looks like they should have.

And so, this is not going to sustain. And so these millions and millions of Americans that now have insurance through the exchanges, those plans are folding up. They're going away. They're not making it because they're losing money.

And the plans that are losing money are the plans that have the biggest churn and that are taking care of those most vulnerable citizens who we need to worry about the person, not these different disparate entities, right.

The person needs continuity of care to have good health and good health outcomes. So, how we solve that I don't know, but it's even bigger now with the ACA.

CO-CHAIR PONCE: Thank you. I just want to have just the last slide before I get to you Nancy.

And here's a group where we do have some influence on, NQF. And I just want to have you review this briefly. Marshall was reminding me we need to move forward, but we have Helen and NQF here where we could -- maybe you could amplify some of

these comments.

DR. BURSTIN: And certainly this is a lot of what Elisa will talk about tomorrow is how we can build what you're saying in terms of the roadmap into our core work as well as beyond that.

So, I mean we're certainly standing at the ready for your instructions of how to do this. So, to me these look like a reasonable way to move it, but I think there may be other ones that will logically emerge.

CO-CHAIR PONCE: Tom?

MEMBER SEQUIST: I don't have a comment on this slide, but I had a comment on the stakeholder list because I feel like you're going to move onto something else in a second.

CO-CHAIR PONCE: Yes.

MEMBER SEQUIST: One topic that comes up a lot is, and I don't know that it's a stakeholder group in the sense that you're describing it, are people involved in health IT and EHR vendors.

We come up with a lot of challenges around -- I mean, they've certainly created

disparities. Patient portals that were developed only to work on desktops and not on mobile phones excluded giant proportions of the minority and low-income population initially.

But even the IOM recommendations on how we collect social determinants in EHRs, they really affect, they impact all this stuff. Every time we write in here "support measurement" it's all dependent on these vendors.

And so, I don't think we have a consistent voice from them until Epic takes over the entire country and then we can just deal with one person who lives in the Midwest.

But you know what I mean? It's not the same kind of stakeholder as consumer, purchaser, payer, but it is a really important stakeholder in this whole discussion.

CO-CHAIR PONCE: Thank you. Go ahead.

CO-CHAIR CHIN: So, we're going to move on. But a lot of the comments you're probably going to say are probably applicable to one of the next two sessions.

There just needs to be a calibration. So, between now and 4 o'clock we have one break and then two sessions. The one that Ninez will end on is basically what is our action steps moving ahead. So, almost like our to-do list and plan moving ahead for the following calls and next meeting.

Before then we have this session now which is basically opportunities and challenges which I think we can actually -- so, the slide is currently outdated in that it was a list that people had come up with at the time that we had the survey. But these are five things and there were more things we could have added.

But I think probably the better use of the time is thinking strategically that this has been a fantastic discussion so far. A lot of great issues have been brought up. And it's a fantastic group that has a lot of practical, real world experience.

So, you can think about this next half hour or so being like opportunities and challenges. And really strategically. Thinking in the context

of if we're next going to come up with our next action steps moving forward for creating the roadmap this is a contextual discussion about well, given your knowledge of the field, your practical experience, you understand the politics and the environments out there.

Just think about what are the challenges that we need to have forefront in our heads as we come up with a plan. And then switch to opportunities. I think that will help Ninez when we go to the last session which will then be next concrete steps moving ahead.

Why don't we start off with the challenges part first. Some of these issues have come up, but if you're coming down to like what are the key challenges that we need to be aware of now, most immediately, as we start thinking about with moving ahead with the actual development and implementation of the roadmap.

What would you think of as the key challenges that we need to make sure we address and keep in mind as we march ahead?

MR. PHEULPIN: And I'm sorry. Before we get to that I had just one quick logistical item which is, as Erin mentioned, we're trying to make a group reservation at Catch-15.

Four folks got back to me and I just was wondering if by a show of hands. We need to get back to the restaurant soon. So, by a show of hands is anyone else interested other than those who already reached out to me? Okay, all right. Thank you.

CO-CHAIR CHIN: Challenges. Ron, then Nancy.

MEMBER COPELAND: So, I just want to clarify you're talking about challenges for what happens to the recommendations that come out of this body at some point? Or challenges in us doing our work?

CO-CHAIR CHIN: I think more like we want the work we do to be impactful, and not just be a report on a shelf. And so it's going to impact then like how we move forward, what we decide we're working on, and just how we spend our time and all.

MEMBER COPELAND: Well, I think one of the major challenges is the fragmentation and lack of alignment of the laundry list of stakeholders that we've identified.

So, trying to put together recommendations that would be meaningful, the right balance of aspiration and practical application and so forth for such a diverse group of stakeholders, I think that's a formidable challenge.

CO-CHAIR CHIN: Nancy.

MEMBER GARRETT: So, I wanted to bring up a challenge that I think also perhaps is an opportunity for a couple of the stakeholder groups which is around privacy laws and data sharing.

And so, I think it's really relevant for disparities because it's really important as we try and address disparities that we're looking holistically at the types of not just collecting patient-level data in the clinical setting, but what other kinds of data do we need to really understand and address disparities?

So, as an example, within Hennepin Health which is an ACO that we're part of we've really struggled with trying to integrate social services data in with our clinical data to really have a full picture of what's going on and have a shared record of all of the interventions we're doing with patients.

And we were actually able in Minnesota to pass a law that specifically allows social services data to be shared with a healthcare provider to the extent necessary to coordinate services is the language that we used.

And so, that's an example of where policymakers and consumers and voters were able to say, okay, we get the importance of this and we're going to make that possible.

But those privacy laws can really be a barrier for this kind of important work. So, I think that's something that we also should put in our roadmap.

CO-CHAIR CHIN: Thanks, Nancy. So we have Romana, Tom, Traci, Philip. Okay, Romana,

Traci, Philip.

MEMBER HASNAIN-WYNIA: Is it okay if we go back one slide? So, I think one of the challenges in that first bullet around expanded collection, reporting, and analysis of standardized data, what I worry about is how we make sure that we ask for the expanded collection and use of these data, but recognize that the barriers to collecting this expanded set of data around demographic characteristics is the fact that there's not a lot of evidence about how best to do it.

And so what we would hear from healthcare organizations is, you know, this is really going to increase our data collection burden. We don't know how to collect.

I mean, there's a lot of information on race/ethnicity and we're not doing a good job with that right now. And there's a lot of guidance on that.

There's less so around sexual orientation. We're funding a couple of projects

on that at PCORI. Not a lot of evidence around disability status.

So, the tension for me and I think it will come out is we don't want to set it up so there's an opt-out because, oh my gosh, there's no evidence.

I think we need to really make the case that we don't want the perfect to be the enemy of the good and move forward.

But I think that that is going to be a challenge.

CO-CHAIR CHIN: Romana, my answer to that question always is I just cite you. I cite Romana.

MEMBER HASNAIN-WYNIA: My points about, you know, expanding our scope to not just be focused on race and ethnicity, I think this is where we're going to hit some challenges.

CO-CHAIR CHIN: Great point, Romana. Traci, Philip, and Michelle.

MEMBER FERGUSON: I think one of the key challenges in the implementation when we get

to the roadmap of how we're going to make those changes, especially if it's going to be a significant paradigm shift for some of the stakeholders.

And seeing if we could, as NQF has a lot of other stakeholders that may not be a part of this committee, whether they're consumer advocates, more non-traditional healthcare advocates but they have a strong community base that can help expand our message. That can I think maybe influence the policymakers in a way, you know, getting people out to vote and things like that.

So, I think once we get to the point of implementing, or thinking about implementing, reaching out to those non-traditional healthcare advocates who can help us get that message and speak where we can't speak.

CO-CHAIR CHIN: Right. So that's partly also then the opportunities side of this part. Philip, then Michelle.

MEMBER ALBERTI: I just want to build off two things that Ron said earlier.

So, you mentioned increasing the alignment of the stakeholders. I think even prior to that it's building a shared understanding of what disparities are, what the role that each stakeholder has to play.

I mean, we've debated definitions now for our introductory meeting and this one. So I think some kind of education of all the different stakeholders about what the issue is.

You also mentioned research funding. So, to pair that to what Romana was saying in terms of the ONC Social Behavioral Psychological Data Panel, we pulled together 13 institutions that had been collaborating on funding applications to actually understand how to collect those data in patients in various and sundry ways, and had three negative reactions from funders.

Just in that kind of are you interested in this? Well, it's too new, there's no evidence base, there's no -- it's not five or six years away.

So, I think focusing on the evidence that we need and on building that shared

understanding.

CO-CHAIR CHIN: Thanks, Philip. So, Michelle, then Bob. Oh, Kevin, and then Lisa.

MEMBER CABRERA: So, this is a little bit of a crossover with the consumer stakeholder, but I think in terms of the -- I agree that the data collection piece is sort of barrier number one.

And I just wanted to mention that in California this year we got a bill signed into law that will start to direct certain state departments to start to collect information around sexual orientation and gender identity as they update forms and just in the course of business.

So, we will start to gather some information and experience along those lines in California. Although it will be self-reported which is good, but it will also be voluntary. So you know, there are sort of trade-offs associated there.

I think it's also a challenge that some of the groups that we're talking about engaging in this conversation are groups that by definition

have been marginalized by institutions, like healthcare institutions.

And so we will need bridges I think as Traci and others talked about. And that's going to require not just sort of bringing folks into our fold, but it will also require changing the nature of our institutions so that our institutions are more cognizant of what is relevant to the populations that we're talking about in terms of the way that services are being delivered, the approach to it.

And so I think it's a little bit of a two-way street. And yes, there are significant barriers in terms of what gets paid for and what doesn't, but you know, I think there's some of this that is within the realm of doable and fairly quickly by health systems in particular.

CO-CHAIR CHIN: Thanks, Michelle. So we're up to Bob, then Kevin, Lisa, then Emilio.

MEMBER RAUNER: I think one of the good ways forward -- I'll drop my doom and gloom hat -- is that I think there's a lot of opportunities to

find the data we've needed. Because we didn't have it for awhile partly because there was sort of a moratorium, but also because it just wasn't there.

