**NATIONAL QUALITY FORUM**

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**DISPARITIES STANDING COMMITTEE**

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**MONDAY**
**MARCH 27, 2017**

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**The Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:30 a.m., Marshall Chin and Ninez Ponce, Co-Chairs, presiding.**

**PRESENT:**

**MARSHALL CHIN, MD, MPH, FACP, Co-Chair; Richard Parrillo Family Professor of Healthcare Ethics, University of Chicago**
**NINEZ PONCE, MPP, PhD, Co-Chair; Professor, UCLA Fielding School of Public Health, UCLA Center for Health Policy Research**
**PHILIP ALBERTI, PhD, Senior Director, Health Equity Research and Policy, Association of American Medical Colleges**
**SUSANNAH BERNHEIM, MD, MHS, Director of Quality Measurement, Yale New Haven Health System Center for Outcomes Research and Evaluation (CORE)**
**JUAN EMILIO CARRILLO, MD, MPH, Vice President of Community Health, New York-Presbyterian; Associate Professor of Clinical Medicine, Weill Cornell Medical College**
**RONALD COPELAND, MD, FACS, Senior Vice President and Chief Diversity & Inclusion Officer,**

**Kaiser Permanente***

**TRACI FERGUSON, MD, MBA, CPE, Vice President, Clinical Services Management, WellCare Health Plans, Inc.**
**KEVIN FISCELLA, MD, Tenured Professor Family Medicine, Public Health Science, Community Health and Oncology, University of Rochester**
**NANCY GARRETT, PhD, Chief Analytics Officer, Hennepin County Medical Center**
**ROMANA HASNAIN-WYNIA, PhD, Chief Research Officer, Denver Health**
**LISA IEZZONI, MD, MSc, Director, Mongan Institute for Health Policy; Professor of Medicine, Harvard Medical School, Massachusetts General Hospital**
**DAVID NERENZ, PhD, Director, Center for Health Policy & Health Services Research, Henry Ford Health System***
**YOLANDA OGBOLU, PhD, CRNP-Neonatal, Director, Office of Global Health; Assistant Professor, University of Maryland Baltimore, School of Nursing**
**ROBERT RAUNER, MD, MPH, FAAFP, Director, Partnership for a Healthy Lincoln**
**EDUARDO SANCHEZ, MD, MPH, FAAFP, Chief Medical Officer for Prevention, American Heart Association**
**SARAH HUDSON SCHOLLE, MPH, DrPH, Vice President, Research & Analysis, National Committee for Quality Assurance***
**THOMAS SEQUIST, MD, MPH, Chief Quality and Safety Officer, Partners Healthcare System**
**CHRISTIE TEIGLAND, PhD, Vice President, Advanced Analytics, Avalere Health | An Inovalon Company**
**MARA YOUDELMAN, JD, LLM, Managing Attorney (DC Office), National Health Law Program**

**NQF STAFF:**
**SHANTANU AGRAWAL, MD, CEO**
**DREW ANDERSON, PhD, Senior Project Manager**
**IGNATIUS BAU, JD, Consultant**
**HELEN BURSTIN, MD, MPH, Chief Scientific Officer**
**KAREN JOHNSON, MS, Senior Director, Performance Measures**

**MADISON JUNG, Project Analyst**

**MAURICIO MENENDEZ, MS, Project Analyst**

**ELISA MUNTHALI, MPH, Vice President, Quality Measurement**

**TARA MURPHY, MA, Project Manager**

**ERIN O'ROURKE, Senior Director**

**ALSO PRESENT:**

**CARA JAMES, PhD, Director, Office of Minority Health, CMS**

**UCHENNA S. UCHENDU, MD, Chief Officer for Health Equity, Veterans Health Administration**

*** present by teleconference**

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

(9:34 a.m.)

MS. O'ROURKE: All right, good morning, everyone, and thank you for bearing with us on a misty Monday morning.

We are excited to bring you all back together to continue our work on coming up with a plan on how we could use performance measurement as a way to reduce disparities in health and healthcare.

We are excited to build on the work that this Committee started last year and today to really start to come up with a concrete plan of what measurement for health equity could look like, in particular focusing on some of the effective interventions that could be employed to start reducing disparities.

So I think with that I would like to first introduce our new CEO and President, Dr. Shantanu Agrawal, to give a few opening remarks.

DR. AGRAWAL: Thank you, Erin. I am still going by the moniker of "new" for a period

of time, it's been two months and one day. I am going to milk it for as long as I can.

So I just really -- I'll be very brief. I wanted to thank you all for being on this Committee. This is an incredibly important topic for NQF and for all of the stakeholders that we work with.

I think there is not a day that Helen and I don't get into a discussion/debate about SDS, we are looking for you to bring resolution to that, for organizational health.

MS. O'ROURKE: Harmony.

DR. AGRAWAL: Harmony. It is I mean vitally important though. This was a topic that I was both looking forward to and aware that we would need to address right away.

And I think, really I mean this with just total sincerity, the team here -- I normally don't actually talk a lot about the internal team at the kickoff of these committee discussions, but I think it is worth saying that the team here has really done an incredible job on this topic.

I think it has shown leadership in a way that is just a high water mark for NQF, it is the way that we ought to do our work generally, so I am extremely appreciative.

And that team, of course, includes you all and I think the next two days are just going to be incredible to keep the momentum up and identify where ultimately we are going to go.

I think the report that stems from our SDS trial is going to be very watched, it's going to be important, and I have every confidence that it is also going to be right, which is always a good combination to have, watched, important, and right.

So thank you again. Let me also just take a moment to thank you Chairs for their leadership, Marshall and Ninez. Ninez? Ninez?

CO-CHAIR PONCE: No tilde, just Ninez.

DR. AGRAWAL: All right, I'm getting there. It's Shantanu Agrawal, yes.

(Laughter.)

(Simultaneous speaking.)

DR. AGRAWAL: Unless you want there to be, I have two n's you can make it happen. Anyway, that is it. Thank you again.

I think you will have, weather-wise, a far better day tomorrow, but this is a good day to buckle down and do some work because it's going to be cloudy. So, thank you.

MS. O'ROURKE: So I think, Marshall and Ninez, did you have any remarks to get us started?

CO-CHAIR CHIN: Well I'd also like to thank everyone for all your hard work over the past year.

I just wanted to remind people why we are here, because we have so much, got into a lot of details, and went through the different reports and sometimes it's easy to lose track of why we are here.

So ultimately this is going to be the final report, and it's going to be the big one here, which is the one about recommending how can performance measurement be used and to reduce

disparities, so issues involving like what measures as well as their use.

And so, again, this is building upon ten years of work from a lot of people here on this Committee. Emilio co-chaired the very first one of these like ten years ago or so and then --

(Laughter.)

CO-CHAIR CHIN: And then there has been a whole bunch of other committees, most recently the one that Kevin and David had chaired on, the risk adjustment.

But what is different about this one in terms of the charge NQF has given us and then the CMS support by Cara and her team is that we have the broadest charge of any of the existing disparities committees in terms of, again, what these measures are and then how they can be used in a variety of different ways to reduce disparities, so it really is a great opportunity.

And I think the last report and I guess the last in-person meeting we talked more about the policy side in terms of the use of

these measures and all as well as the risk adjustment of those.

Today's meeting is a little bit different, I think it's actually, of all the NQF meetings that I have been to, the one that has the most brainstorming time of any particular one, and it actually is going to really focus on something that I actually didn't get when I first saw Cara's charge to us, but now I think in retrospect it's one of the most innovative parts of the charge, which was think about equity measures.

So I think like a lot of us, and myself, I used to think about it in more terms of this, it's really like well the stratified measures and then, you know, their use, and we'll talk more about that I guess at the next meeting, but this one we are looking at well how do you measure then like if a provider group or a clinician or an organization, how far they are along the way towards, excuse me, equity, as well as the degree that they are especially

implementing, utilizing, evidence-based measures.

And so a lot of what today is going to be trying to think about the conceptual model we have been developing as a team and then how do you start measuring them like, well, these different steps along the way to achieving equity, so it's a different type of measure than the other ones that we will eventually incorporate in terms of the stratified performance measures and all, but also I think one of the most innovative parts. Ninez?

CO-CHAIR PONCE: Thanks, everyone. I wanted to thank everyone for coming here to D.C. I am excited, I hear the blossoms are finally out.

And I also wanted to thank Cara and CMS support for our work here. I think in-person meetings are very important. I know that many of us were engaged, you know, through email in discussions, but I think in-person is really, really important.

And what we have the next day and

tomorrow are, as Marshall said, ways and chances for us to interact more. I do want to -- a refresh that the charge is to both develop a roadmap for NQF on measurement and ensuring that the equity framework is in that measurement and that we also evaluate the SDS trial.

So then again those two as a refresh, and I really look forward to also chatting to each of you here and hear about all the exciting things you have been doing since November. Thanks.

MS. O'ROURKE: Thank you so much. And I want to add the team's thanks to the Committee for all of your patience and willing to work with us innovatively through technology to get through the first two reports and hopefully have a solid strawman for you all to build on today as we start to think about the domains and sub-domains.

So we appreciate you bearing with us through web meetings and Google docs and all of the other joys of technology.

Cara, I don't want to put you on the

spot, but if you had anything to, but I will, anything just from the CMS perspective to illuminate for the Committee on the charge as we get started.

DR. JAMES: Thank you. So I think from CMS's perspective we really just want to thank you all for the work that you are putting into it.

We have been watching and reading all of the reports that are coming through and I think just timing wise I feel like stars are sort of aligning where there is a lot of opportunity here to really advance the work that you are doing here but also pulling together all of the ASPE work, the trials that is happening here, and also some of the other opportunities.

So you'll hear more from me later, but I just think there is a lot of opportunity to have a real impact on the work, so thank you for the brain cells and I agree that, you know, the in-person meetings I think are where a lot of really good thinking just happens.

And while we were all paying attention on webinars we were also multi-tasking, so I thank you for being here.

MS. O'ROURKE: Great. Thank you so much. So, Helen, if you wouldn't mind taking us through the disclosures of interest and then maybe going right back into the overall -- Helen is going to define for the Committee some of the, perhaps, NQF speak we have been using throughout this project and give us an overview of what we really mean when we say a measurement framework and things like domains and subdomains that we recognize are not clear, so just a little bit of level setting.

DR. BURSTIN: Perfect. Welcome to everybody as well, just adding my welcome. Thanks to Cara, obviously, and the Co-Chairs for sticking with us.

As we promised early on this would be a crosscutting longitudinal action of the NQF and this will hopefully continue with funding, but it started without it and it will persist

regardless.

So this is important enough and it's being woven into the fabric of what we do and so delighted to have your energy and expertise. It was extraordinary to see how many of the references for the papers that we pulled together were in fact all of yours, so we obviously chose very well.

So very briefly, because we haven't been together in a while, we'll do a quick round of introductions. As part of the introduction we would also ask you to indicate if you have any potential disclosures you would like to make, related work.

In this particular instance we are not reviewing measures so it's not really an issue of, you know, you have a particular interest in a particular measure, but we also know you are incredibly skilled so we don't expect you to give us a recitation of your CV, or we'll be here for days, having seen them all, but more just a sense of is there something you are already working on

that might introduce something that the group should maybe want to know about, any potential bias, any potential -- just work you are doing that might factor into what you are doing today.

Again, it's not a typical disclosure of interest so take it more as an opportunity to introduce yourself and let us know what you are working on and, again, you don't have to be fully disclosure, everything you are doing, but anything related to particularly I would say measurement around disparities. So with that I will start with Ninez.