We now have because of meaningful use race/ethnicity/language preference we didn't have before.

Other things we need to start working on - how will we get it? How will we develop it? And so we had Lisa talking about can we capture disabilities somehow. How can we capture sexual preference?

Income is hard. Sometimes people use insurance status as a surrogate. Education level, how can we get that?

And to work with the folks who would be collecting the data. I think someone was talking on that earlier. Was it Susannah? About how a lot of patients and front-line providers are happy to collect the data as long as they see it as important and get it.

And the ONC unfortunately did not do that at all. That was one of their problems. If

they could work with the front-line people and say hey, you know, if you would do this for us we would love to collect this data, but there's got to be something we can see that it's useful for, not because some random group wanted us to do that.

And so I think one of the things we need to do is create -- because we're never going to answer this stuff because the research isn't there. We need to actually literally create the data to do the research and get the answers.

And I think that could be one of the outcomes of this is the active encouragement of collecting and not hiding some of this data.

Like in the school environment, boy, do they hide free and reduced cost lunch. It is so hard to get access to that data, but it's like the biggest confounder. But for political reasons on both the left and the right they want to hide it from everybody. But we need it out there so we can make good judgments.

CO-CHAIR CHIN: So, it sounds like you agree with Romana about getting to the nitty-gritty

of how you're going to collect this data and implement is going to be a cradle issue.

So, Kevin, Lisa, Emilio, and then Susannah.

MEMBER FISCELLA: I'll frame this as both a challenge and an opportunity. And we've talked a little bit about this.

And I think this has to do with CMS. It's been 10 years since we've had, or actually 11 I think, 12 years now since we've had AHRQ reports.

And there's been a fundamental disconnect between what various agencies within HHS have been doing and the focus on disparities, and CMS's ability to really effectively integrate disparities elimination into the CMS program.

And CMS actually was probably one of the most adamant opponents to the SES adjustment.

But I think as CMS moves rapidly towards a value-based payment, and even in their draft of their plan they do talk about eliminating disparities as a core principle.

Now, what's lacking is how they're

going to operationalize that, what that means and all of the steps that we're talking about.

But if CMS could really begin to walk the talk here it would have a profound effect on many of the other payers, and data collection, and various approaches, and incentive programs.

I think if the concept that both value and equity go together, and it's not just we put all of our resources into improving value, but we also need to do the same with equity in tandem, if that could begin to happen as things roll out I think that could really begin to shift the momentum here.

CO-CHAIR CHIN: That's a great point, Kevin. So, for those of you who haven't seen it like in the fall, just four or five months ago CMS released their equity plan for Medicare in which they talk about REL data collection, they talk about quality improvement. They don't talk about payment at all.

But the time is different even in the past half year. So I think there is this great

opportunity.

So, Lisa, Emilio, Christie. Oh, Susannah, then Christie.

And we can -- feel free as we start going through this now to start talking about the opportunities now too.

MEMBER COOPER: So, it's been so long since I put my hand up that I'm trying to remember what I was even thinking. And I've heard so many challenges and opportunities going hand in hand that it's hard to know which side we're on right now.

I guess what I was thinking about, and it may have been said in all the things that have been talked about, is that one of the challenges is a lack of technical expertise in the delivery system as well as in communities.

But the opportunities on the other hand are that we do have a lot of technical expertise in the research world that could actually be paired with some of the clinical expertise to actually bring about some of the changes that we're looking

for if we can just sort of get people out of their silos which is another challenge that I think we need to try to overcome.

I also think that there are community strengths that we're not leveraging as well as we could because we're not including all the people that are in the communities.

And so one of the challenges is messaging and getting the engagement of this broad and diverse group of stakeholders.

CO-CHAIR CHIN: Thanks, Lisa. So, Emilio, Susannah, and Christie. I'm assuming Ron yours is from the past so I'm going to skip you. Okay, yes.

MEMBER CARRILLO: Just again, it's the cycle. You put it up when somebody mentions, and then by the time you get back it's already been awhile.

But I just wanted to again, we need to double down on the REL, on the race/ethnicity/language preference. It's been around the block years. NQF like in '05 supported

the HRET as a way to do it, standardized, done by the RWJF.

I mean, been there done that. So, we've just got to get serious about it. It's got to be done. Really come down very strong on that. Get that stratification done across all those standard measures.

But also we have to be aspirational. I think that in terms of the LGBT, I mean right now the Joint Commission had a great report they put out a few years ago that all hospitals read looking at measuring LGBT community and looking at LGBT needs.

The Human Rights Campaign is really pushing the health equity index. All the hospitals are trying to make sure they're part of the leadership group. And these surveys every year are pushing further and further the envelope in terms of collecting data.

So, we have to join the chorus. I think that really double down hard on the established measures, but things like the LGBT, begin to

really push on the disability measurements, begin to gather more on that, and go on record in terms of these aspirational and developing emerging measures, but really be very, you know, enough said already with the REL measures.

CO-CHAIR CHIN: Thanks, Emilio. So, we have Susannah, we have Christie, and I think we're going to be thinking about the opportunities. Because we're still thin on the opportunities. So, Susannah.

MEMBER BERNHEIM: I'll try to frame some of my challenges as opportunities.

So, we've talked about it, but I think it has to go on the list of challenges is sort of attribution.

I think one of the toughest things in measurement right now, and thankfully Helen is going to solve it all with her new committee, is what the entity is that's being measured and being held accountable for. And I think with all of this that's going to be really critical.

There are also some technical

challenges. And I don't think this committee wants to get into them, but I do think they're worth acknowledging.

We develop risk-standardized outcome measures and we've tried to do some work around stratifying, but sample size is a real issue.

And so, if we want to look at a hospital and really understand the differences between their black and white patients we can look at about 10 percent of hospitals in this country and really know what we're looking at. And that's tragic.

So, we're trying to think about those issues, but stratification if you have risk adjustment and you need a sample size gives you -- so, you can do unadjusted stratification. I mean, I can tell you raw rates, but hospitals aren't going to be happy with that.

So, there are some real technical challenges with this. I think they have to be overcome. I think there needs to be a big push for us to just figure out the best way to do it, but I think it's worth acknowledging.

CO-CHAIR CHIN: Susannah, you make excellent points. So it was Christie, then Nancy, and Michelle.

MEMBER TEIGLAND: So, I just wanted to build a little bit on Kevin's comments about CMS and just add a little bit of color to that.

Some work that has been done recently by CMS, work done by RAND that found the same disparities that we found in quality measures between dual eligibles and non-dual eligibles, but found no contribution of socioeconomic status.

Why? Because of the issue Bob and I were talking about last night, that they used five-digit zip code Census data which is too gross. It's not granular enough. I mean, yes, a county, a five-digit zip code in Manhattan has super rich people and very poor people. And so you're not going to find any SES impact.

And so the data is poor, but they dismiss the fact that SES has any impact on outcomes.

They now have two interim SES

adjustment proposals in their request for comments to sort of help fix the star system over the short term to account for SES, but they're defining SES as dual status or low-income subsidy status.

That only explains a tiny percentage of the disparity because it doesn't capture all of these impacts of poverty, and community resource availability, and education, and all these other things that we've been talking about.

So, it just closes a little bit of the performance gap. It doesn't close the entire performance gap. So yes, recognition that there's an issue would be really helpful.

CO-CHAIR CHIN: Thanks Christie. Let's do Nancy, Michelle, and then anyone who hasn't spoken yet who wants to speak will get the next shot at it. So, Nancy, and then Michelle.

MEMBER GARRETT: So, just to throw out one idea of a potential challenge. It feels like a lot of our discussion has been focused on taking the existing portfolio of quality measures and stratifying by the characteristics we talked

about.

But maybe we need a different set of measures. Maybe there's a set of measures that we haven't thought about that would really help us understand better populations that are vulnerable and disparities we need to close. And maybe that's where we need to put some of our development effort.

So, it could be -- Lisa and I were talking about some kind of way of doing social risk stratification as opposed to just medical risk stratification, or maybe there are other measures that we haven't thought of.

So, again, I just encourage us to kind of think big and not just be limited by here's the way we've always thought about performance measurement and let's just add some other variables to it.

CO-CHAIR CHIN: A couple of resources -- it overlaps with some of the population health issues.

So, this IOM report "Vital Signs." IHI is currently coming up with like a dozen measures

of use for population health measurement. RWJF Culture of Health, you have a group working on it, trying to come up with -- they have like a 41-measure set for population health.

Some of those start getting more into like some of the mix with the social determinants also.

So, Michelle, and then folks who haven't spoken recently.

MEMBER CABRERA: I'm trying to heed the call to opportunities. And I will say there's a huge opportunity on sample size in California.

We're incredibly diverse and lots of -- a majority Latino state now, so if you can wrap your head around that. You know, we're not just a majority people of color, but majority Latino.

One question, and this, I don't know if this is a follow-up, but people have referenced meaningful use and the impact that that's had. And I feel like we're sitting on top of it and so I can't really see it. Like, I don't have a sense yet for what is the actual impact that that's had today.

Just last year when we were having conversations about trying to raise the level of this, and the importance in the context of our 1115 waiver conversations I had Medicaid plans and safety net providers going you got some of that data? I'd like to see your data because it was clear, you know, they weren't really confident in the data they had on either side. And so I just saw the hot potato, kind of.

So, for me a question is how much of the gap has meaningful use filled, and what's the lag time on when we'll be able to actually start to put that to use is the real question.

And then on opportunities, I mean I guess pay-for-reporting. We could ask for that as well, because if we're not getting the data and we need to prioritize it somebody could actually pay for collection of the data if we need to pay for everything. It seems a sad thing, but hey.

And then the other thing, Lisa and Philip and I were talking with some others I think about community health workers, and again, peers

and navigators.

For me it's like a super bright spot to think about how that workforce can have so many different uses and purposes with the goals of eliminating disparities both in improving the cultural competency of care in much faster ways than improving the physician diversity would, right?