CO-CHAIR PONCE: I am currently working on a project on the collection, classification, and tabulation of American Indian/Alaska Natives in seven federal surveys in the California Health Interview Survey.

This is for ASPE and I've just recently completed work for the Robert Wood Johnson Foundation on how surveys measure Asian Americans and Native Hawaiians, Pacific Islanders.

I think these two particular ones could have some bearing on race ethnicity and its use in SES measurement.

CO-CHAIR CHIN: So there are three things that I think may be potential, just be aware of in terms of like perceived conflicts of interest or where there is intersecting space.

So the past seven years I was Director of a Robert Wood Johnson Foundation program called "Finding Answers" and our last iteration uses payment reform and cure transformation to try to reduce disparities, so pretty related to this particular topic.

Soon Monica Peek and I, one of my colleagues, will be co-directing a Merck Foundation program office that's going to be looking at diabetes of an inter-sectoral health solution, so community healthcare integration for the solutions.

And then third I have been active within our Academic General Internal Medicine Society, the Society of General Internal

Medicine, I am the immediate past president. I have been involved in a whole variety of activities, including very recently regarding I guess more generally healthcare reform and primary care interest and reimbursement, that type of thing.

DR. BURSTIN: You could also just -- we know who they are, but just introduce your name and your role overall, please, as well.

MR. BAU: So, good morning, everyone. I am Ignatius Bau. I have been delighted to be brought on as a consultant to the project team to give another set of eyes and ears for the work.

I will talk a little bit about some other work I have been involved in through, funded by the HHS Office of Minority Health and at the National Academies of Sciences, Engineering, and Medicine, but another project also that Sarah Hudson Scholle, one of your Committee Members is leading, funded by Dr. James at CMS is the Health Equity Innovation Incubator, which is looking at a variety of different issues

related to health equity and I am a small consultant on that project as well.

MEMBER ALBERTI: Hi, good morning, everyone, I am Philip Alberti. I am the Senior Director for Health Equity Research and Policy at the Association of American Medical Colleges.

Two projects that I think might be relevant to this work, so we've just completed a qualitative review of over 150 implementation strategies related to Academic Medical Centers' community health needs assessments with an eye toward understanding how AMC's are addressing social determinants of health and what programs have been actually impactful, so looking for real measurement of short and medium-term outcomes.

And then we just launched in February a project funded by AHRQ aimed at building a systems approach to community health and health equity for Academic Medical Centers.

So bringing it together, eight institutional teams of six to map all of their community-relevant work across research,

administration, education, clinical missions, and then to build those into mutually reinforcing efficient non-redundant, you know, well-aligned systems, measure it, and discuss what you learn and what you achieve when you approach community health work in that more systematic approach.

So we're at year one, or year half of a 3-year project.

MEMBER CARRILLO: Good morning. Emilio Carrillo, Associate Professor at Weill Cornell Medical Center.

For over ten years we have been developing a population health program in Northern Manhattan which entails collective impact working on social determinants of health with a wide range of a community-based organizations and other institutions creating a linkage between the clinical dimension with the community dimension.

Now I am more recently also involved with the Disparities Solutions Center in Boston where we are looking to bring the same model to

very qualified health centers in the Roxbury area.

MEMBER HASNAIN-WYNIA: Good morning. Romana Hasnain-Wynia, I am the Chief Research Officer with Denver Health, two months, so I am still wearing the "new" banner.

Prior to Denver Health I was the Director of the Addressing Disparities Program at PCORI and I left PCORI on December 1, 2016. So I will probably be talking about some of the work that was funded while I was at PCORI because I think a lot of it will have some application to our discussions here, especially around developing some of the evidence base.

I don't know if that's a conflict or not, it's just something that I want to make sure that, you know, my prior hat I think is very relevant to the conversations that we are going to be having here around the evidence base because the program was specifically targeted to addressing, reducing, disparities across multiple target populations, racial, ethnic groups,

individuals with disabilities, rural populations, and so forth.

And I am also hoping that my current position, my current new position, kind of where the rubber meets the road working in a safety net that's incredibly mission driven.

What I have recognized is it's very different studying the safety net or funding the safety net versus working in the safety net, so I think that there are really important lessons in terms of some of the community work that is taking place and a real focus on looking at the social determinants and integrating social determinants into what we are doing within the Denver Health healthcare system.

MEMBER YOUDELMAN: Good morning. I am Mara Youdelman, Managing Attorney of the D.C. Office of the National Health Law Program.

I am really happy to be here and not doing something else today that I thought I would be doing instead, but I think a lot of what I had been working on over the last couple of months

actually points to the need to really -- good SES data and analysis of SES data because it has been very hard sometimes to make the case about what some of the programs we have been fighting to maintain, sustain, and expand mean for different population groups and different SES groups, et cetera, so I am really excited to be here.

I don't think I have any conflicts other than I am on NCQA's Technical Advisory Panel on SES.

MEMBER SEQUIST: Good morning, everyone. I am Tom Sequist. I am the Chief Quality Officer, Chief Quality and Safety Officer, for Partners Healthcare System in Boston.

I don't think I have any conflicts with any of this work.

MEMBER IEZZONI: I am Lisa Iezzoni. I am Professor of Medicine at Harvard Medical School and the Director of the Mongan Institute Health Policy Center at the Massachusetts General Hospital.

I don't have any conflicts of interest, in terms of financial conflicts, but we recently are about to complete a PCORI consumer-driven project on steroids.

I actually think where people with disabilities have developed their own quality measures and try to assess their own quality of care and we developed a survey called the Persons with Disabilities Quality Survey that very much brings in the principles of independent living into how you assess quality in the context of the demonstration project for dually-eligible persons in Massachusetts who are ages 21 to 64, that's the One Care Program.

That has attracted a lot of interest and attention around the country because it's the only dually-eligible demo program that's for the under 65 population. Thanks.

MEMBER TEIGLAND: Good morning. I am Christie Teigland. I am Vice President of Advanced Analytics at Avalere Health.

Avalere Health was purchased by

Inovalon a year ago and so I don't have any direct conflicts of interest.

I will say that we do do some work for Inovalon, whose clients are primarily health plan companies, but now increasingly pharmaceutical companies, and we are working on them a lot with identifying quality gaps with the Star Measure Program, for example, and developing research and predictive analytics to support outcomes-based and value-based contracting with all of the data that we have, so that's one thing.

The second thing I will mention is that I was recently awarded a Commonwealth Fund grant to really dig into and profile the high-cost, high-need Medicare Advantage population.

We have done a lot of work with the SNP Alliance and, in fact, we have a small retainer with the Special Needs Plan Alliance as well, but this work will really -- they've done a lot of work with Medicare fee for service, but Medicare Advantage they have not been able to do because they didn't have the data.

So a very exciting project and we will be pulling in some very granular data on socioeconomic social risk factors that will bring a lot to bear to that work.

MEMBER FISCELLA: Kevin Fiscella, I am Professor of Family Medicine at University of Rochester. Probably my only potential conflict of interest is the same NCQA panel on the SES that Mara talked about.

MEMBER GARRETT: Good morning. I am Nancy Garrett, I am the Chief Analytics Officer at Hennepin County Medical Center, which is a safety net provider in Minneapolis.

And some of the things we are doing relevant to this work, we have an ACO called Hennepin Health where we have, it's a kind of total cost of care program where we are partnering very closely with the county to provide not just medical care but also social services that kind of support our population on medical and social needs.

And so through that work we have been

doing a lot of tests of change around measurement and better understanding social determinants of health.

So we have created a homeless indicator based on patient's address, for example, and we are going to start universal screening for food insecurity this year in all of our clinics, and so we are doing different experiments to try and figure out how to better identify needs and then figure out how to address them.

And just in terms of some other work that might be relevant, I was on the Technical Expert Panel for the CMMI, a kind of a health communities model where the expert panel made recommendations for a standard set of questions to screen the population in that program for social determinants of health.

And I don't believe that has been released yet, but I know they are still working on it.

And then at NQF I also have the

opportunity to be on the Cost and Resource Use Committee and was on the Committee that looked at social determinants of health and risk adjustment with Kevin.

MEMBER FERGUSON: Good morning. Traci Ferguson, Chief Medical Director for WellCare Health Plans.

In terms of any potential conflicts of interest, just been nominated to sit on the Medicaid Technical Expert Panel through Yale University.

Otherwise, in terms of our company, we are a Medicare Advantage and Medicaid-managed health plan with a large significant portion of our population that are dually eligible.

MEMBER RAUNER: Bob Rauner from Lincoln, Nebraska, and I actually have my feet in two canoes right now. One is community health, where I am working on a State project with their FQHCs around improving their cancer screening rates and finding a lot of structural barriers.

You know, if you look at them compared

to each other their quality measures are very dramatic partly due to their varying demographics and they are completely different across the State.

The other issues, there are problems with executing things because of their staff turnover and sustainability problems that are kind of severely limiting what you can do.

And the other canoe I am in right now, I am going to spend the other half of my life as the Chief Medical Officer of an ACO, and it's a Medicare Shared Savings Program ACO.

DR. JAMES: So I'm Cara James, the Director of the CMS Office of Minority Health. In addition to sponsoring this work you have heard already, as Ignatius mentioned, we have our Health Equity Innovation Incubator in which one of the projects that we are working on sort of relatedly that Sarah may have talked about is looking at developing a health equity index that kind of builds on how we can incorporate a focus on health equity into our payment models and

quality improvement programs and also have done some other things.

So that's the main one I will talk about and then --

MEMBER BERNHEIM: Hi, I am Susannah Bernheim. I direct the quality and measurement work at Yale CORE, which is an outcomes measure development group.

Most of the work we do is for CMS, but we also do some work with the State of Connecticut, and in both those realms in the last year we have started to tackle some of these issues around measure stratification or building kind of equity measures.

So that will be helpful to this Committee.

MEMBER SANCHEZ: Good morning. My name is Eduardo Sanchez. I serve as the Chief Medical Officer for prevention at the American Heart Association. We are headquartered in Dallas, Texas.

I don't think I have any conflicts to

disclose as it relates to the conversation we are having. I will say that we, like so many other organizations, have vigorously embraced not only the notion of but the importance of being mindful of the concept of health equity and the desire to achieve health equity but with that comes a) understanding what that is, and we are involved in that, not only for staff but also for the 30,000 or so researchers and others who consider themselves members of the American Heart Association who are conducting research and/or doing clinical work.

And among one of the things that we have done as an organization is that we have created this different way of funding research, strategically-focused research networks, where we are asking proposals to bundle proposals that are basic science, clinical science, and population science, demonstrate how those are interconnected, and one of the themed areas of funding is around disparities.

So not only trying to build capacity

but trying to better understand and do that by having researchers develop some of that work.

DR. BURSTIN: Do we have members on the phone?

Sarah, are you with us, can you introduce yourself?

MEMBER SCHOLLE: Good morning. Good morning, it's Sarah Scholle. I am sorry I am not feeling well today so I thought I'd stay home and see if I could get better before tomorrow's meeting.

I am Vice President at the National Committee for Quality Assurance and I am leading the Health Equity Innovation Incubator for the CMS Office of Minority Health as Cara mentioned and we are doing a lot of good work that looks at trying to identify opportunities for addressing disparities in CMS and other data and also stratifying reporting of data and we are very excited about this work on the quality index and looking to get some great ideas from this group. Thank you.

DR. BURSTIN: Let us know if you need us to send you some soup or anything, Sarah. You sound sick. Ron, are you with us, Ron Copeland?

MEMBER COPELAND: Yes, I am. Good morning.

DR. BURSTIN: Good morning.