But also creating career ladders for folks, and helping to actually directly address some of the issues that are underlying barriers. And getting people more knowledgeable about healthcare systems, and more health insurance-literate, et cetera, et cetera.

And so it just seems to me like we talk about it a lot, but that's a huge opportunity and a huge bright spot if it can be done better, or done on wider scales, and researched and shown to have those benefits.

CO-CHAIR CHIN: Thanks, Michelle. I think most people have spoken. Uncharacteristically I think maybe Mara, Lisa and

Eduardo. So, if you have anything that you want to say first, you guys?

MEMBER SANCHEZ: I resemble that statement.

CO-CHAIR PONCE: And Jose.

CO-CHAIR CHIN: Lisa?

MEMBER IEZZONI: I've been holding my fire because I knew I wanted to talk a lot when the ONC person came.

But I think it's important to note that there's been a ton of research on how to ask questions about disability.

The six questions that the Office of Minority Health have come up with have been vetted every which way you can internationally as well as nationally and there's pretty good consensus that those six questions are a great way to start.

And the point that I would make is that it might be viewed as burdensome to ask people to collect those data.

But in fact, knowing what you know by having asked those questions is critical to caring

for patients.

AHRQ asked me quite a few years ago. Helen, I don't even remember when. You used to have an M&M series online. An M&M series. And you asked me to write an M&M about a patient who'd been an inpatient who was diagnosed with diabetes and had been taught by the care providers while an inpatient before being discharged how to self-inject insulin.

The patient went home, didn't self-inject insulin, didn't follow through, came back in really sick. The patient was low vision. Nobody had noticed that. The nurse who was training him did not notice that he was actually blind while she was training him.

And so you know, if you ask questions, "Are you low vision?" and you put that in the medical record, that's actually going to help you care for the patient.

We just completed a project for the National Institute for Child Health and Human Development where we looked at a mixed methods way

at women with disabilities who'd had babies.

And we did a qualitative component to that. I personally interviewed 22 women for 2 hours who'd recently had babies having had significant physical disability before becoming pregnant.

Not 1 of those 22 women was routinely weighed during her prenatal care. They used wheelchairs. Not one of those women was routinely weighed.

If the providers knew that they used wheelchairs and that they were coming into the clinic they might actually think that they're coming for prenatal care, that it would be a good idea to weigh them. And so it might give providers information that would allow them to actually give good care to these women.

And so, I think that we're limiting ourselves if we're talking about data collection simply for quality measurement, or measuring disparities.

I think we need to get into the mindset

that some of the data we're asking for are data that actually are necessary to care effectively for patients. And that changes the way that you think about it.

CO-CHAIR CHIN: Yes, it's interesting, Lisa, that like from your shop a guy named Tim Ferris did grand rounds at University of Chicago yesterday. So he's the VP for population health.

So, the way he framed it was that, you know, the central philosophy that he described at MGH, trying to figure out what is the way that clinicians feel that care should be delivered ideally first. And then he sort of wrapped then thinking about the payment and then the other essentials around that. So, start with that first.

So, that's what I'm hearing you saying, that we're talking a lot about performance metrics and the tools that we have, our availability, but you're making the point that we also just can't leave out thinking about what --

MEMBER IEZZONI: Caring for patients?

CO-CHAIR CHIN: Yes.

MEMBER IEZZONI: Yes. Exactly.

DR. BURSTIN: You know, that's a great point, both of you. And I think that in some ways the ideal state of measurement is the data that's collected through the routine process of delivering care, or dyssynchronously, whenever patients want to provide the information they want to provide.

And so in some ways ideally what you would want is the data you're already collecting for the sake of patient care should be to the betterment of quality. And if it's not, then we have a problem.

And I think we have a problem in our country right now that we collect a lot of data that isn't to the betterment of quality. So, I think there's a real opportunity there for us.

CO-CHAIR CHIN: So, why don't we take a 10-minute break now and aim to come back around 3:20 or so. That will give us 40 minutes to come up with sort of marching orders before we have the

ONC session. Great.

(Whereupon, the above-entitled matter went off the record at 3:08 p.m. and resumed at 3:30 p.m.)

CO-CHAIR PONCE: Okay, let's reconvene. It's 3:30 and at four o'clock we have another item on the agenda and David Hunt will be joining us. So, let's try to put some parameters in this discussion, but also know that it's, again, not the end of the discussion. And then we have tomorrow.

This is the part where we try to tie everything together and come up with a concrete plan, or suggestion of a plan on how -- here it says the current state to the desired state, but more of what is the standing committee going to do, and what are we going to produce, and how do we get from here to there.

I know that Sarah made a point earlier today that you want to be aspirational and say this is what should be and also, you know, very normative about it, but we also want to have recommendations

of what you can do now, what you can do today.

So, saying from the current to the desired state doesn't mean that we're not going to touch what is actually feasible today.

I'm also going to -- so this is again are some ideas. But I want to go directly to the questions on getting to this path. Because a lot of the items, the bullet points in the previous slide we've touched on and talked about today.

So, I think I want to -- before people start putting their tags up I actually wanted to call on Sarah to talk about what you said what the framework should be. Because you had this appeal. I don't know, going it by bucket by bucket, stakeholder by stakeholder.

MEMBER SCHOLLE: Actually, I think I was building on a lot of people who were saying what we need is a logic model. We need the actors and we need the steps. And then we can kind of tie the actors to the steps.

And to make it concrete for myself I'd love to use an example like the accountable health

communities as a way to say what's the future going to look like. And who would the actors be involved?

And we don't have to look at what CMS or CMMI wrote, but we could say, okay, we're going to think about a community as being -- including a number of different stakeholders and having these responsibilities. And then we could try to tie the activities that need to be done to the stakeholders who would need to be involved and working together.

And I think actually working -- thinking about that future would get us back to -- I'd start there because then we could say well, what could we build today that would get us along the future, without building something that's just an interim piece that's not going to survive to the future. That's really what I had in mind.

CO-CHAIR PONCE: Great. Any other ideas? I was looking at Eduardo. How do we get from here to there?

MEMBER SANCHEZ: So, I agree that starting with a conceptual framework makes a lot

of sense.

I agree that we might want to describe, as I think about this notion of an accountable community. And I totally agree with Sarah that rather than be constrained by how anybody has defined what that is we ought to be talking about what it should be in the context of the work that we're doing.

And that is the future state that will include in it some of the elements we already recognize. Clinical care is going to be inside of there. Hospitals are going to be inside of there. But how they interrelate may look different.

Emilio may have some experience because of the work that he's doing, thinking more expansively, but others of us who may live in different kinds of communities do not.

The other, I think, is to begin thinking about how were we going to describe what it is that we're wanting to do, and that's the elimination of health and healthcare disparities. So, at the very least we need data.

And while on one of the previous slides I saw some good language around data at a clinical level I would say to you that at the very least as we think about communities of health we will need community-level data because that clinical care data sometimes -- you know, one of the things that we as an organization that is about measurement would want to do is to assure that data that we're looking at is compatible.

And there is still an ongoing conversation about how representative and generalizable is clinical setting-derived data to the health of populations outside of the clinical setting, if that made any sense. So, when there are data that's collected at a community level.

So, conceptual framework, one. And then the beginnings of thinking about what are those things that we want to be able to measure.

And then work our way upstream with both in terms of mapping. Upstream meaning if we're going to eliminate disparities how will we know we did it. What has to be in place to do it in the

context of this conceptual framework.

CO-CHAIR PONCE: Thank you. Emilio.

MEMBER CARRILLO: I think that's terrific. And just to mention the work that we've done in New York, in northern Manhattan, which has been published in Health Affairs and which Phil and AAMC recognized a couple of years ago, a regional health collaborative where at the very center of this universe is the medical home which at its heart has an interdisciplinary team that is culturally competent, that includes community health workers, includes the registrar, front desk, and is armed with data from data registries, predictive models which are managed by data analysts working with nurse and social work care managers.

So, this central medical home is at the hub of a medical neighborhood which is where you have the emergency room that's triaging care, determining those that are higher risk, having patient navigators working with the community health workers. Getting patients from the ED into the medical home. Working with the 30-day

readmissions from people who are admitted to the hospital, discharged, managing folks.

So, collecting together the medical home with the various different facilities that provide care.

And then in the outer rim is the medical village where you basically have community-based organizations, providers of behavioral care, those providers that are dealing with the social determinants of health creating the linkage between the medical home and those agencies that can provide the housing instability support, the nutritional instability support, the transportation support, et cetera, so that using IT and using culturally competent workers like community health workers and patient navigators you create this village with the neighborhood and the medical home at the center.

So, I think that that's the model that we're doing in New York.

MEMBER SANCHEZ: Ninez, can I just -- that's great. I will offer -- and I bet there's

others who can offer others. Bill Dietz was the lead author on a recent Health Affairs publication on an integrated framework that I think complements some of what you're saying, Emilio, except it puts people and families in the center, and then the other stuff is outside of it.

But it is about how you integrate clinical and community. It's a different way of looking at it -- no, I got that. I get that part of it.

That's still -- to me that's a different way of looking at it. It's actually -- all of these things are more than just two-dimensional.

One dimension is to look at it through the notion of a patient-centered medical home that still makes the patient-centered medical home the center of the universe.

This is a different way of looking at it. This is looking at it, putting patient and family at the center of the universe and other things kind of extending outside of it.

But I think it begs the question.

There are probably multiple models and we might want to have a look at a few of them and develop a -- we might want to adopt one, or develop our own framework that sort of captures what we think is important in order to accomplish our goal of measurement to address and eliminate health and healthcare disparities.

But your model is an awesome model. I just put out there that this integrated framework is trying to get at the same thing of how do you connect these things that are unnaturally connected in most of our communities.

CO-CHAIR PONCE: Great, thank you. Nancy, and then Ron. Oh, no. Okay, Ron.

MEMBER COPELAND: Yes, I really resonate with the conversation about integrated frameworks. It makes perfect sense.

What I would ask us to consider as we move in that direction if that's the one we choose is get very clear within that framework around the accountable unit for delivering on whatever it is that we're going to ask the community, or the

provider community, or the payor community to do.

Be very clear about the accountable unit and understand the implication of that.

And then secondary to that is be clear about within this integrated framework the shared responsibilities that we're asking for.

So I think we can't just put a framework up unless it's just for our analytic purposes. But if it's a framework around models of actual care, and services, and payment, and so on, we've got to have some understanding of the presumed shared responsibilities.

And those two words we haven't used a lot today. Accountability and being clear about an accountable unit, whether it's at a system level and defining that, and then the shared responsibilities that encourage the kind of integrated collaboration that has to be in place to impact what we're talking about.

CO-CHAIR PONCE: Noted and thank you. Susannah.

MEMBER BERNHEIM: Just one thing to

add. I think it would be useful in terms of -- I mean, I think you're trying to figure out how we're going to get from all these great ideas to writing a report.

I think that taking it in steps and really making sure that we're aligned on goal and principles will be useful because when we try to build this framework when issues come up if we have set our own goal and principles they'll help us reflect back and say, okay, that's aligned with our principles, this is getting a little out of scope.

So I think I'd recommend we go back to that piece of work and kind of settle there. And then I really like the idea of sort of drawing out what an ideal state would be within a community that would be addressing health disparities, and who the key actors are, and therefore what their actions are, and what actions can move us in that direction.

CO-CHAIR PONCE: Well, on the guiding principles. I wonder if we could just use this time to finalize. The first part was health and healthcare disparities. So, how do we -- do we

vote here, or is it -- whatever I'd like. Because you know, we can go back, do a survey, have a low response rate.

(Laughter)

CO-CHAIR PONCE: Everybody's here. Everybody's here. So, at the table what I heard this morning was the -- well, actually, I think Philip had a nice way of saying you want to include health and healthcare, but when you get into in terms of operationalizing, in terms of precision then you can zoom in on healthcare, and even within healthcare -- or health outcomes it might be healthcare-specific health outcomes.

But I think just a guiding principle -- who would like to just focus on healthcare disparities?

Okay. So, both health and healthcare disparities.

Okay. So that's done. You don't have to do -- okay, great. We're done.

(Laughter.)

CO-CHAIR PONCE: Okay. So that's the

guiding principle. So when we are up late at night going over the text of the roadmap we can call on our guiding principles and this vote of 100 percent.

Oh, sorry, Jose? Are you still on? Okay, well -- oh, David.

MEMBER NERENZ: Just a small caution and qualifier.

I'm okay with the statement except I go back to the comment I gave before lunch about the accountable entity.

I'm going to get really nervous about health disparities for which we cannot identify an accountable entity, nor can we link a measure back to some entity that can feel shame about bad performance, or take action.

So there's a domain that I'll call public health that I will have some strong concerns about. But that still leaves open some useful territory where health would be the right word. So, just a qualifier.

MS. MUNTHALI: So, this is Elisa for

those on the phone.

One of the things this discussion has brought up is similarities between -- Emilio and I were talking about population health work. And Emilio was on our endorsement project.

And one of the things that our team struggles with and the committee as well is how do you make -- how can you change those things that are outside the healthcare delivery system, the broader health of populations, the social determinants.

And so as a qualifying statement what we have decided to do is use the term modifiable, you know, health determinants.

And I don't know if this would be applicable here, or if this would be something this committee would want to consider as you're looking at disparities that are looking outside the clinical healthcare delivery system and looking more broadly at health and determinants.

CO-CHAIR PONCE: Sarah, then Tom.

MEMBER SCHOLLE: So, as a measure

developer I would very much say we're going to have to be addressing that in the measurement work where we're saying what measures are used to encourage improvement, to monitor improvement over time. And they can also be used for payment and other kinds of incentives.

But the ultimate goal of our measurement work is to improve health. And so I think it's -- you can still have a measure that says are people improving, but I would not want to encourage the use of that measure for public reporting or payment unless it was really clear who was accountable for it and how to do it.

So, that's been one of the challenges for our measurement system today where we create measures for the accountable entity. We make measures for hospitals. And the hospitals say well, I'm not responsible for that. You can't hold me accountable for it.

And then we make measures for doctors and they say I'm not responsible for that. Health plans, I'm not responsible for that.

So that's why I really like the idea of trying to put this in the context of a community where you're going to have joint accountability.

And even ACOs, or whatever entity that includes hospitals and doctors, I think that kind of entity is going to be responsible for the population it serves.

And at that point we're going to be wanting to know something about whether they're achieving the Triple Aim. Are they improving population health, or maintaining it, depending on what you'd expect for the population, improving care, and managing costs well.

So, that's where -- so I completely agree with you, how we use quality measures has to be taken into account. Level of accountability, level of influence over the problem.

And we need to keep our sights on this bigger goal, and try to lay out what's that goal compared to what can we measure.

And we're not always going to be able to measure that health outcome, but we might be able

to measure the things that we think are going to get us to that improved outcome.

CO-CHAIR PONCE: Tom, you had -- you changed your mind. Which way?

We can't wordsmith a statement right now. I think it's just, again, just general guiding principles. Are we on the same page? It sounds like we are in terms of considering both healthcare and health.

Operationalized differently, perhaps, but it's -- so what we'll do is with Marshall and NQF staff is come up with some alternative wording then that you all can react to, can finesse.

The second guiding principle is the population. Rob. Sorry, Bob.

MEMBER RAUNER: This came up actually during the rural panel last year because one of the political problems with the ACO movement is that it pits physician organizations against the hospitals sometimes. And in a small community it really divides the community sometimes.

And one of the proposed solutions goes

back to what they were talking about is making anybody who operates in the sphere jointly accountable for a community measure.

So like, for example, flu vaccination. The hospital and the clinics and the health department all have a stake in improving flu vaccination within a community.

And trying to figure out how to develop maybe some community-level measures that all can be held jointly accountable for.

Again though we get, like Dave was talking about, who is the real ultimate entity that's accountable.

But if you could say that -- and Medicare of course can produce, for example, community-level vaccination rates at least on the Medicare level. Like, say, Lancaster County flu vaccination rates are X. If you are an ACO or any of these entities within here this is a measure for you. You have to improve community-level.

And you might find ways to maybe hold them jointly accountable and align incentives

instead of pit the groups against each other.

I'm not sure exactly how to operationalize it, but there was a lot of interest during that rural to try and figure that out, especially because in most rural areas there's one dominant clinic and one dominant hospital that may or may not be the same organization, but still it really does promote that community side of it.

CO-CHAIR PONCE: Thank you. Eduardo.

MEMBER SANCHEZ: I think in terms of populations, I don't know if you're asking for a yes or a no.

I think edging towards maximal inclusivity, but rather than list every single population out we list them in categories. Whether they be race/ethnicity, whether they be about sexual orientation, but that it be rather than an explicit include everything and hope to God you didn't leave someone out, you use language that covers as many as possible, and can accommodate others if issues were to come up.

CO-CHAIR PONCE: Well, I heard using

the words vulnerable populations. I heard using historical advantage, disadvantage.

MEMBER SANCHEZ: Yes. I'm not a big fan of words like vulnerable populations because it sort of victimizes people. And so if we can just think of how we can be inclusive.

And I recognize that those are the words that are often used, but even disproportionately or adversely affected, that has less judgment, I think, than vulnerable.

But again, that's just my own personal opinion. And it's not to -- it's to be sensitive about the words we use. And we're all learning to be more sensitive about the words we use.

And I have found in the past, I think minority health has some negative connotations. Vulnerable populations still sort of puts people in this place like they can't take care of themselves. That's not really the issue. The issue is that they're underresourced and they are disproportionately burdened with challenges, not necessarily that they're -- and they may be very

resilient. But given all the challenges they have it's a tough slog.

CO-CHAIR PONCE: Lisa Iezzoni. I know you're saving your questions for the next -- for four o'clock, but you did open up our session about populations. Do you have a suggestion?

MEMBER IEZZONI: I think that we do need to list examples. For example.

And I think the proposal was made to compare these groups to advantaged populations, you know, the people who have historically not been stigmatized.

But I don't have anything more to say other than that, although I also do not like the phrase vulnerable population.

And I also don't like -- I'd rather not use metaphorical words, like saying people suffer healthcare disparities. Well, maybe they suffer, but people experience them. Or they have them. Or they happen to those populations. You know, rather than using metaphorical language, just use very straightforward subject verbs would be my

suggestions.

CO-CHAIR PONCE: Okay. Philip. If you just look at me I'm going to call you.

(Laughter)

MEMBER ALBERTI: I mean, I agree. I think listing examples. I think steering away from language that is insensitive potentially.

I think framing it in terms of social advantage leaves an opening for things to change, for other groups to become disadvantaged relative.

I think my personal decision about who is the right comparator group for these measures, I'm not necessarily sold that it should always be who it usually is, whites, or white men. I think there's probably a rich discussion to be had there about who the appropriate comparator group is, but I like the idea of a for example section, these kinds of groups and other groups disproportionately affected because of social disadvantage.

I think something encompassing, inclusive, and sensitive.

CO-CHAIR PONCE: Including, not limited to. Mara.

MEMBER YOUDELMAN: I was going to sort of suggest that. I think there are some groups we would -- or I would definitely want to see have examples however it's framed.

I think race, ethnicity, language, people with disabilities, immigrants, LGBTQ, sexual orientation, gender identity, figuring out how the best way is to do that one, and rural.

I think if we don't then -- particularly rural, some people just don't think of that as a disparity when you're thinking healthcare disparities.

We haven't really talked about sex or age as sort of stand-alones and so I didn't include those because I'm not sure that we're going down that path, but I'd be curious what others think because there are pros and cons of it.

But I think if we're talking in a, I don't know, in the frame that I think I heard people say this morning, at least the other categories I

mentioned are some of the ones we would want to see more explicit mention, examples, a non-exclusive list, something like that.

CO-CHAIR PONCE: And the intersectionalities that was also raised this morning.

MEMBER YOUDELMAN: Yes.

CO-CHAIR PONCE: Tom.