MEMBER COPELAND: I'm sorry, I just patched in so could you repeat the questions, is this just introductory IDs?

DR. BURSTIN: Introduction and anything, any disclosures of any work you are doing that might be relevant to the discussions we will be having over the next couple days.

MEMBER COPELAND: Okay. Dr. Ron Copeland, Chief Diversity and Inclusion Officer for Kaiser Permanente, and I have no disclosures.

We've had a longstanding body of work in the areas of disparities and to stratifying our performance data with a particular focus on HEDIS data to identify and then try to eliminate the health and healthcare disparities.

The internal conversation we are

having now is pivoting to a more focused discussion on equity and increasingly trying to build models of care and intervention that are inclusive of the non-clinical social determinants.

So we have a couple of pilots out in the field testing the various areas of that. Our traditional HEDIS-based disparities work is now focused on diabetes, following a lot of work that was done over the last few years on cardiovascular disease and cancer screening.

And we are going to be part of a nine-organizational pilot launching this year with IHI regarding equity models of care.

DR. BURSTIN: All right, thanks, Ron. Any other Committee members on the phone? Are we expecting anybody else? Dave, Yolanda, anybody else, no?

MEMBER NERENZ: Yes, David Nerenz here.

DR. BURSTIN: Great. Hi, Dave, welcome.

MEMBER NERENZ: Thanks. I am from Henry Ford Health System, Detroit. I am Director of the Center for Health Policy and Health Services Research there.

I don't have anything that I would call a conflict. The things I have done are probably reasonably well-known to the group. I have been involved in work on racial and ethnic disparities and quality of care for 25 years now focusing mainly on health plan as the organizational context and HEDIS measures aligned with the work by the previous NQF Committee.

I have been active more recently in the issue of adjustment of standardized quality measures, particularly those used in public reporting and pay for performance programs, adjustment for social and demographic factors, done some presentations, publications about that.

What I see is I think pretty much in line with what the NQF panel reports, so I think that's the base that I come into this realm.

DR. BURSTIN: Great, thanks. Any

other Committee members on the phone?

(No response.)

DR. BURSTIN: Okay. Well, that was obviously incredibly enlightening, not for your disclosures but for the breadth of work that all of you are doing and obviously bringing a phenomenal amount to the table.

If anybody has any questions of each other this would be an appropriate time, though I think they will emerge over the course of the Committee.

And really our only sort of final thought is at any point during the discussion if you feel like you are getting a little uncomfortable and there may be sort of a potential bias that you are feeling bring it forward to the Chairs or myself, and we have learned it's always easier to try to sort those things out in real time rather than after the fact, but again I don't think that's really an issue for this Committee.

So we are just delighted to have all

of you here and several of you on the phone and I think we are ready to go. Am I next?

MS. O'ROURKE: Next slide.

DR. BURSTIN: And I'm just going to keep talking.

MS. O'ROURKE: You are.

DR. BURSTIN: Is there a dinner, tonight? That's above my pay grade. Guys?

DR. ANDERSON: Yes, we are having dinner at P.J. Clarke's, which is at 16th and K, so that will be at 6 o'clock. We have made a reservation. We will check during the break who is interested in joining, but, yes, we'll give you more information a little later on.

DR. BURSTIN: Always important to get the really important stuff on the table early. I love it. Thank you, Nancy.

Okay, so with that, since we are going to be spending a fair amount of time today talking about the context of creating this equity framework we thought it might be helpful to give some guidance from the way we have done this in

the past.

Again, you can kind of go outside the lines here, use different colors, whatever sort of fits your schema of how to do this well, but we want to give you a sense of why we think measurement frameworks, and in particular around equity where it hasn't really been done as it needs to be in the past is important.

So next slide, please. It's a --

CO-CHAIR CHIN: Just to give you a heads up that the words and concepts that NQF uses are their words and concepts which don't necessarily translate to how we use them.

DR. BURSTIN: Yes, true.

CO-CHAIR CHIN: So Helen's talk is going to save us hours of time in terms of later confusion or eliminate confusion.

DR. BURSTIN: And if you have better words we're good to go. It's really okay, this just comes out of sort of the literature or framework, so we're really not trying to impose our language, especially for this Committee, we

can't impose our language on you.

So the very basic idea here is at the end of the day how would we have a measurement framework for equity that would capture all the most important issues that you really want to make sure get done, and those could be both issues of things you want to make sure get measured, they could also be sort of balancing concepts, and if you're going to look at cost, for example, you want to consider access, so you're really thinking about those tradeoffs.

We really think about it in terms of these domains, subdomains, and measure concepts. Let's walk through the next couple of slides and put it in English perhaps.

Next slide, please. So when we think about a measurement framework, and however works best for you, the basic concept here is it's a conceptual model.

How do you organize the ideas about what's most important to measure, in this case in equity, and then how should measurement be done,

what would be the most important things to measure, which settings, et cetera, really just a way, if it's helpful for you, a structure to think about how to organize what is most important so that you assure at the end of the day that the key domains are captured and you are not missing anything.

The subdomains allow you to get to sort of those sub-categories of the key issues again you think are going to be really important for comprehensive measurement.

Next slide. So this is our definitions, and actually I will tell you internally we had an interesting time over the last few weeks ensuring we were all aligned, but essentially domain, the highest level ideas and concepts group together to help further describe the measurement framework.

The measurement framework includes five domains. You have all been through this. You may have called it different things. Subdomain, the smaller models, really the two

important ones here, because you'll be spending a lot of time talking about concepts, is a measure versus a concept.

So I think you've all spent enough time to know measures, and, well, you know what they are, in our parlance is it's that they are fully developed in some way, somebody has actually put specifications around them. We hope they will have undergone scientific testing, but not necessarily.

The contrast here is you start trying to hang some of these measure ideas on their domains and subdomains is really the idea that you have enough of an idea for what a measure is that you could say in words the description of the measure, including who the target population would be as well as what's the planned measure focus.

And I often think about measurement frameworks as sort of a tree, and if we know you want to measure equity the biggest branches off of it are domains, the subdomains are the smaller

branches, and those leaves hanging off of them are the measure ideas, what do you most want to be able to measure at the end of the day to feel like you are making, being able to hold our healthcare system accountable for equity.

Next. This is just something we did very recently. Just to give you an example we did a measurement framework for telehealth, it turns out, very different from what you are doing, but at the end of the day the most important domains they thought were really important were things like access, financial impact, experience, and effectiveness.

But when you dive into like, for example, financial impact, just saying financial impact isn't as helpful as being able to say to whom, and so they have specifically had subdomains about to the patient of the caregiver versus to the care team. So just to give you a sense of that's how we use these kinds of terms.

Next slide. Am I continuing?

CO-CHAIR CHIN: Yes.

DR. BURSTIN: Okay, excellent. I am going to tell you about the goals --

(Laughter.)

DR. BURSTIN: It's just relevant. Next slide. So as we tee this up for you it also is helpful to think about it in the context of a series of questions, and these will be the questions you'll be working on later on today.

What are the most critical disparities, reducing interventions that you'd want to be able to measure, what types of measure, measures that have the greatest potential to reduce disparities, and we'll loop back around to the work Emilio and several of the rest of you did around this concept we had promulgated around disparity sensitivity, see if we could further define it and build it more into a hope processes broadly, which measures could be implemented now versus in the future.

And, interestingly, several of the last measurement frameworks we have done questions from the Committee have immediately

arisen of whether you want to build a framework that works for the now or works for the future.

And I think the goal would be the framework should be something that you can update, but it should work with an eye towards where you want to be, not necessarily where you are.

Now that being said, we'd love to have some measures, some of those measure concepts hanging off this framework though that you could use now to begin understanding where we are in terms of equity measurement and to have a baseline to move forward. So I think it's both now and future.

You are going to inevitably as you start thinking about the concepts here start running headlong right into this issue of data availability, as we have seen for most of the SDS trial as well, but what will be the data availability to actually do these measures, how much do you need to do surveys, the kind of things you've heard from Lisa, the ability to

really interrogate the data like you heard from Christie and others.

And then finally what are the gaps out there and how can they be filled, how easy will it be to really push these issue forward.

Next slide. So with that I am actually going to stop and see if you have any questions and also invite you to introduce yourselves.

Sorry at the end there, you missed introductions, but if you could just introduce yourself.

MEMBER OGBOLU: Hi. I am Yolanda Ogbolu from the University of Maryland School of Nursing.

DR. BURSTIN: Great, thank you so much. Any questions? Does that make sense? Is the wording still fuzzy, does it kind of work, maybe for you guys in particular? Suggestions?

CO-CHAIR CHIN: Yes. The part that confused me last night that we don't want the Committee to get confused with also is it's the

leaf part of the tree where Helen I think called it a concept whereas Ninez and I thought the concept was like the tree, the broader part.

So it's clear, as Helen describes it, so don't fall in the same trap that Ninez and I did, otherwise we'll just go around in circles, yes.

DR. BURSTIN: If it's easier for you to just call it a measure idea that's fine, too, if that sort of resonates better as you are working through your working groups that's fine.

We're just trying to make the distinction. We can't expect you to walk out of this room, well maybe Susannah could, and maybe Sarah, with an actually specified measure in hand.

But we want to be able to in some ways if you could think about coming up with a measure idea or a concept that as you prioritize them and say what's most important, we hand this back over to CMS, that there is then a possibility a measure developer could take that and run with

it.

It's enough information there to actually get pretty far down the path in terms of thinking through this measure concept rather than just sort of don't put something forward that says access.

It isn't very helpful. It may be helpful as a domain but it's not going to work as something you could hand off, and because this has an urgency to it, developed, you know, in the next few years.

MS. O'ROURKE: Great. So I just want to jump in and explain some of the things.

CO-CHAIR PONCE: Kevin had a question.

MEMBER FISCELLA: Yes. Just to be clear, when we talk about measures are we talking about measures at the patient level or could it be broader and include measures at an organizational or at a plan level as well?

DR. BURSTIN: Any level you'd like. They could be community level, they could be regional measures. We've got, for example, you

know, I think -- just as an example we have a measure that looked at a late-stage presentation of HIV from CDC that's at the State level.

Again, wherever you think it's important and appropriate to think about where that level of analysis should be is fine, and especially if you could think about a model where that can kind of cascade.

So if it is something you are thinking about at more of a regional level is there may be an intervention at the clinical level that might help feed that overall view of changing those high-level outcomes. Another question? Please, Mara.

MEMBER YOUDELMAN: This is completely personal and I really apologize, but I have now gotten two calls from my daughter's school, so I am going to have to leave. Sorry.

I will try to get on by phone later today and hopefully might be back tomorrow, but I really apologize because I was really looking forward to the conversation.

DR. BURSTIN: No problem. Thank you, Mara.

Yes, it's the phone call that trumps all other phone calls in our minds, so no worries.

Okay, are we good to go? Again, we'll have lots of time to work through this. We'll have staff in each of your work groups as you are thinking about it and making sure we are kind of directionally moving right.

So with that I will turn it back over to you guys.

MS. O'ROURKE: Great, thank you. So, Mauricio, if you could queue up our meeting objectives slide.

I just want to spend a little time orienting people to what we are hoping to accomplish today. I'm sorry.

So today our goal is to identify and prioritize measurement areas that could be used to assess really how well and to what extent stakeholders are employing some of the effective

interventions to reduce disparities.

So to support that conversation Tara is going to go through some of the findings of the first two reports. Again, probably not a surprise to many of you.

As Helen was saying we cited I think mostly literature from people around this table, but perhaps just a refresher to what we found and some of the themes that rose to the top as we went through the literature, because that's what we used to put together the strawman domains and subdomains that we will be working through with you this afternoon in small group exercises.