MEMBER SEQUIST: So, I just -- on this topic of listing specific populations, I guess it would help me if I understood better how we're generating these lists.

Because if someone objectively said well, how did you pick those four things I would want to be able to say I picked them based on prevalence, or literature supporting a certain level of adverse outcome.

But if it was what popped into my head when we were generating lists, then I would say well, what about people living in poverty. What about intermittently homeless people. And I could list, we could all list 15 other groups.

And I just want to make sure that I'm clear on how we're generating this list. Because even when you say race/ethnicity, what do you mean? Ninety percent of the literature is on black/white disparities. So, like what do we mean by race/ethnicity? Which races? Which ethnicities?

So, once we start generating a list it just opens up a whole, what's it called, can of worms about what's on that list, what's not on that list.

So I just want to make sure we've carefully thought this through and all in agreement that that's what we should do.

CO-CHAIR PONCE: Emilio and Traci.

MEMBER CARRILLO: Yes, I totally agree. Things are so fluid.

CO-CHAIR PONCE: And we have two minutes.

MEMBER CARRILLO: So fluid. The immigrant paradox. The Hispanic paradox. The healthy immigrant effect.

You have some Latino immigrants who are

healthier in cardiovascular diseases than their comparison groups.

So, I get back to recommending that the reference group should be the historically advantaged group. We need to be -- we can't just have a list that's hard and fixed.

CO-CHAIR PONCE: Traci.

MEMBER FERGUSON: Yes, just really quickly. I would think that if we included some supportive background literature and see what other studies have shown then we can just list those, or even in the reference section.

But then I don't know how expansive we want to go because there might not be literature on the other groups that we want to name, but at some point in the report or what we do we name those ones that have traditionally not been identified like in the incarcerated individuals, veterans, homeless. And we can just list those. That's where we can do it I think, in the body of the report of the roadmap.

CO-CHAIR PONCE: Okay. I think that

those are clear suggestions and also that what I heard is that we want to look beyond race/ethnicity. That seems to be one consensus here.

And then how we are going to state it is going to be tricky. But the language including, but not limited to is one way.

And making sure that there's evidence in terms of choices if we're going to list some. Eduardo.

MEMBER SANCHEZ: So, I do think it's worth noting as we prepare people to think about these issues that even when it comes to race/ethnicity sometimes we're a bit blunt in how we make our -- how we aggregate folks.

And so we may need to articulate that Asians are all lumped together. And whether you're a South Asian, or a Pacific Islander Asian, or Eastern Asian, all lumped together, very, very different in many, many ways.

And similarly, when it comes to Latinos, Caribbean Latinos, and Mexican and

Central American Latinos, and South American Latinos at the very least those three are kind of different and there's nuance there.

And it's not that we want to parse it down to 330 million ways of describing disparities, but at the same time we want to be a little bit more precise sometimes than we are.

Again, to lump Asians all together. Talk about doing the average and finding it the same.

And the same actually goes for the Native American populations. The difference in diabetes prevalence between Alaskan Natives and Pima Indians is astronomical, the order of magnitude difference.

So, we might just want to talk about the fact that race and ethnicity for the audience sometimes is three colors, but it's really much more nuanced than that.

CO-CHAIR PONCE: Yes, very important point. Is Dr. Hunt on the phone?

DR. HUNT: I am. Can you hear me okay?

CO-CHAIR PONCE: Yes, we can. Thank you for joining us. I think we can move to the next section. We'll come back to our section on how do we get from here to there. So, thanks for hearing some of that discussion.

DR. HUNT: I love what I've heard so far. I've been listening in for the last few minutes and I don't know all that preceded, but I really like what I heard so far as far as some of the discussions that were going on.

CO-CHAIR PONCE: Thanks, Dr. Hunt. I'm going to turn it over to Helen Burstin.

DR. BURSTIN: Great. Hey, David, how are you?

DR. HUNT: Hey, how are you, Helen?

DR. BURSTIN: Good. So, we -- since David is not here in person, it's always odd to have this disembodied voice of somebody, especially if you don't know. So, we at least put a picture of you and your bio on everybody's table so they're at least --

DR. HUNT: Oh gosh, okay.

DR. BURSTIN: It's a lovely photo with the big flag in the back, David. It's all right.

DR. HUNT: I'd hoped you'd use the one of me from my movie Independence Day.

(Laughter)

DR. BURSTIN: So, anyway, David is perfect for this task, partly because he not only has been at ONC really since the very beginning. He's the Chief Medical Officer at ONC. But also had been at CMS before that. Very steeped in quality measurement.

I've known David for years, from my AHRQ days as well when he led the Surgical Care Improvement Program, and really steeped in quality, steeped in all of these issues, but I know cares deeply, deeply about the issues of healthcare disparities.

So, David, we wanted to leave this pretty open for you. I had sent a quick note, a warning, perhaps, a quick note to David just letting him know the issues that have certainly come up so far that he'd likely hear about and

perhaps he can talk about the issues around which groups got included or not, included as part of the meaningful use work to date, particularly the absence of disability I'm sure you'll hear about. And a little bit from Dr. Iezzoni.

I think there was some questioning about some of the recent comments we heard from Andy Slavitt about MU is going away. Well, what are the implications? How can HIT and MU potentially still be leveraged? We want to think about in terms of this pathway for disparities reduction.

And then finally some interesting comments as well we heard about are there examples where IT has actually negatively affected efforts to reduce disparities. And actually Tom Sequist gave the example of how, for example, if patient portals are only on a desktop and leave out the ability to access it on cell phones you exclude a lot of patients. So, those are some of the big issues.

If you want to just maybe give a little bit of an opening commentary I'm sure the group will

have lots of good questions for you.

DR. HUNT: Sure, I sure will, and thank you all for having me.

I think the best way to sum what we do particularly at ONC around health IT and disparities is to make the statement that our expectation is that health IT will support health benefits for all.

Namely, that all Americans should really have equal access to quality healthcare, and that includes all of the benefits conferred by health IT.

To that end all of our work is really completely subsumed under that larger work and the larger umbrella of disparities action that HHS has.

And to that end I always will let you know that we defer and are incredibly grateful for the leadership that Dr. Gracia at the Office of Minority Health has been providing.

They were the lead and have released the HHS Disparities Action Plan. And we regularly update that plan, particularly highlighting some

of the implementation progress that has been received -- that we've achieved, rather.

Not only that, I think is probably one of the big drivers. And this will speak a little bit to Mr. Slavitt's comment.

One of the big drivers for our work in health disparities is no surprise is the Affordable Care Act. That act, we want to make sure that health IT supports and enables all the important aspects of that.

So, examples are including the new standards for the collection of data by race, ethnicity, primary language, sex, have always been -- is one of the big factors as well as making sure that we support national standards for culturally and linguistically appropriate services, the CLAS health standards, as well as making sure that all of the work in health IT supports the work of our sister agencies such as SAMHSA, the Substance Abuse and Mental Health Services Administration, which they've incorporated health disparity impact statements in all of their granting activities.

But getting back to the topic of health IT, in particular I like to think about EHRs, but not exclusively EHRs. We like to think of them as sort of catalysts for healthcare delivery system reform.

And to that end we have been included in the work of ONC has been included in the National Stakeholders Strategy for Healthy People 2020 as well as the disparities reduction action plan that I had mentioned earlier.

The big goals that we have around health IT and disparities really mirror and are actually not just, but are the goals that we have in the broader context of health IT at ONC.

Namely, to make sure that we have broad uniform adoption, and the interoperability, and the exchange of information, that we are able to facilitate the use of health IT to improve care, particularly population healthcare, as well as reducing healthcare costs.

And one big, big thing, and this really touches base in a lot of the disparities work is

having health IT help inspire confidence and trust in the healthcare system in general.

Now, with that being said, I know that you wanted to just briefly highlight some of the things that in particular the Administrator of HHS, Mr. Andy Slavitt, made some comments about meaningful use is going away. And that's very true.

And I think many of you probably haven't been following the work and the rules that ONC promulgates, and the work that we've been doing like you would with an inside baseball-type focus on the details.

But I think to many of us that have been working in the field, his statements weren't revolutionary; they weren't actually novel. It's been the succinct statement of something that we've all been moving toward for some time.

And that is to look at the world of healthcare beyond meaningful use and what does that mean.

And in particular, I want to make sure

that everyone understands that our work in health IT as far as supporting the Medicare Access and CHIP Reauthorization Act, or MACRA, and the merit-based incentive payment system is strong, is healthy, and is seen as absolutely essential for making those two policy initiatives actually effective.

The thing that we hear time and time again is that health IT is a grand equalizer in so many ways.

First and foremost, health IT -- as I already heard some of them mention -- allows us to have widespread and efficient collection of data. Okay? And particularly data around areas where disparities are obviously very, very prominent.

Gone are the days when years ago -- a few years ago I wrote a paper on disparities in patient safety, in inpatient setting.

And the data collection burden for that was rather large, and it was something that it took quite awhile. And I anticipate that with the more efficient, more effective data collection at the ambulatory care level as well as the hospital level

that health IT will facilitate that data collection.

The thing that I love working with health IT in particular is the fact that it actually provides a possibility, a pathway to have the equitable delivery of care.

I wanted to mention times when there are opportunities where health IT actually accentuated disparities. The issue of access and different portal types is definitely one.

I have to say unfortunately language still remains a strong barrier, in particular having appropriate language, having language that is best for the individual patients regardless of what language is spoken by the provider, that healthcare information can be provided in the patient's language of choice. Those are big, big barriers.

But when we say that I also like to try to balance that with healthcare as the equalizer in so many ways.

One of the best examples of that, one

of my favorite articles of all, if you ever have a chance to read. It's a little bit dated now, but the old Circulation article by Mauricio Cohen, where they talked about the use of the American Heart Association and American College of Cardiology combined efforts of Get With the Guidelines.

And they were able to use health IT to drive performance metrics in the Get With the Guidelines program well beyond what is usually expected as reasonable and good to the point where they were able to see some of the most recalcitrant disparities in heart care.

And I think most of you are probably very familiar with. That's one area, cardiac care, or vascular care is one of the areas that have been studied the most and is the best documented in terms of healthcare disparities.

They were able to use health IT to demonstrate that when you use health IT to push performance of standardized guidelines well beyond what is considered good to exemplary, the

disparities seem to melt away.

So, I often -- as we well know there are a number of challenges that we still have around health IT. And there are areas where we need to work and improve the access, the capabilities and the functionality of health IT to support greater disparities reduction efforts, but also to point out that I think that the solution and the final path that we're going to take to improve healthcare disparities is definitely through health IT.

So, to that end the work that we're doing through meaningful use will be to a large extent some of the major policy initiatives.

And the intent of the quality initiatives are definitely going to be carried on in the work in MACRA as well as, you may have heard of it as MIPS, but the Merit-Based Incentive Payment System.

And those are the programs where you're going to see, and I already heard them mentioned, was accountable care organizations. We're going to have a strong emphasis on a shared

responsibility among providers. And a use of the medical home that's actually armed with data is going to be emphasized more and more in those programs.

So you'll start to see a continuation of the same theme in terms of improvements in quality of care, but it's going to go under the umbrella of MACRA and MIPS.

And if I can just say one other thing. It's a little bit of a pet peeve of mine. And I heard the term, and I know it is used with the best of intentions in terms of helping us to become culturally competent.

I sort of bristle a little bit about that when I think about being culturally competent as though it were a test to pass.

I like a term that I heard at a Native American reservation one time when one of the leaders of the group said they're not looking for cultural competence, but they're actually looking more for cultural humility.

And I think that's a wonderful phrase.

And it sort of embodies what I think we need to think about and use moving forward if we want to look at how we're going to actually become effective partners in improving the care of so many of the populations that to date have been receiving and have seen disparate care and disparate health outcomes.

I can talk a little bit about the issues of the disability standards. And I want you to know that at HHS we've been working across -- at ONC we've been working across HHS with standards stakeholders to hopefully identify the disability standards. And we've been working on that for some time.

ONC's goal for including standards has always been to include adopted standards that are already in use, and preferably those that are already relatively mature.

And the problems and some of the issues that we've had as far as disability standards is concerned is there are very few, if any, agreed upon health IT standards around disability.

And there have been a lot of discussions at our advisory committees -- both the policy and the standards committee -- about what is meant by exactly by a disability.

And while it seems obvious to so many in the particular context that you may be viewing it from, but there's a lot of different detailed descriptions of disability for the purposes of Social Security, or the VA.

They use the international classification of function. Is it a patient-reported disability, or is it a provider-determined disability? And is it a disability for the accommodation of the ADA, or the Americans with Disabilities Act?

And each of these potential use cases actually ends up having a potentially different standard which is why we are, or have struggled to date with coming up with one standardized vocabulary to be used for disabilities.

But to that end, that's not to say that we have stopped. And we actually are continuing

to move ahead. And I can share with Helen to share with the entire group the link to the latest standards advisory where we simply are trying to incorporate the best available standards.

Whereas before we tried to always go with ones that are in use and mature, we realized that that may be a little bit too high a threshold to actually get things going.

And so moving ahead, particularly around issues that have been a bit of a quagmire like disability, we are moving ahead with the best available standards around. And we'll be asking input from a lot of different organizations on what they think meet that criteria.

With that, let me sort of stop. I've been speaking for probably far too long. I'm more than happy to go over and answer any questions that you might have.

DR. BURSTIN: Great. We appreciate it, David. Let's see if anybody on the committee wants to ask David any specific questions. A couple of cards going up. Okay.

DR. HUNT: Sure.

DR. BURSTIN: Bob, go ahead. And if you could introduce yourselves so David knows who he's talking to.

MEMBER RAUNER: Bob Rauner. I'm from Lincoln, Nebraska, a family doc by original training and had worked for Regional Extension Center at one point.

DR. HUNT: Bless you.

MEMBER RAUNER: Yes, thanks. Given the latest on what's going to happen -- the transition between Stage 3 and MIPS -- is this now the opportunity to frankly insert disparities stuff in that, what might I guess maybe could be considered Stage 4 as going into MIPS? Or a revision, maybe rolling back some of 2 and 3 to what 2 should have been, things like that? Can you say much on those?

DR. HUNT: Yes, it gets very confusing if you try to say that. I'm never going to be able to go on record in any format of suggesting or uttering the words "Stage 4," so I won't.

But I think that, yes, to answer your question I think this is a tremendous opportunity, particularly as we're going to a very outcomes-based system where we're actually trying to incentivize improved outcomes, identifying and inserting language that is specific to improving disparate outcomes.

I think this is a tremendous opportunity because the effects of the MACRA and the MIPS, the effects of that are clearly going to be profound. They're going to cause tremendous transitions in healthcare. And I think now is probably the best time of all to include that.

One caveat that I always like to make is we put out an awful lot of material at HHS. But I beg, beg, beg everyone to always take a look at whenever we particularly CMS is putting out a proposed rule and ask that you please comment often and very loudly in terms of getting input back to us. Because we really do take those comments to heart.

So, as you're seeing more and more of

the regulations begin to roll out around the Merit-Based Incentive Payment System, I would ask and plead for you to make sure that you speak to this issue in particular. And that will help assure that we can actually meet some of the goals that this committee has.

MEMBER GARRETT: Dr. Hunt, my name is Nancy Garrett from Hennepin County Medical Center.

And my question follows up on Bob's, perhaps a little more specific is one of the things our committee has talked about is the need for better data on social determinants of health.

And it feels like ONC is positioned to really help set some standards. I think it's a really important time as more and more entities are realizing the importance of collecting this data. We really need to set national standards quickly so that we don't end up in five years with a mess of all kinds of different ways of collecting it and no way to compare across organizations or nationally.

So, have you looked at the IOM report,

for example, recommending social and behavioral questions to be included in EHRs? And are you thinking about incorporating that into some of your future standards?

DR. HUNT: Actually, yes. And to that end, many of you may know that we have advanced a few different certification pathways now beyond just what was considered the standardized, generic pathway that met the criteria for meaningful use.

And so we've advanced behavioral health as one example of a certification pathway. Another is long-term care.

And the incorporation of that information and data, particularly in those alternative certification pathways, I think is probably one of the best ways to do that.

I'm a big believer in -- and I'm not sure if many of you are familiar with Montgomery County right outside the District here.

They have had for awhile a very impressive program in which they are able to collect -- the county health department is

collecting information around the social determinants of health and making sure they have no wrong door, or I've forgotten the exact name, where basically any door that the citizens go in for social services, make sure that they link services, particularly healthcare services that are appropriate even if that isn't the core function of the agency.

But to be able to do that they desperately needed access to healthcare data. And they've been able to effect that in some ways.

Now, there's always going to be a challenge -- I'm not going to say there's always going to be a challenge, but I think many of us recognize some of the special challenges associated with mental health data. And that probably deserves a separate discussion.

But absolutely this is a fantastic opportunity to include more information around the social determinants of health.

And we've taken the report and the recommendations of the IOM under serious

consideration. And I believe our policy council and the standards committee have both had hearings, and will probably have additional hearings on that report.

MEMBER GARRETT: Thank you.

DR. BURSTIN: Michelle, Lisa, and I think Kevin, you had your card up? No?

MEMBER CABRERA: Hi, and good afternoon, Dr. Hunt. Michelle Cabrera with ---

DR. HUNT: Hi. Oh, please call me David. I wanted to tell everyone I bristle -- I'm always in trouble when I hear "Dr. Hunt." It's always, "Dr. Hunt, the patient is crashing." "Dr. Hunt, you forgot to write this order and there's a problem." So please, David.

MEMBER CABRERA: Okay, David, we have toggled a lot in our conversation today between sort of trying get a handle on what, you know, I think folks feel like should already be happening, that is, the collection of race, ethnicity, and language data.

And then how to push the ball forward

more significantly to include other areas of data collection like data around disability, sexual orientation, gender identity, et cetera. Social determinants I feel like falls in that latter category.

We know that -- and I will just preface this by saying my understanding of meaningful use is very limited so please bear with me, but we know that the ACA provided wonderful directives and incentives for better data collection.

As someone who works a lot in policy, I feel like we're still struggling with this issue of we don't have some of the more basic information.

So, can you give me a sense of when those investments will bear fruit? Do you have a timeline? And also, can you talk about what kinds of information we'll be getting, and the application of race, ethnicity, language data especially. Thank you.

DR. HUNT: Okay. And I think most of what you're talking about, particularly around the Affordable Care Act is what we like to talk about

as Section 4302 where we were able to adopt, or at least we're adopting the new standards of data collection that are a lot more granular for ethnicity as well as other demographic information, including some of the social determinants that you had already mentioned.

Those have -- while we've started to say that we're moving in that direction, you'll know that the regular cycle, the regular clock that we have around certification criteria for electronic health records usually is about I would say typically around a year or two behind.

That is to say that it takes that amount of time to, one, have the thorough and in-depth discussions, come to a consensus, and then begin to write solid policy around them.

So, I typically say at least about two years that these -- to be really effective that it takes.

The bigger problem is -- and this is one thing that we've seen time and time again. In some situations we actually have affected the

functionality already in health IT. And the problem really is more one of getting providers knowledgeable about the capacities that they actually have available to them right now, and encouraging them to use it. So, it's really a bit of a two-pronged approach that we have to have.

And while we can work on the standards and then implementing or pushing those standards in the certification, I think that we cannot dismiss the amount of work that really has to be done in terms of, for lack of a better term, social engineering or marketing if you would.

What we want to do such that this data is actually collected. I think making sure that we have the various -- particularly on the provider side, the professional societies onboard and understanding why the collection of this data is useful, and why it's so important, and what are some of the best practices to having this information collected is incredibly important.

One of the things that we spearheaded just as an example of that is we, at ONC we had some

grants around the collection of -- the better collection of race and ethnicity data.