Tomorrow we will shift and pull back up the conceptual framework that the Committee had been developing over the past year or so and think if there is anything you'd like to refine on that before we finalize it going into the third report, in particular do the conversations today come up with anything that you'd like to change in the conceptual model.

After that we will be shifting a

little bit to think about the environmental scan that we'll be performing after this meeting to help support the Committee's June deliberations. Yes?

MEMBER BERNHEIM: Sorry, just a quick clarification on the first one. The way it is written really points towards a whole realm of measures that are sort of the process measures, right, and I think that's a mistake.

Are we employing effective interventions, we can also build measures that say are we successfully improving outcomes or narrowing outcomes? So I just want to be careful with that.

A whole slew of new issues come up when you look at outcome measures, but obviously they are where we are going to see how far we have gotten on health equity, so I don't want our language to limit us to just measuring if people are doing things that should reduce disparities.

MS. O'ROURKE: That's a great point. I think probably for everyone an outcome measure

might be the ultimate goal, so, yes, we are certainly not limited to just process or structure.

CO-CHAIR CHIN: So it's my understanding, Susannah, is that you are exactly right, that's going to be like the next meeting. So the thing about like, if you have, like, stratified performance measures, outcome measures or process review measures, how would they be used, how would you measure them, absolute thresholds, improvement, et cetera.

But for the focus of today it is this area that's on the Day 1 thing here, which is something that as far as I can tell has not been really dealt with much in the literature and was part of Cara's original charge that, and this is the part I didn't get until recently, so I'll say yours is incredibly important, maybe even more important than what we are doing today, but that's for next time.

Yes. Good.

MEMBER RAUNER: Are we looking for

measures that are, for example, specific NQF measures that can be used across these or can -- It doesn't, it may or may not be an actual NQF measure already?

Okay.

MS. O'ROURKE: Yes. You are not limited to NQF measures or even measures that currently exist.

As Helen was saying we want to get some ideas down on paper of where developers could go with this and give them a starting point for developing maybe this next generation of measures, if you will.

DR. BURSTIN: Romana?

MEMBER HASNAIN-WYNIA: So, Marshall, I also didn't understand, so I am just going to push in terms of what you were trying to clarify in terms of what we are doing today versus what will be for the next meeting because I thought the comment about outcomes was really important.

CO-CHAIR CHIN: Yes.

MEMBER HASNAIN-WYNIA: But I also

heard, I think Helen you said that we want to focus on what we can do today but also the future, so there is a tension there, so just a little clarity would help.

CO-CHAIR CHIN: Sure. So the ultimate charge of the Committee is to look at the full range of tools and levers at the nation's disposal in terms of performance measurement and how measures can be used to reduce disparities, including within payment programs.

I think the type of mission that we, probably the most familiar with all of us, are like the traditional, clinical process and outcome measures, A1c value, for example, or blood pressure control, or whatnot.

And we all are familiar with like the idea of like stratifying these measures by whatever is your risk factor of interest, whether it's race, ethnicity, disability, et cetera.

And a lot of our talk as a committee so far has been on thinking about, well, if you are doing that measurement then thinking about

then how do you link it then to drivers of actions, whether it's public reporting, whether it's linked to reimbursement, and whatnot.

So that's going to probably be a very important part of the final report. So it's going to get into things like, well, risk adjustments of these issues or what are the best ways to use these measures.

Do you lose absolute thresholds? Do you reward relative improvement? Do you stratify analysis, comparing apples to apples in terms of comparing safety in hospitals to safety in hospitals, tertiary care to tertiary care, academic hospitals to academic hospitals, et cetera? I mean a whole range of different issues.

My understanding is that today we are delving at other types of equity measures, and here is the insight that I think Cara gave me that I didn't get beforehand, was that besides like in some ways these more distal measures, so it was Susannah who was talking, like these more

distal process and outcome measures.

There are, maybe structural isn't the right word to use, but in some ways like these intermediary measures that somehow potentially lend additional understanding of where organizations are in terms of moving towards achieving equity and now measuring it.

So, for example, you remember like the first couple of reports we've done there was like the document of disparities and these five conditions and then the evidence review of like effective interventions.

And so you might think then that from that review there are then potential measures that we can use of kind of to conceptualize, well, things that we know that the literature shows works.

Are there ways to create measures that show where a clinical group or a healthcare organization is towards adopting those measures or the types of processes or culture that leads to that?

So a couple of examples when we come to like the strawman, cultural competency training, the cultural competent of a clinician as well as the culturally competent organization.

So something like, for example, there are like some -- Actually, like there are a couple like NQF-approved measures which are of this ilk where like they are, they are like opening up like these overall missions of how culturally competent an organization is.

So you've got to theorize that, well, if someone scores better on that measure they are probably in a better position to achieve equity than if they get a zero on that particular score.

So you'll see eventually, to get back to some of the prep materials, we've tried to like take like the conception model the Committee has been building with, integrating with like Lisa Cooper with the drivers of the disparities model, with the socioecological model with the six different levels.

It gets back to Kevin's point about

you have a provider level, you have an organization level, you have a community level, you have a policy level, you have a patient level, et cetera, but trying to sort of like tie that all together.

So in other words, we're going to get to like the process and outcome measures, which I think probably still are going to be the most important ones, but there was this whole realm that we haven't talked too much about as a committee that is potentially a missed opportunity unless we explore it further to see whether there are potentially things that could be, especially the equity accountability measurements.

At least that's how I interpreted like Cara's push to us at the very beginning and Ignatius most recently when we had talked, Erin, Drew, and the team here. Ninez?

CO-CHAIR PONCE: I think you'll get this later, but it's the measure concept idea generator, so then the examples really help. And

I know, Helen, your call was at the end of the day come up with these, the leaves of the tree, but some of us think more about the tree first, right.

DR. BURSTIN: Right.

CO-CHAIR PONCE: Then we get to the leaves and then some of us are measurement folks, metric folks, and think about the leaves first and then think well how does this map up to the tree.

So the example here is cultural competence. Again, restating what Marshall said, that's the measurement, that's the measured domain, is cultural competence, and then from the first report there was evidence that cultural competence was associated with reducing, eliminating disparities.

The measure subdomain would be effective language services for limited English proficiency, patients.

So cultural competence could be at the organizational level and then the potential

measure concepts for each measurement subdomain then you start getting into the metrics, what the numerator would be, it's the number of hospital admissions, for example, visits to the emergency department, and then what the denominator would be.

And then the last part, the feasibility part, is the data source, coming up with available data. So is that helpful in trying to understand what we are --

MEMBER BERNHEIM: Yes, it is helpful. I think, Helen, you were going to talk about this, but what helps me is thinking about how this would get used, right, because this group isn't going to develop a bunch of measures.

I mean we might come up with some ideas more to sort of illustrate what our domains and subdomains are I think is more realistic, but we will allow NQF and CMS and other groups to say okay, I mean sort of the way we do with the other domains of quality.

You know, do we have a portfolio of

things that really get at this concept of cultural competency, do we have a portfolio of things that get at this concept of, you know, equal rates of process of care, do we have -- All right, so it's building a, I mean a framework, obviously, but I think people will get, I think it doesn't make sense to start with the measures.

I mean I think you just think of them as illustrations of sort of where do the baskets of equity measures that you would like to eventually fill, right.

MS. O'ROURKE: And I think, Susannah, that's a great explanation. So I think just to maybe jump ahead and steal some of Tara's thunder here, but perhaps it could be some helpful framing for what we are discussing.

I wanted to just draw everyone's attention to this last bullet. So through our review of the literature and the first two reports the straw person we are putting out really is a 3-step plan to use measurement.

The first step, as Marshall was

saying, is to use the relevant process, structure, and outcome measures to really anything you are measuring, but perhaps the ones that are most of interest to the topic area and use those to identify where disparities exist.

The next step is this new domain, as Susannah was saying, where do we go to start to measure what people are doing to reduce those disparities and what interventions could be effective.

And then the third step is how do we incentivize and support the reduction of disparities and how do we really use those measures to understand where people are, where they need to go, and how we can perhaps jump in on system reform to really push forward on disparities reduction.

So, Marshall, I'm not sure if that helps clarify, if I -- just to at least lay the plan out for where we are going, we're building through our review of the literature.

CO-CHAIR CHIN: Yes. Part of the

challenge is that like our Committee's current conception model I think is a really nice model, still in evolution, it's still missing some parts, and the parts that aren't quite linked still are like the fundamental driver disparities.

Again, these are like Lisa's model, I just give this model as an example of one, the socioecological models, so we talk about this in multiple levels of where the interventions are then how it all relates to measurement and its use.

So in some ways like they are like little boxes on like a conceptual model but it needs to be blown up in terms of like more detail, and so that's probably what we are struggling with to try to tie together partly through today's meeting a further building out and further linking than all those different elements, from the driver disparities, what works through these disparities, and then measurement and how those measures will be used and

incentivized in payment programs.

So that's the overall scope that sort of has to fit together. So you see like your point, like yours and Susannah's about like the traditional process of outcome measures that we usually think of, they are going to be critical and again probably still the most important things ultimately in terms of then how they are going to be used.

But we are trying to sort of fill out some of the other pieces of this jigsaw puzzle which haven't been as well delineated compared to things like the traditional process and outcome measures.

My guess, for example, is that it is going to be very helpful today brainstorming because I don't think we are, we're not, at least the staff here, and Ninez and I weren't aware of, of much work done on this area beforehand.

CO-CHAIR PONCE: Yes, Romana? And I also want to note that I believe Bob had his hand up and then Emilio, maybe Bob, Emilio, then

Romana. And Bob concedes to Emilio.

MEMBER HASNAIN-WYNIA: So I just want to make sure that I understand. So I am going to come back to Kevin and Kevin's kind of multi-level, multi-component, you know, looking at organizational or policy level, organizational level, and drilling down.

So in some ways I think what you are asking, as I am doing a little bit of hopefully reinterpreting and I am trying to understand as we deliberate today that as we start to think about the measures, you know, we have had this traditional model of thinking of process or outcome, but we don't necessarily think about connecting the dots through all those different levels.

So, for example, the cultural competency model, the cultural competency domain, and then the subdomain and the specific measure being around measurement of language services.

We can try to think about connecting that to an individual organizational level metric

around providing interpreters for individuals with limited English proficiency.

But if you think about it at a policy level the policy, or maybe in this case the law that we might highlight is, you know, Title 6 or, you know, something that connects to policy.

So in some ways we are doing the work of connecting the dots because organizations that are using these measures sometimes have a really hard time connecting those dots. Does that make sense?

DR. BURSTIN: Yes.

MEMBER HASNAIN-WYNIA: Is that what you are -- I mean is that the linkage? And I think that's what you are getting at, Marshall, but I am not sure. That is how I am interpreting it though, trying to find the linkages for every measure or measure idea that we brainstorm today, so a broader framework than Lisa Cooper's, for example.

CO-CHAIR CHIN: So I haven't seen the final materials that the staff has put together

for the packet, but one of the ones in an earlier iteration was there is going to be like six different levels ranging from, you know, patient, clinician, microsystem, organization, community, and policy.

So for each of those different levels there are potentially measures that could be used to look at then, you know, some range of equity from not very well prepared for equity to very well prepared, at that organizational level here are some measures that might be used to assess how good that organization is at equity.

So it came down to six different levels that will eventually need to be the matching between the measures and then the action or policy, and so that's where like the final report is going to come in of our recommendations of, well, how should we, how should measures be used or whether from reporting or payment or QI or whatnot that would match the chance that you'd move someone, an organization, higher on their level of equity skill or equity ability to

achieve that. Erin?