And we found, to no one's surprise, that when it was collected at the provider level the data wasn't as good as it could be. But when we have practices and provider organizations that provide the self-identification that have, for example, a little kiosk off to the side where the patient can register and fill in details about this type of information that you get more data, you get better quality data, and you get data that you can then use and is much more trustworthy.

So, I say that all to say that we're definitely moving ahead in terms of the discussions and the policy levers that need to be pulled to actually get this capacity in the health IT.

But just having that capacity in the health IT is just one step. And it's not necessarily the largest or the hardest step.

The thing that we really, I would love to hear and partner with different individuals in this group with is how do we have the discussion

to the broader healthcare community that we need to use and collect this information once we have that capacity.

And it's something that requires a very focused effort. It has to be methodical, just as you would any marketing campaign.

And then we need to have some discussions around sustainability -- how we make sure that we continue after everyone says yes, rah rah, this is great, when all of the inflamed passions begin to cool, that we still collect this information until it's completely ingrained in the next generation of healthcare providers, such that we'll have some sustained data that is useful.

So, I think that to answer, we're moving ahead at the standards and the policy level at those committees.

And I think you'll be pleased to see a lot of the information is finding its way in both the standards certification and the alternative certification pathways.

But I think there's a tremendous amount

of work that still needs to be done at the very ground level on making sure that the providers actually use these capacities.

DR. BURSTIN: Thank you. Lisa, and Kevin, and then Philip.

MEMBER IEZZONI: Hi, David. My name is Lisa Iezzoni. I work at the Massachusetts General Hospital in Boston.

DR. HUNT: Yes, I know your work very well. It's an honor to meet you virtually here.

MEMBER IEZZONI: Yes, you probably know my former boss, David Blumenthal, pretty well.

DR. HUNT: Gotcha. Yes.

MEMBER IEZZONI: Exactly. I took over for him at the Mongan Institute.

But anyway, I'm a little bit, and I'm sorry to do this to you. I know it's kind of nasty of me to do this to you, but I'm a little --

DR. HUNT: No, no.

MEMBER IEZZONI: I'm a little troubled to hear you refer to disability, different ways of talking about disability as a quagmire.

Because it is literally true that there are so many federal programs that require people to be qualified as disabled.

And I was on the Institute of Medicine Committee on the Future of Disability in America that produced its report back in 2007.

And one of the things that we did was look at all the different federal definitions of disability. And there were something like 50 of them.

And so if you always realize that there's going to be these 50 different definitions of disabilities in the federal government statutes around eligibility for different benefits, it is true that you would literally throw your hands in the air and say, how can I possibly ever figure out which one to include?

But I wanted to tell you a story because of what you just said that you want to hear the use case made for practitioners.

And so if people would just bear with me for a minute to make the use case that would --

is that okay?

So, I work at the Massachusetts General Hospital which is partnered with Brigham and Women's Hospital in Boston.

And back in 2006, Boston Center for Independent Living had just gotten the MBTA to become accessible. They'd filed a huge lawsuit and gotten a $326 million settlement for the MBTA.

And so now actually I, who use a wheelchair, can use the subway --- well, not all subways, but most of the subways.

And so they turned their eyes to healthcare. And they said, okay, what should we do next? Our constituents are telling us that they can't get access to healthcare.

And one story, and she's very public about this, and the MGH is actually pretty public about this, is a young woman who was in her forties when she developed early stage breast cancer.

Well, she's a wheelchair user. The day of her high school graduation, she'd gotten into a car crash and became paraplegic.

And so now she is somebody who uses a wheelchair, has early stage breast cancer, had her surgery, but afterwards needed adjuvant chemotherapy.

And as you know, to get the dosage for adjuvant chemotherapy, you need to know the weight of the patient.

DR. HUNT: Yes.

MEMBER IEZZONI: The Yawkey Healthcare Cancer Center at the MGH -- this big, huge gleaming building -- did not have a wheelchair-accessible scale.

So, the way that they got the weight for this woman was that her oncologist lifted her out of her wheelchair in his arms, stepped onto a scale, weighed the two of them together, put her back in the wheelchair, weighed himself, and did the math.

Well, Boston Center for Independent Living talked to people out in California -- DREDF and some other people who'd actually sued Kaiser Permanente back in 2001 about disability access.

And they decided that they did not want

to sue Partners. But what they did was they came up with a six-year memorandum of understanding where they said, look. We want to work together with you to improve the access of people with disabilities to your big huge hospitals that dominate basically the medical marketplace in Boston.

And so after a while, which I won't go into how long exactly, the Brigham and the MGH agreed to this memorandum of understanding.

And the memorandum of understanding just ended as of September of this year, but the MGH is going forward, and I believe that the Brigham is going forward as well because they found it to be very beneficial.

Well, one of the things that they needed to do was they needed to know which patients were coming in who needed accommodations.

So, they needed to know through the registration system when somebody was going to be coming to the clinics at the hospital, or coming as an inpatient who was a wheelchair user, or needed

an accommodation around hearing, or needed an accommodation around vision.

And so one of my colleagues who's a survey scientist actually did focus groups with MGH patients to try to come up with measures that the registrar's office could use to ask about disability.

Well, in fact, the six questions that were put together by the Office of Minority Health, as a response to Section 4302, pretty much go a long way to getting there.

And so, the MGH has now kind of implemented through the registrar's office routine collection of information about whether somebody has a disability that requires an accommodation.

And so there is a very clear use case which allows you to not only give good care to your patients with disabilities, but also allows you to follow the law, which requires you to give equal care to people with disabilities.

And so I think that -- I know that there has been a lot of pushback, or for some reason this

has just been one area that nobody has been willing to just say, okay, we're going to do it. There's a good use case for doing it.

But I would really urge you to talk to people out there in the community who have been involved in these legal actions, quite frankly. Kaiser Permanente would probably be happy to talk to you about how they're collecting information on disability and so on.

Because I guarantee to you places that realize that they have a problem with the care that they give to people with disabilities are having to figure out how to do this.

And they probably would appreciate having an EHR that allows them to record the information.

So, thank you for letting me go on at length. Sorry about that.

DR. HUNT: No, I appreciate that. And I think you make an incredibly valid point. And I think that what you're saying really speaks to the need for us to really act on and move with the

best available standard that we said we would use in other areas.

MEMBER IEZZONI: That's exactly what I was saying. Yes, that's exactly what I'm saying.

You just need to move on this because it's happening out there right now. And people with disabilities are not getting the care that they need right now because the accommodations are simply not in place for them when they show up at the clinic.

DR. HUNT: I'm making notes as you're speaking. I appreciate that.

MEMBER IEZZONI: Oh, I could go on at length at some other point. I'm going to stop right now, but thank you.

And I am happy to help if I can in any way.

DR. HUNT: Thank you so much.

MEMBER IEZZONI: You're welcome. Thank you for listening to me.

DR. BURSTIN: Thanks, Lisa. So two more comments. Kevin and then Philip. Kevin.

MEMBER FISCELLA: Kevin Fiscella. I'm a family physician, health services researcher with a focus on disparities at the University of Rochester.

Actually, I have several things. Hopefully not too long.

The first is just a suggestion with the vendors based on what you said. It would be great, for example, if EHRs were automatically linked to portable devices that made it very easy and inexpensive for patients to self-report much of this data. Right now a lot of the vendors don't make that easy to do. So that would, I think, be an important thing on the vendor side.

My first question is: is there a place that tracks how we're doing --- at least with race, ethnicity, and language --- in terms of the impact of meaningful use so far?

DR. HUNT: That's a good question. We don't have an evaluation of that.

The evaluations that we've had which have shown that we have -- it's a very heterogeneous

data set in terms of the amount and the quality of the data around race/ethnicity.

And that's one of the reasons that prompted us to begin to explore some grant opportunities to find out what are some of the best practices, which is how we found out that it's probably best -- patient self-reported information in a private kiosk, and training the healthcare providers' staff to be able to get the patient at least started on that -- is probably the best way.

So, we don't have a more thorough, or more complete evaluation of that.

Now, I did want to just highlight one thing that I should have mentioned actually long before now. And I thank you for actually bringing up the idea that the EHR should be able to link to portable devices.

In the latest certification rule that came out just this year that will be in effect I believe -- I'm always bad with the actual starting date, but I want to say January 2018, I believe. No, it might be '17. I'm sorry.

But for the next round as far as certification is concerned there's a requirement that the EHRs provide access to the software and the functionality through an API, or an application program interface.

And that will allow third party application developers to provide a lot of the functionality that you've already mentioned and some other capacities, primarily because the vendors have told us time and time again they can barely keep up with the requirements that we currently have in place, and that they're stretched beyond their capacity to add in greater functionality.

So we did provide this certification criteria. And I think that a lot of what you might want will be achieved as far as linking to portable devices. You'll be able to see that more and more through third parties and APIs.

Now, having set that criteria, that requirement in the certification rule, and we'll begin testing and implementing that in later

editions of EHRs means that we've got to somehow or another spur and incentivize the marketplace for third party users -- third party application developers rather, I'm sorry -- to be able to build these applications that are needed.

In that regard, that actually is probably again another case of the next step that has to be done in terms of awareness, education and marketing of this need, and making sure that those who can write these small apps have access to the information that they need to be able to do it, and the marketplace to be able to make their products viable.

MEMBER FISCELLA: That's really great to hear.

Just to come back to the reporting piece. You know, I would just like to humbly suggest that if there could be an annual reporting on progress -- both in terms of the quantity of data as well as the quality -- I think it really would help to jumpstart this.

I know CMS does report on disparities,

and I think just perhaps adding this and making this an annual report really could help to provide some leverage as well as inform what other additional steps need to be taken in order to move this ahead since, you know, we've been talking about collection of race and ethnicity and language data now for more than a decade.

I think we've had lots of discussions here today about being hamstrung with even this very basic data, if not moving on to social determinants, and assessment of disability, and other critical factors.

DR. HUNT: I agree. And I think that what you said is probably a very good start. And including that in the annual update that the department has around progress around disparities is probably a very, very good way to go.

But I'd also, again, like to talk with you and the rest of the group in finding the best way to make sure that the healthcare community knows and pushes, and that we can find ways to push them not just from the HHS side because they

recurrently hear that and that's not necessarily always the best way to effect change from a large -- centrally.

And I would love to find ways that we can work together to have all of the groups that, for example, that are represented in this meeting begin to make sure that we push the healthcare community to use the capabilities and capacities that we already have.

And that's the struggle that we have currently in being able to get good, solid homogenous data around something that we would think is -- well, I won't say straightforward, but as -- that the need is clearly there around race and ethnicity for reduction of disparities.

DR. BURSTIN: That's great, David. We can follow up with you and see if we can get some input from folks. But definitely we'll keep you in the loop as we go forward.

So, last question. Philip.

MEMBER ALBERTI: Thank you, David. My name is Philip Alberti. I'm the senior director

for health equity research and policy at the Association of American Medical Colleges.

I have to say there was a lot of excitement at the AAMC and among our teaching hospital members when the final rule came out for the 2015 HIT certification criteria that included that social/behavioral/psychological panel.

And we convened a bunch of folks to think about how we could facilitate the valid collection of data around social isolation, and intimate partner violence, gender identity, and I would say data points that are potentially even more sensitive and difficult to collect than race, ethnicity and language.

So, given your candor in talking about the heterogeneity and perhaps the lack of validity or reliability of the REL data, do you have any plans right now to either support, or fund, or partner similar assessments and how best to capture some of those social/behavioral/psychological data points?

And if that capability arises, the

ability to communicate to the healthcare landscape that this exists, and here's how to do it, and here's how you can use it. We might have more data on hand to position ourselves in that way.

DR. HUNT: I'm glad you're saying that. Actually, we are discussing that with -- it's going to be tough because their budget is rather tight as many are, but a combination of work between the Office of Minority Health and the Agency for Healthcare Research and Quality, or AHRQ.

They've started into discussions on finding ways because that's one of the best things that AHRQ does -- identify best practices and actually begin to think about how we can get that information out.

And I know those discussions have started between OMH and AHRQ. It was back in November. I'm not sure where they are, but I can follow up and find out whether or not basically they've green-lighted some grants around those questions and let you know.

MEMBER ALBERTI: Oh, that would be

great. We'd appreciate it. We definitely have some teaching hospital systems and members that would be interested in participating and helping build that evidence base.

DR. HUNT: Okay, thank you.

DR. BURSTIN: All right, David, thank you so much. Any parting words for us, or we'll certainly be in touch. But again, thank you for your time.

DR. HUNT: Oh, I just want to thank you. And I'm sorry that I wasn't able to be there in person. And I feel as though I've got to make a promise to whenever you have your next in-person meeting to be there with bells on.

DR. BURSTIN: We will hold you to it for sure. Great. Thank you so much, David. Appreciate it. Bye bye.

DR. HUNT: Thank you. Bye bye.

MEMBER CARRILLO: Lisa, can you share those six items that you mentioned?

CO-CHAIR PONCE: They're the OMH, yes.

MEMBER CARRILLO: Okay. They're

right there?

MEMBER IEZZONI: He asked the question: who should be measuring disabilities? Should it be a person self-reporting, or should it be a clinician?

Trust me, clinicians are clueless. Sorry. It actually really does need to be the person with the disability because after all if what you're using it for is your first use case is to make sure that the accommodations are available for the person. The person themselves is going to know best what kind of accommodations that they need.

CO-CHAIR PONCE: How is everybody doing? You look spent. I just said exactly what Helen just said.

CO-CHAIR CHIN: We're going to go now and wordsmith all the documents now.

(Laughter)

CO-CHAIR PONCE: Yes, yes. You think you're spent. We're going to go now back.

I think one thing we didn't cover was

a time-line of action plan. And we are -- I think we have a two- to three-year -- that's not our time-line. That's our service.

But our time-line though, as Marshall opened up, February is too soon for that policy windows.

CO-CHAIR CHIN: We haven't talked about it yet, as a committee yet. But just based upon the SDS committee experience that took about a year.

I think that sounds --

DR. BURSTIN: I tend to be a bit glass half full kind of girl. I don't see this taking a year. I think this could be quicker.

This isn't kind of part of our traditional consensus process. We will of course put it out for public and member comment because we get great comments and it always enhances the work.

And I think, given the remarkable range of organizations here, we'd also potentially love you to put it out for comment within your own

organization, to your own networks. So I think that would be great.

But I think -- staff will probably kill me, but I think we could do this probably in six months with some comment and get it in, get it out.

I think there's a sense of urgency here that I'd like to get something out to at least iterate in the next few months. She's saying nine months.

CO-CHAIR PONCE: So, this is the roadmap.

DR. BURSTIN: The roadmap.

CO-CHAIR PONCE: The roadmap piece.

MS. O'ROURKE: So, why don't we commit to getting a draft of the roadmap to the committee for the next web meeting I believe in April.

And we can use that meeting to iterate on it and get it ready to go out for public comment, and allow you to circulate it among your networks for commenting, and go from there.

We can also, if you're amenable to emails we can reach out with some draft language

and questions in the interim, rather than just waiting for a web meeting if that's something the committee is open to our team blasting your emails.

CO-CHAIR CHIN: So, I think it's going to be an iterative process.

For example, like I doubt we're going to be able to have a first draft of the whole roadmap before the next web meeting because we haven't talked about a lot of the details. So, the payment part, for example, you know.

So, I would say less than a year. Probably somewhere between six months and one year.

DR. BURSTIN: Elisa says nine months.

CO-CHAIR PONCE: And I know, Susannah, your hand was up before so I just want to give you the opportunity.

MEMBER BERNHEIM: I don't remember now what it was. I think I was in the weeds. I'm more interested in this conversation about how we'll do this.

It's hard to write together as a group of 30 over email, but it's also hard to have

something arrive in April sort of fully fleshed out and then you feel like you can't go back to the beginning.

So that's a -- you have a lot of experience doing this, but I think it's worth thinking about sort of how we'll have a way to help form it that's feasible.

CO-CHAIR CHIN: I wonder what's realistic. So our next in-person meeting is in April, is that correct?

MS. O'ROURKE: I believe our next web meeting is in April. We don't have another in-person on the books this year. So, the rest of the work will be via web meeting.

DR. BURSTIN: We could certainly do a web meeting sooner than that obviously.

MS. O'ROURKE: Maybe we could brainstorm with staff and Marshall and Ninez and come up with a plan forward of how we can make this iterative and get committee feedback so that we're not sending you a fully baked draft, but we're maybe sending some annotated outlines and things along

the way.

CO-CHAIR CHIN: Yes. Maybe one of the things that's going to happen as we start thinking about getting concrete we could probably have the 15,000-feet version of the roadmap.

But we'll probably identify areas that we need to have more detail, and more input, and more discussion from the overall committee on calls. What those exactly are right now I'm not sure.

But my guess is that once we -- so, actually, one of the sort of secrets about I guess any organization is that the people who really run it are the Erins and Michaels of the world. And so we're lucky that we have really great staff on this committee. So we're very fortunate with that.

We'll sort of huddle with Erin and Michael and then get back to you on what's realistic.

CO-CHAIR PONCE: I think sometimes in a group this large some smaller working groups

might also help get the work done in a focused way. And even a writing group might actually be -- so that it doesn't all fall on the staff.

And also, I took a lot of notes while trying to -- to make sure I saw your card. But it's -- the fidelity of those notes may be suspect. So, I think it really requires perhaps another, perhaps a writing group might be helpful. I'm just putting this out there.

And if there are any volunteers now, or I can take you for drinks tonight.

CO-CHAIR CHIN: Let's see how it goes. This is a very busy group. And traditionally what's happened is that the NQF staff takes the first crack at it after discussion, and then gives the committee drafts then for feedback. Because everyone here is busy.

But we'll see what works best for people and for staff and team.

CO-CHAIR PONCE: I do think that this conceptual framework is important to nail down first. And maybe we'll get more clarity on how to

sketch that out with tomorrow's presentation on what the SDS and risk adjustment panel, the report and also some of the evidence on this robust trial.

I think that will put some legs in this, ways of thinking about this roadmap.

CO-CHAIR CHIN: Okay. Thank you for a first great day. This is -- I think everyone here probably had very high expectations.

A lot of people know many of the people on the committee. So I think Chris Cassel was right that this really is sort of an all-star committee.

And I think that's predicted. I mean, it's a great discussion, far-ranging. People have -- they understand the issues, and they have a lot of prior experience. And there's enough diversity in this overall group that we're not just sort of an echo chamber.

So, I think this went very well. So thank you everyone.

CO-CHAIR PONCE: More to come tomorrow.

MS. O'ROURKE: With that, we do need to open for public and member comment. Operator, could you open the lines on the phone?

OPERATOR: Yes, ma'am. At this time if you would like to make a comment please press * then the number 1.

MS. O'ROURKE: Do we have any comments in the room?

And we did have a few come in via web chat that I wanted to read to you.

So, these are from Clark Ross, a member of the NQF Dual Eligible Work Group and the American Association on Health and Disability.

"When thinking about persons with disability and community connections remember the thousands of non-health community-based organizations.

"Most of these are publicly funded including with substantial Medicaid funding for persons with intellectual disabilities and recently seniors and persons with physical disabilities, there are existing quality

measurement systems -- the National Core Indicators, personal outcome measures, CMS HCBS experience survey as examples.

"These address both health and related community/social supports.

"And reminder, the Affordable Care Act precisely added persons with disabilities to the list of populations facing disparities, a middle ground between historically disadvantaged groups and a longer list cite the ACA provision."

OPERATOR: There are no comments from the phone lines at this time.

CO-CHAIR CHIN: Okay, well, thanks very much everyone. Oh Bob, did you want to say something, Bob?

MS. O'ROURKE: Yes, if you could meet at Catch-15. Michael will follow up with the exact address. And the reservation is in my name, although I am unable to join you for dinner. But the reservation is under Erin O'Rourke.

(Whereupon, the above-entitled matter went off the record at 5:00 p.m.)