CO-CHAIR PONCE: Can I --

CO-CHAIR CHIN: Yes, go ahead.

CO-CHAIR PONCE: And I hope that that's the goal because that is not being done in any space, so I hope that that's the goal.

I think for the next -- but to achieve that in the next two days I am not sure we can do that for all of the buckets that Susannah said, the health equity buckets.

I just think we have to find the constituents or the elements and the different levels first and then -- and that I believe is the third report, and then the fourth report is then I think putting on the policy handles and hopefully linking, you know, all of the different, and I don't know what to call them now, domains, all of the different domains and the different levels within those domains.

CO-CHAIR CHIN: And just to stress to both, you, Romana, and Susannah, your initial point of like the importance of the traditional

process and outcome measures, yes, they are going to be incredibly important and they will be, I would assume, probably going to be a big part of the final report.

This is just filling in other parts along the sequence that would be easy to lose, because I think it would actually be -- Frankly, I hadn't thought about it in as much detail as these folks of like the value of this particular part, but I can mention like just jumping to the outcome and process measures and then potentially missing out on the value of, the potential value of what we would be talking about today.

CO-CHAIR PONCE: Susannah?

MEMBER BERNHEIM: Sorry, I know you are trying to move on, but can I ---

(Simultaneous speaking.)

MEMBER BERNHEIM: All right. So I see this as a domain, a critical domain that could get lost, which I think this comes as a sort of preparedness, whether it's the physician, the patient, the community, right, sort of what are

the enabling, I don't know what the right term is, and I think it's a critical domain but I think if we don't put it in a framework of other domains, even if we say we are only looking at this domain today, I think we are going to confuse ourselves quite honestly, right.

I mean to my mind, and I'm going to use re-admissions as an example, which is really not a particularly good example, so forgive that it's not that apt, but, you know, when we thought about re-admissions we could have said what makes a hospital ready to think about what happens outside their door, right, and that is valuable, right.

We could have said what are the processes, the discharge instructions, the making sure they understood the follow-up call, and we measured some of those things, but we had to also be thinking -- like the re-admissions also drove places to sort of innovate in that area.

And if we only thought about sort of are we ready to think about care transitions I

think we would lose the forest for the -- I don't know if that's the right -- Anyway, I think that would have been a mistake.

And so if we are going to focus on what are the things that patients, health systems, providers, policymakers need to sort of be ready to do to tackle disparities I would recommend we make that a domain or two but we think about those other domains of what are the things that work, the process measures that work, and what are the outcomes it will tell us that we are achieving something and what are the earlier things about sort of tackling community disparity so that we see it as part of a broader tree.

MEMBER CARRILLO: Yes. When we think about domains, there is another cut at domains in cultural competence. We have looked at the domain of leadership, community engagement, communication, system integration, so that is another cut that has been developed from looking at the literature on cultural competence and would be very -- very open to measurement in each

of the domains.

CO-CHAIR PONCE: Noted. And Philip?

MEMBER ALBERTI: I like this idea of equity preparedness, but I think there are some complicating issues, right? So there's metrics that get at whether an institution or an organization or a community is prepared. Then there's metrics that assess the activation of that preparedness, and then I think what we have not talked about yet that is perhaps the most complex is metrics that assess the connective tissue between these domains, right?

So you could have independent siloed actors who are prepared and doing the stuff, but how do you actually measure the collaboration connectivity synergy between domains, so kind of the hidden domains between the domains? And I think that is a really crucial thing for all of us to think about, and I certainly don't know if there's any work that has been done on that kind of hidden connective tissue, but I think that is where kind of the rubber hits the road on this

equity conversation.

CO-CHAIR CHIN: I was going to say that this is exactly the type of session that we want to have, and we agree with you 100 percent Susannah that that is the overall goal, the overall model that we want you to come up with. We will have it full. It is obviously in part here. Your point about making sure we don't lose sight of like, you know, what you and I are saying about the progress and outcome measures, very important.

We will see like in -- at least in like some prep materials, it is more simplistic, and so you're starting to get, Philip and Emilio are starting to get into areas where that's great, and yeah, that is going to be the reality, and we need to sort of forward that, so this is exactly the type of conversation that is going to be helpful.

CO-CHAIR PONCE: Eduardo? Oh, I am sorry, Bob.

MEMBER RAUNER: And -- and maybe this

is preempting a later conversation, but I think we may need to pay a lot of attention to the data source problem because that is what I am running into in Nebraska a lot.

So specifically, for example, I am -- I think colorectal cancer screening is a very good measure for a lot of reasons. There's a lot of QALYs that would be saved by improving it. It can be measured at patient level, clinic level. It is a reportable measure for ACOs. It is on -- it is on -- it's a standard HRSA UDS measure. It's our Blue Cross plan measure. You can calculate it very -- a lot of different ways.

The problem -- one of the problems is that it -- a common way of verifying it is claims data, and claims data has a couple problems. One is it is often incomplete. It may be off by 15, 20 percent. And claims does not have any of the SDS things we are looking at like race, ethnicity, language barrier. So there is a potential great area, which is EHR-based measures, because it is -- well, assuming we can

clean up the EHRs in the United States, that is going to be a much better measure, plus the EHRs are collecting race, ethnicity, language preference, insurance status, so it could be a great measure if we could clean up some other things.

And so I think we need to talk at some point along fixing -- having a better data source. In even a lot of published literature, they are imputing SDS because claims doesn't have it, again. They are using ZIP Code and things like that, which has its own issues. But it's a potentially really good measure if we could fix some of the logistical problems around the data source.

CO-CHAIR PONCE: Thanks for pointing out the data sources. Eduardo?

MEMBER SANCHEZ: So I was going -- I was going to stay silent because I was just trying to listen and understand, but Philip's point reminded me that while what Philip was talking about, very very important, that the

notion of cultural competence at any kind of organizational unit level is dependent on a set of other factors that may presuppose or inform the ability of an organization to become culturally competent, or that unit, or that team, I just wanted to add in there that the measures we use for cultural competence, and I would argue those are intermediary outcomes at best, don't necessarily assure that the desired effect, cultural effectiveness, is actually achieved.

So too often, people can check the box that everyone got the training, but in fact, for reasons that might be measurable, the desired outcome is not being realized, and I would hope that as we do this, we are careful to understand that cultural competence, as in its current construct, is at best an intermediary measure, and probably not one of the complete set of things that we ought to be looking at.

CO-CHAIR CHIN: It's a point well-taken, Eduardo. I have to remember what Helen said about what we're coming up with. It

somewhat should be sort of a general model that should be good for a long time with the understanding that some of the different measures or domain areas, probably most of them for things we're talking about today, good measures don't exist. So it's going to be a lot -- some of it is going to be aspirational.

CO-CHAIR PONCE: Oh, sorry. Yolanda?

MEMBER OGBOLU: Hi. I just wanted to piggyback on what others were saying as well, to think a little bit too outside of the box for measures that might not directly come from healthcare in the way we traditionally think about it.

As we are talking about equity preparedness, I am thinking about some implementation science measures like organizational readiness. You know, when I think about the work that I have done around cultural competency, looking at organizational cultural competency, I am beyond adoption, which basically is an organization making a decision and agreeing

that they want to be competent, and looking further into implementation, which is that kind of activation I think that Philip is talking about.

So I would just say, you know, I am also hoping that this measurement development is open to thinking of bringing in kind of these measures from other fields that we might not normally think of right away.

CO-CHAIR PONCE: Thanks, Yolanda.

MS. O'ROURKE: Okay. So I think with that, Tara, if you could just quickly run through what we found through our literature review? And after that, we are going to have a few brief presentations on some related work that the committees brought up that you want to know more about, in particular NQF's population health work, our work around rural health on home- and community-based services to think about how we might go into some of these new frontiers of measurement that are pretty closely linked to health disparities, and where we need to make

connections.

MS. MURPHY: Good morning, everyone. I am Tara Murphy. You recognize me from the emails, I am sure. So I am just going to take us through a quick overview of where we are to date in our timeline and in our -- over the first two reports.

So just a quick refresher on our project objectives: the I am sure you are very familiar right now with our five conditions that have been chosen for focus in this particular project. Again, those conditions are cardiovascular disease, cancer, diabetes and chronic kidney disease, infant mortality/low birth rate, and mental illness.

We are looking at these five conditions across the social risk factors identified in the National Academies report, accounting for social risk factors in Medicare payment, identifying social risk factors. Those risk factors are race, ethnicity, gender, social relationships, socioeconomic status, disability,

and the residential and community context.

Just a quick overview of our project activities to date: over the course of this task order, we will complete three interim reports and one final report, which will include an environmental scan, and that we will also identify gaps in measurement, develop a conceptual framework to guide performance measures, and make final recommendations to CMS. All these activities will culminate in a set of recommendations for potential development to assess efforts to reduce disparities in health and healthcare in those five target conditions.

To date, we have submitted the first two interim reports that looked at, first, what are the disparities and what is causing them, and second, what are some effective interventions currently out there working to address these disparities?

Next, we will perform an environmental scan for existing measures or measures under development to assess effective interventions.

We will then identify gaps in measurement and the extent to which the stakeholders are employing effective interventions. We will continue to develop our measurement framework to guide performance measures, and we dedicate some significant time to that tomorrow afternoon. And then finally, we will make our recommendations.

Here is just a broad timeline that I know you have all seen before on the project activities. We are currently at -- two-day -- the first two-day in-person. We will have another one in June. The -- between now and then, we will submit the draft and final version of the third report, which will include the environmental scan measures, and we will again seek your feedback on that draft report.

Our final report will be drafted by mid-July. We will go to a public commenting period. Then we will reconvene on the web to discuss those public comments and submit our final report in September.

Just a quick overview of Report 1:

this report focused on existing disparities and the causes of those disparities in the five select conditions. The goal is to review the evidence currently available that describes the disparities. We -- the staff performed a literature review focusing on these five conditions and also began to include the framework, building off of the committee's work last year and some other frameworks that we will go into in a moment.

The literature review results were fairly significant. We found significant disparities across all the selected conditions, which confirmed what we know is an urgent need for a systematic approach to eliminating health disparities through measurement. We have also been able to note several ways that disparities have already been reduced.

The -- we included in that report the first draft of the roadmap, the framework which built off the committee's previous conceptual framework as well as the NAM social risk factors,

the modified Lisa Cooper framework, and identified measures -- excuse me -- that can be used -- or built a -- in order to build upon that in future identify measures and interventions that can be used at all levels, like we have been discussing.

Here is just -- this is -- I am sure looks familiar. This is the NAM framework. We introduced the committee's conceptual framework in the first report, which seeks to illustrate mechanisms through which performance measurement can be used to reduce disparities. CMS tasked the committee with using this framework from the National Academy of Medicine as a lens through which to develop a new framework for measurement. As you can see, the social risk factors identified in this framework are those that we have chosen to use in our own.

Another framework that the committee drew from to inform our own is from a member of our own committee, Lisa Cooper. We drew from this framework to create our modified framework,

which was included in both our first and second reports. We used this framework specifically in the second report to draw interventions back to specific barriers.

Using those frameworks as our lens and starting point, the committee developed the framework you see here. You all recognize the potential lack of measures to assess the use of interventions that reduce disparities in quality and access. As such, the current iteration of the conceptual framework largely focuses on developing measures of health equity. Health equity measures include performance measures that assess care that is sensitive to disparities. For example, these measures include measures developed for condition areas where there are known disparities. Excuse me. A large component of the current iteration of the conceptual framework recommends the identification and development of measures that can assess health equity.

Report 2, the final version of Report

2 was submitted last week. Thank you all for your input on this. The purpose of the second report was to look at existing effective interventions to reduce disparities in the five selected condition areas. We focused on existing systematic reviews and other literature reviews already in existence to find those interventions. We identified many cross-cutting interventions that did not stay within one of the condition areas, and we used the selected conditions as illustrative examples, types of common interventions, to paint the picture. We organized these interventions by the level at which we operate and found a good variation there.

The findings from our literature review for Report 2: the majority of the research focused on improving outcomes, and we are not surprisingly focused on race and ethnicity. Several of the social risk -- excuse me, the condition areas found a lot of interventions that were focused on these upstream interventions,

these lifestyle interventions, and so we dug into that a bit.

Also, in the second report, we included an updated version of the conceptual framework roadmap based on the feedback we received from you during our web meeting in January. These changes emphasized a higher-level approach to reducing disparities through measurement; improve quality and access; target the use of effective interventions. We identified -- focused on the identification and development of measures to assess equity, incentivized the support and reduction of disparities, and hit at all of these drivers that we discussed on our call, as I am sure you are all familiar.

The findings of our literature review, like I said, we focused on existing systematic reviews. We recognized the influence of factors outside of the control of the healthcare system. That was a reoccurring theme that the team came across a lot. Healthcare organizations can best

influence these disparities by improving access to health and social services; by addressing behavioral risk factors; and we also discussed considering interventions to reduce disparities in the context of quality improvement.

AHRQ noted limited evidence but identified a number of promising interventions, such as collaborative care model, patient education that accounts for language and literacy.

And some more findings from our literature review: a systematic review by Marshall outlined best practices in promising interventions, noting a need to commit to reducing disparities; establish mechanisms for quality improvements that integrate efforts to reduce disparities; and promising effective interventions are culturally tailored, use multi-disciplinary teams, address disparities at multiple levels throughout the healthcare system.

We recommended -- the IHI recommended five approaches to increase health equity. We

included all of these findings in our report as well. One specific note that we found was the caution against unintentionally worsening disparities with some of these interventions. If the -- and one of the ways to eliminate that threat would be to tailor improvement efforts to meet the needs of individuals with those social risk factors rather than to the broader population, and then therefore worsening the existing disparities.

We found some best practices, including commit to reducing disparities and promoting equity; collaborate with public health systems to address disparities across levels of prevention and level of the system; collect data for the detection of disparities; quality improvement frameworks must incorporate interventions to reduce disparities; partner with communities; and ensure buy-in from patients; and cultural competency person and family engagement in multi-disciplinary teams focusing on care coordination can all help to reduce disparities.

We had some findings that were more specific to conditions. I don't want to read these all, as I know you are all familiar with the report, but we found differences among the conditions. Cardiovascular tended to focus more on the upstream interventions. Cancer focused predominantly on screening, improving access to screening. Diabetes and chronic condition, most of those focused on patient education. Infant mortality focused on access to care, educational outreach, management of high-risk pregnancies. And mental illness mainly focused on access and quality.

Next we will focus on promoting equity through increasing access and improving quality. The measurement is -- we will now develop our framework for focusing on measurement as a tool to ensure people with social risk factors receive the care -- the quality care they need.

We have our three-step plan. This is where Erin went over. We have seen this slide before. Erin just discussed this with us. But

our three-step plan to use measurement is to identify disparities through relevant process, structure, and outcome measures; access use of effective interventions; and incentivize and support the reduction of disparities.

MS. O'ROURKE: So thanks, Tara. Could we go back?

MS. MURPHY: Sure.

MS. O'ROURKE: If it is okay with our Chairs, perhaps we could see if there is any overarching discussion on the findings of the first two reports, what worked, what didn't. Just to kind of sum up what Tara just presented, we really found there is a need to improve both access and quality to start to tackle disparities, essentially reiterating that equity is an essential part of quality.

We need to ensure that people are getting the right care for them, and to do that for people with social risk factors, we need to make sure that the system is using these interventions that have been found to be

effective to reduce disparities, and measurement is a crucial tool to ensure that this is happening.

And then, as Marshall was outlining, we put together a draft three-step plan. First, we need to identify disparities. Then, we need to start to think about the use of these interventions. And then we need to incentivize and support the reduction of disparities.

So if it is okay with our Chairs, perhaps we could pause, take any cross-cutting conversations, questions. We can then go through some other related work and present the strawman that staff has put together based on these findings.

CO-CHAIR PONCE: Emilio, then Bob.

MEMBER CARRILLO: That is great. A lot of the emphasis is, as necessarily it would be, on healthcare, and we know that healthcare is maybe 10 percent of the attributable impact. And we have the social and environmental so-called social determinants of health, which maybe are

20, 30 percent.

So to what extent do we think about how to integrate the social determinant world with the clinical world in terms of integration with social agencies -- social service agencies in the community, community engagement, sort of to take that step, not just focus on the healthcare, but the integration of the healthcare with the social service in the community?

CO-CHAIR CHIN: This is a great committee. Right on target, Emilio.

My guess is that some of the prior literature has not been as focused on social determinants. That wasn't in the lit review. It just wasn't there. But when we come back to the brainstorming session, and especially when we think about like the social ecological model, parts of what we have basically been talking about, and things like social determinants of community health, we need to make sure it is in there somewhere.

I think also when Erin goes over some

of the other NQF work, particularly the population health work, some of that may be related in terms of like some measures they have thought of, but clearly, my take on what the committee has said in the prior meetings was that this was an area -- actually, from the very first meeting, this was an area that the committee felt strongly needs to be part of a forward-thinking way of measuring and intervening on equity.

CO-CHAIR PONCE: Bob, then Philip.

MEMBER RAUNER: A question you might want to just dodge, that -- sorry. Oh, wearing my rural white guy hat now, one of the disparities for rural America is a combination of factors of drugs and alcohol use, which often impact the other two big ones, which is driving with no seatbelt, especially in a pickup, and/or suicide with readily available guns. Can we go there, or is that something we probably ought to avoid just because of current politics?

CO-CHAIR PONCE: I think we can go there. Is that okay? I mean, that is what I --

(Laughter.)

MS. O'ROURKE: I will agree with Ninez. Let's go everywhere we need to go, and --

CO-CHAIR PONCE: Let's go where we need --

MS. O'ROURKE: Yes.

CO-CHAIR PONCE: -- to go. Philip?

MEMBER ALBERTI: Emilio, I really appreciate that point, and I think it is something that we all need to be mindful of in terms of when we think about how to incentivize action for hospitals and health systems, kind of the characteristics of quality measurement don't really dip into that space, so, you know, thinking about, and I will look at Tara as kind of a federal player here, how do we link these kinds of efforts and incentive structures to things like community benefit policy where hospitals and health systems are not given the kind of formal benefit recognition for many of their upstream interventions? Housing was a recent change.

So are there conversations that this panel can suggest that CMS and the IRS and CDC have to think more holistically about a suite of policy drivers that would allow hospitals and institutions to get the kind of support that they need for this work, particularly upstream work, but also the recognition and credit for a job well done which lives largely outside of the realm I think of quality measurement today?

CO-CHAIR PONCE: That speaks to the incentivization and support. Eduardo?

MEMBER SANCHEZ: I think I will just continue with that line of thinking. You know, there is an evidence base. I don't recall if it's in the report or not, but you have got the community guide, probably not as rigorous from a methodologic perspective as the U.S. Preventative Services Task Force recommendations, but they are not bad, about community interventions.

And back to the point that Philip is making, it seems to me that this is still, maybe for good reason, very patient-care-centric, and

there is some evidence out there that there are some things that can be delivered to people, but not in the clinical care setting.

And I think the perfect example of the beginnings of something that is moving outside of the clinical care space that folks who think in a clinical care way can latch onto is the diabetes prevention project and program that begins to make the case that there are things that we have thought of as being only in the domain of clinical care, you've got to write a prescription for it, it is indeed a treatment, but it is delivered in a community space, and we may not even be measuring all of the important things that we might want to measure, like a person's sense of well-being on the other side of that kind of experience.

And so I think it behooves us as we think about the domains that the community domain be one of those, and back to the point that Philip was making, is how do we begin thinking about the infrastructures that exist, the

interventions that have been demonstrated to work, and start connecting those two? Because I think Philip would agree that one of the shortcomings of community benefit right now is the language is pretty loose about, it is still pretty loose about what to do, and we might be able to inform this issue of disparities by citing the fact that there is an infrastructure in place, there is a measurement mechanism in place, and there are some interventions that can make a difference and broaden the conversation into the community domain.

CO-CHAIR PONCE: Ignatius? And then there is a whole row here which I didn't catch who went first, but we will start with Ignatius.

MR. BAU: So when Tara did this overview, again what really struck me was I think we are sort of going through this entire continuum and paying a lot of attention to what has not been discussed previously, which are some of these social risk factors and these upstream social determinants issues, but I also don't want

to lose sight of the fact that the gaps in what we found in the effective interventions.

So when you look at diabetes, it is about sort of the upstream education. It is not about diabetes control. It is not about diabetes outcome. Similarly with cancer, it is about cancer screening. It is not about outcomes of people who actually have diagnoses of cancer.

And in some ways, that is reflective of where we are in quality overall, that we are doing much better at those upstream screening diagnostic levels than we are in the ultimate outcomes, but I think we also shouldn't lose sight of the fact that there are gaps on the other end of the spectrum in terms of those outcomes as well in which we don't have really good evidence of interventions or measures at this point.

**CO-CHAIR PONCE:** Okay. Traci, then Nancy, then Kevin, then Lisa -- oh, were you first, Lisa? Okay, then Lisa and Susannah.

**MEMBER FERGUSON:** So I think what

really helped I think solidify in my mind reading the second report is that in all of the areas and conditions that we're focusing on, that we needed a multi-disciplinary multi-stakeholder response or intervention, and that as we, sort of as a work product in the deliverable, that when we are looking at sort of the patient, the provider, institution, community, and policy level, that in order for us to be effective in eliminating the disparities and move towards health equity, we need to address and basically fill in each of those levels for each of those conditions.

So we won't be finished, or at least the first phase of finished, until we have effective either they are established interventions or measures, or we have outlined clearly how measure developers could address each of those for all five of those conditions. So that is what I think of during sort of this work product here today.

CO-CHAIR PONCE: Thanks for the clarification. Nancy?

MEMBER GARRETT: So I just wanted to build on a lot of the comments about community, kind of the level of analysis and measurement. What I was struck by in the report was how many of the -- how much of the existing research is really within a provider organization looking at disparities within a particular population, but we really need to kind of look up from that and realize that patients are not equally distributed across providers.

And, you know, one way to do disparities would be to really look at the safety nets, and where are the most vulnerable populations, and increasing -- improving the quality of care and reducing social risk for those populations. That would reduce disparities between provider populations.

And so I think this is really important as we think beyond the clinical world, but also even within the clinical world, that what level analysis are we looking at? And that kind of traditional way of patient-level analysis

within a provider group might not serve us well in this domain.

CO-CHAIR PONCE: And there is also mismatch in the data availability for vulnerable populations. Kevin?

MEMBER FISCELLA: A comment and then a question I guess for the NQF, since I don't have a sense of where this is at.

I am looking here at the summary of the report on measuring vital signs, you know, from the IOM report on core metrics for health and healthcare progress, and let me just briefly review the measures here because it is hard for me to remember. Maybe some of you have better memories than I do.

But the vital signs are life expectancy, well-being, overweight, obesity, addictive behaviors, unintended pregnancy, healthy communities, index of community profile, preventative services, care access, patient safety, evidence-based care, care matched with patient goals, personal spending burden,

population spending burden, individual engagement, and community engagement.

You know, it occurs to me that, you know, that the IOM, you know, tried to prioritize, you know, measures that matter, and we could all quibble with some of them, but, you know, the committee did try to, you know, find ones that really get more at the outcome even beyond things like, you know, readmissions, for example. And we certainly know that there's huge disparities across these. And so my question is how this has informed NQF and where we are with beginning to integrate these sort of broader types of measures of health and community.

DR. BURSTIN: No, it's a great question, Kevin. We spent a lot of time thinking about it actually at our annual meeting. In a couple weeks, next week, goodness gracious, we will actually be talking about this measurement framework we have been rolling out, which really starts with the idea there is a set of these top outcome measures for the top outcomes for the

nation, like the list you have just listed, and then really thinking about a set of criteria that we would use to say which measures drive those as we think about what tends to live inside the NQF box.

What measures drive those? Where are the gaps in measurement that would potentially help drive those as well? So we are very much keeping an eye towards it, and one question would be, you know, some of those would logically be the kinds of measures you would use to assess the quality, again, we are about quality, the quality of care provided broadly by the health system. Some of those may go a bit beyond that. High school education rates, for example, may push the border I think a bit more than we are I think able to wrap our heads around at the moment.

But that being said, health days from school, you know, healthy days missed from school might be a very logical metric that crosses beyond the number of preventable asthma ED visits for kids, right? So I think we are willing to

push that border. You will hear more from Elise and Marshall shortly about our population health focus work. But keep that mindset of what logically makes sense as you think about quality of the overall healthcare system? Some of these indicators could very much be the kinds of indicators Eduardo was listing out, but we want to have something that allows us to also measure our progress as a nation towards reducing -- towards, you know, reducing issues around equity.

I also really just want to -- as long as I have the microphone for a second, I really want to go back to Ignatius's point as well about we want to think about, even in the areas that we have looked at that are the usual suspects we have been looking at forever -- God, we have been writing these papers -- you have been writing these for decades, as have I and others -- you know, we have been measuring these things for a long time, and even in that instance, most of the things we found around cardio care are around access, even though we know it is a much broader

lens of the quality issue.

So again, keeping a very comprehensive view from the community to care I think is where we would love to have you think really broadly, and then we'll think about prioritizing what makes sense.

CO-CHAIR CHIN: Just a point of clarification, Helen --

DR. BURSTIN: Please, yes.

CO-CHAIR CHIN: -- because like one of the charges for our committee was to integrate equity within the other parts of NQF, so like when we hear for example like NQF's activities on population health, if this points -- that aren't reflected in there, then I take it as the charge that we need to basically insert ourselves in terms of helping to improve those other parts of NQF?

DR. BURSTIN: Absolutely, and very much so. I mean, we just had this conversation at the meeting Ignatius ran, which you will hear about later, which Marshall and Sarah and I were

all at, around thinking about the class standards, and, you know, one of the things that was really striking, I looked it up as we sat there during the meeting, there is not a single measure in the MIPS program for clinicians at this point that has anything to do with equity. Hundreds of measures, none of them having to do with equity.

So my point would be how do we then reflect equity into the work that the Measure Applications Partnership does around selection of measures and ensuring that gets pushed forward as well? So absolutely. You are here to stay, and you are here to help advise us to make sure equity gets built into everything we do.

CO-CHAIR PONCE: Great. So we are glad you're all here to stay. Lisa.

MEMBER IEZZONI: As I was listening to the earlier conversation that really broadened out and focused on the community and a variety of different kind of factors affecting just population health, I did have to go onto the

Organization for Economic Cooperation and Development website and look again at the fact that of the 13 major developed countries, the United States continues to be at the end in terms of health overall.

And so when we talk about healthcare equity, we are talking about equity within a system that for everybody is not getting a good outcome compared to the rest of the world. And so I think that if we are going to think more broadly about community, that we need to at least bring that up, you know, that we in the United States, even though everybody -- there's a lot of political rhetoric about we are the best healthcare system in the world, well not, you know, given how people's health is ranked compared to these 13 other developed countries.

And I am reminded, and Helen, Marshall, and probably Tom as well, do you remember that Eric Peterson paper in JAMA from like 30, 20 years ago about how black men got higher rate, or had better outcomes than white

men did from heart disease because they were less likely to get unnecessary surgery? And, you know, it's a very old article, but the whole point was that there are a lot of people with a lot of health insurance who are getting way too much care, and some of that care is dangerous to their health. Some of that care is very inefficient to their health.

And I really think that if we are going to look very broadly at disparities, that we need to think also about disparities of overuse that could also deleteriously affect people's health. That might head us in a very different direction than CMS kind of wants us to head into, but I think at least in our conceptual discussions, we need to remind people of this.

CO-CHAIR PONCE: Thanks. Susannah then Emilio and then Romana.

MEMBER BERNHEIM: Just a quick thought as I was hearing this conversation. Like Kevin, I thought about the IOM work.

And in general the chatter that I'm

always hearing about there's too many measures. And I'm hearing us think about sort of all the detailed levels at which we want to assess providers, including whether they're active in our community.

And so I would -- I think what would be useful for us to do is think about two kinds of measures. Right, there's the more bit dot accountability measures. And then there's all of the things that maybe used within a system to drive achieving success on those larger ones.

But that I don't think we will be successful as a committee if we come out and say we need one thousand more measures. And CMS is going to assess every hospital on this one thousand more measures.

All right, so let's be strategic about where we're heading towards. And think about identifying these. These might be key measures that might be more used within systems, and here's a couple of things that we think you want to look at if you're a payer or a policy maker at

a sort of higher level accountability measure.

DR. BURSTIN: It's a really interesting point Susannah. I just want to also point out, I think a big part of our vision, or our strategic vision going forward, is we also need to reduce a lot of the measure burden that isn't actually adding value.

I'd kill to have some of these measures kind of front and center in pay performance in the way they're not. But I think some of it is that very sort of comprehensive view of what's measured and how it's used.

But completely agree.

MEMBER BERNHEIM: So I'm thinking about how you could move for us population of a measurement.

CO-CHAIR CHIN: But where it's at for now then that like a -- I think we're probably still in brain storming mode. So that I wouldn't worry too much about being a parsimonious right now.

Even today as part of the exercise,

we'll do some improvisation. But probably better to have a, I think a different document for, you know, people over time.

But having a centralization out there. And then maybe a final report where it's going to be more sort of recommendations that will be particularly relevant. You're past the point about having a parsimonious set.

CO-CHAIR PONCE: Emilio then Romana. And then Bob.

MEMBER CARRILLO: Yes. I think that in terms of focus, the geographic neighborhood is an incredibly important focus for disparities. There's a lot of literature, emerging literature.

Neighborhoods in Cincinnati, New York, Atlanta, Los Angeles, New Orleans where you have an amplification of adverse social determinants that basically build on each other. And you get tremendous self-disparities. And that amplification factor hasn't been sorted out. But there's components. There's the healthcare in those neighborhoods. There's the housing stock.

There is the third grade reading level for kids.

And I think that to the extent out of the box we begin to think about the neighborhood geographically, some geo-coding linking that to the individual, I think that that's an area where there's a lot to be developed.

CO-CHAIR PONCE: I'll be on that subcommittee. I agree. And CDC has a five hundred cities project that's being rolled out. It uses small area estimation when surveys just aren't enough to get at that granular level.

Romana?

MEMBER HASNAIN-WYNIA: So, I wanted to get back to a couple of comments. Your comment about, you know, where are we targeting?

Where are we really looking at disparities? And the comment about, whether we need to be focusing on between versus within disparities.

And then the more recent comments about measurement glut. Because I agree, I don't think we need a thousand new measures. I think

we have a lot of measures.

What I do think we need, and I hope we do as a committee, is provide some guidance around context. And I'm going to link this to our earlier conversation about linking to some of the drivers.

So whether it's incentive payments, pay for performance, et cetera. It just reminded me that back in 2011, I had to actually pull it up, because I couldn't remember exactly what we said.

But, a paper that I coauthored with Jan Blustein and Joel Weissman and others, looking at analysis of pay for performance in Massachusetts. And the title of the paper, and I'll send it around, is analysis raises' questions about whether P for P and Medicaid can efficiently reduce racial and ethnic disparities.

And what happened in Massachusetts was, looking at both structural measures around cultural competence and the tool that the hospitals use there was a cultural competence,

organizational self-assessment with 28 items that were divided into four domains.

There's absolutely no evidence that those items had any relationship to reducing disparities. And the target incentive payment was about 20 million. So 300 thousand dollars per hospital.

The context in this was incredibly important. Because what ended up happening when this program was implemented, was the recognition that there wasn't enough diversity within Massachusetts hospitals to be looking at within hospital disparities.

So, to me it's just a lesson and a lesson learned. And a lesson in going back to something that we should all be aware of in terms of how our measures target disparities.

And whether we are really articulating what the context is. Because I think nationally, this will make a huge difference. Context will matter whether we're measuring the between or within disparities.

And the last thing I'll say, and it's a broader conversation, is I know that we've, you know, kind of talked about this round and round, not just here, but you know, in many different professional communities, is you know, targeting improvement.

And so I'll just take it a little bit further. And I think there is probably a lot of opposition to this.

But, when we're thinking about within hospitals, I'll just target hospitals because that's what the paper was focused on. And that's the evidence that I'm bringing up right now.

If we're talking about within hospital disparities, then if we are focusing on improvement, then we should focus on improvement of the measures versus kind of the traditional definition of disparities. Which is showing a closing of the gap.

Because even within measurement, we probably can't show a closing of the gap because we don't have enough diversity in the patient

populations that we're serving. So the context and the framework of how we think about disparities, you know, this focus on closing the gap is really important.

But in certain circumstances, improving outcomes maybe the more important metric. And then over time hopefully, we'll see a closing of the gap.

So, I think it's a complicated construct. But it's one I just want to put on the table.

CO-CHAIR CHIN: That's a great comment Romana. And that's a great article that I cite often, of yours.

This is a question for Cara and Helen. So one issue is that it's just a fast time course. It's a one year that CMS funding, and a lot to do in the year.

And I guess the danger is it's so fast that we want this to be evidence based and all, in some ways this maybe like this year's work, maybe just one stepping stone onto ongoing

things.

But, from your perspective Cara and Helen at NQF, in terms of our final product for this one year project of, I guess, the degree of -- on one hand if you had like, well most of the time you'd have the gold standard report with oodles of evidence-based recommendations you feel very confidently about.

Versus if you on the other hand if you don't have a lot of time, understand you start raising issues that need to be explored versus something in between where there were some interim recommendations in areas for like ongoing exploration.

Can you use a little more guidance on like if you're thinking like our end goal, which is going to be pretty soon, like in September, at what level do you envision if this report and this work is done well, you think is the ideal for the report due in September?

DR. JAMES: So, sorry, sort of the flippant answer came into my mind. But, I want

an extremely detailed report with everything perfectly weighed out and documented with two hundred citations.

(Laughter.)

DR. JAMES: No. I think, and I know I'm supposed to talk later. And I'd actually prefer to cede my time to talk about the equity plan.

To actually focus on some of the things that have come up. Because I think that in the conversation, you guys have touched on a lot of the pieces that need to be wrestled with.

So, I think, you know, what would be realistic, I would like a quality sort of directional report. And to the extent that you're able to indicate clear-cut pieces, we've spent now a couple of hours just throwing out a whole bunch of stuff that some of it needs to, I think, connect some of those dots.

So some of the pieces that have come up, I think, you know, Ignatius's comment and Helen's comment about what we don't know, I mean,

was striking in that second report. That decades later there's a lot we just don't know about how do you actually reduce disparities?

And that goes back to ultimately what the charge of what we were trying to do is, what do we know about how we reduce disparities? And how do we sort of get at those measurement pieces while we're ultimately looking at reducing the gap? The closing that gap.

How do we know if you're actually -- what does it take to reduce those disparities? Because I think, you know, from a population health standpoint, you know, Helen did the first AHRQ disparities report a little while ago when she was 20.

And that report and every report since then has shown that we're improving health outcomes and quality of care. We still have a long way to go from our systems standpoint. We're improving that.

But the disparities really are not changing. So, doing a population health approach

of a rising tide lifts all boats, does not mean we're actually going to achieve health equity.

So, we're trying to get at what is that piece that we're looking at? Because ultimately, I am looking at there's nothing in MIPS.

We don't have anything in a lot of our other pieces. So how do we put that in? Because people do what you pay them to do.

So as we look at the drivers of disparities, can we incentivize people to start working on those drivers as we ultimately are trying to get to those gap closings that we're looking at. So what is it that we can sort of look to put into some of our opportunities?

And it is a concept a bit of the what do we have now? But what do we need to get to in five years? And because that's reality.

But I think that, you know, a good in-depth, here's where we have gaps in our knowledge about what it takes to actually reduce disparities, as well as here are some of the

things we do know that can be drivers of them that we could start to look at with an eye towards a little bit of a framework for that.

DR. BURSTIN: I just agree with everything Cara just said. I think the only thing I would add is specifically thinking outside even the context of the CMS funded work here.

Again, the broadest vision here was this roadmap idea. So I think keep the roadmap as broad and as comprehensive as we need to be.

Fully recognizing, you know, that there are tollgates along railways. And one of our first tollgates is to really address head on what Cara had said, so we can try to put some of this into programs not in five years, but hopefully in just the next couple.

But to do that we have to focus on some that might seem a little bit pedestrian at the moment. But I still think they're really important drivers.

CO-CHAIR PONCE: Bob. You've been

waiting patiently.

MEMBER RAUNER: Yes. I'd say kind of going back too not creating new measures. Is that I think we already have plenty of really, really good measures that are already in broad use for several domains.

And they're being used by HRSA EDS. They're being used by MIPs. They're being used by Medicare Shared Savings with focus on the measures.

There's good population, they're already out there. I think what we're really talking about is how each of those measures is combined and stratified and measured.

So, you know, with cardiovascular, it's blood pressure control for example. Cancer, colorectal cancer screen. All -- they're being used by all three programs.

What we want to focus on, I think, is how they're used at the neighborhood level. Because those could be combined and measured at the neighborhood level.

They could be at the clinic level. They could be stratified in community for Hispanic population versus African-Americans.

So, it's a combination of the two measures. Not needing new measures. Because we have plenty of good measures and they're already in broad use.

DR. JAMES: If I could though, just to push back a little bit. There are a lot of measures, and I sit on the impact report committee.

There are a lot of things we actually don't have good measures about. And I think to Romana's point, the other question that we need to know is, are those measures actually going to disparities?

Who knows. And that's -- I mean, that's a question. But I do think it's -- it is going to be combination of stratification and looking at the measures that exist.

But I think there's also measurement gaps in what we have available.

CO-CHAIR PONCE: Cara, are you going to be talking more about the health equity index later? No. Okay.

DR. JAMES: So this is work that we're trying to tie all of the stings together in sort of the opportunity. So, Susannah and her team are working a little on where we can do some more stratification in our existing quality measures efforts that we have.

We have also sort of looking at some of the ASPE work, this work, and then what we're looking to do is to get to a here and now. Is there a strong end that we can start to pull together to look at a potential health equity index.

But it literally just in the formative pieces right now. So, there's not much to share.

MEMBER SCHOLLE: And this is Sarah. I'll just jump in that we're -- we are looking for models for how different organizations are, or communities are thinking about health equity.

And trying to put together some

thought models as well as some examples from the -- from existing work. But, yes. We just started on that.

CO-CHAIR CHIN: Anyone else on the phone want to comment? So David or others on the phone? So I know it's hard to sort of jump in when you're on the phone.

MEMBER NERENZ: Yes. I appreciate that. Dave here. And yes, I don't want to interrupt.

But, I just had a couple of thoughts. And may tie in a little bit to comments both Susannah and Romana had made. And probably others as well.

I'll sort of start with Susannah's comment about, you know, what happens if we come up with thousands of new measures. I think the friendly amendment I'd make to that is that they wouldn't have to be all then loaded onto hospitals.

I think one of the contributions we can make, although it's going to be difficult, is

to try to be clearer then we have been about where perhaps the best or primary locus of responsibility for any one measure should reside.

And I understand we have concepts of shared accountability. And maybe it's a little hard to load it on one place.

But, as we go along through the discussion, given the breath of the factors that we're talking about, I think one of the things that we could do that would be very useful to people is to say, here are the measures related to the broad concept of health equity that most clearly relate to what hospitals do. Boom, boom, boom, boom.

And then CMS can, in future actions, embed those in hospital public reporting and P for P programs. We can say now on the other side, here are measures that most directly reflect what either individual or group of clinicians so, physicians. Boom, boom, boom, boom.

These now become part of MIPS. Or

they become part of some future physician-based program. Same thing for post-acute care.

And then if the scope of this is beyond the kind of license provider entities that NQF typically deals with, then we say well, here are things that really play out most naturally at the community level. And here's where that measurement belongs.

Now, what CMS does with that, I'm not quite sure yet. But, maybe there's something.

So, I guess my only addition would be, well let's think as carefully as we can as we go through this, where in the various levels of organization the actions and lever points are. So that measurement can be linked most clearly to those points.

CO-CHAIR PONCE: Great. Thanks Dave. Ron, are you still on? Do you have any comments?

MEMBER COPELAND: Yes. Just a few. I would echo what Dave just said. I think customization of the totality of these metrics and so forth, both for health and for healthcare

disparities, is going to make sense.

Particularly if we are viewing the primary customer of this report being CMS. If that's the primary customer. And then what information do they need to drive hospitals or individual providers or communities, et cetera.

And the other point I would just make is that a comment was made earlier about the focus -- should the focus be on quality improvement alone because of varying levels of diverse populations people are caring for, versus the traditional orientation of disparities of gaps between different referenced communities.

And I can just say from our experience at Kaiser Permanente over the last 10 to 15 years in this space, when we look at our work through the lens of quality improvement, we do see all boats rising with solid implementation of quality improvement efforts across the enterprise. And also minimizing inappropriate variation.

But, even though all boats are rising, that alone has not been sufficient to close gaps.

The closing gaps component comes more around customizing and understand the unique barriers that an individual family or communities or geographic zip codes are experiencing.

Many of which are in the non-clinical realm. And then what do we have to do in that space to begin to change the playing field and the opportunity?

It's identifying all those inequities. Including as the IHI has identified in their model, a structural racism. Which I don't think this group has brought or talked about at all, as one of those nuanced barriers that's part of the mix.

So, I think we just have to be clear from a scope management and not try to measure everything there is to measure and impose standards on everything that the standards can be imposed on.

There's what is our unique focus and purpose for this group addressing CMS or whoever the end customers are. And the levers they have

at their disposal.

And then Dave's point about a freestanding hospital taking these issues on is different than a large integrated system that has a large population to manage. And has more levers at its disposals.

So if we customize those things by where you are on the delivery or plan scale, it will help each of those individual entities decide which ones make the most sense for them to document moving forward.

But I think it's a both. And I think it's increasingly trying to understand the drivers of these disparities gaps. And the different ways they show up.

And that's a set of measures and interventions and so on. And then there is the quality improvement. Which is overlaid on that. Which is across the board. And how we integrate those two.

So, those are just the reflections I have based on hearing the entire conversation

this morning.

CO-CHAIR PONCE: Thanks Ron. So I just want to check with Erin. How we're doing on --

MS. O'ROURKE: Absolutely.

CO-CHAIR PONCE: So while we're doing -- we're doing very well in the discussion.

MS. O'ROURKE: Yes.

CO-CHAIR PONCE: We're doing a very great discussion.

MS. O'ROURKE: The conversation's been, I think, exactly what we were hoping for. Perhaps just to get us back on time and to make sure we don't lose the opportunity for the afternoon's brainstorming, we could have the presentations abbreviated.

Then break for a working lunch. If people could grab their lunch and then I can present the straw person that will -- we put together as a starting point for the breakout sessions while you're eating.

To just get back on schedule. And

that way we don't lose our afternoon work. So, Karen and Elisa, if you wouldn't mind coming to the table.

And Cara already ceded her time. So, if perhaps others could keep it to maybe five or so minutes. Feel free to skip your slides. And we can condense this into 30 minutes or so. And then take lunch.

CO-CHAIR PONCE: Okay. We are very appreciative of the conversation this morning. I think it was -- we were able to air out some of what we've been thinking through this process. We're able to understand the differences.

Romana, I will have a conversation about your closing the gap comment. I'm sure you'll get some conversation during lunch or during dinner this evening.

It does make me think about, because I do both global and immigrant health, global and domestic health. And I think one way is, you know, we teach students to think globally but act locally.

So, it's sort of that thinking of as Helen appealed to us. It's, you know, thinking globally and open about the larger domains. But then to really think about more precision in terms of the measurement.

So, that's -- Elisa?

MS. MUNTHALI: Thank you very much. My name is Elisa Munthali. I'm Vice President of Quality Measurement at NQF. And had the pleasure of working very closely on our population health work.

And so I'm going to try and condense this topic to five minutes. So, if you can advance the slide for me.

And this work was a three-year project. It started in 2013 and ended last year in September. And the output of which was a community action guide for communities that are working towards population health improvement.

But I did also want to recognize the amazing work of our multi-stakeholder committee. If you can go to the next slide.

This was led by Kaye Bender to the accreditation, the Board of Accreditation for Public Health. And Steve Teutsch who is Fielding at UCLA. If you could go to the next slide.

We work very closely with ten field testing groups. They represent ten communities within the United States. Very different for NQF.

We worked with folks that were actually implementing population health improvement programs. They came as far as Tulsa, Oklahoma, Oberlin, Ohio, and Trenton, New Jersey.

And we also had a group that was out of the University of Chicago that worked very closely with Marshall. So, they were phenomenal. We couldn't have done this work without them. If you can go to the next slide.

So, essentially through this guide, we wanted to put together, you know, guidance. A practical guide for our folks that are working towards population health improvement.

It was an evidence-based approach in

which we looked at common themes and definitions. And identified ten key elements for communities that are working across sectors.

So, not just looking at folks that are in the private sector working towards population health, but truly taking on that mantel of population health. Folks working across local, state, national, public, private sector to improve the health of those that live and work in their communities. If you can go to the next slide.

And the next one. I'll explain the National Quality Strategy to you. And how it fits in. So, this work and all our work on population health at NQF is guided by the NQS.

And essentially we want to prioritize those communities that are working across public and private to improve the lives of the people that live and work in their communities.

But it also is guided by foundational work that was done by our Co-Chair of the Committee, Steve Teutsch. At the time he was

working with the L.A. County Department of Public Health.

And we commissioned Steve to help us think about how we should be assessing and measuring population health. And Steve encouraged NQF to really move away from the medicalized model of population health.

And to focus on all of the other determinants of health that make us who we are. And our reflection of our health.

So, the work that we do on measure endorsement is guided by this. And the work that we do through selection of measures that have a population health focus for the measures applications' partnership is also guided by this.

All of our work, we look at the challenges around population health. Including challenges about data. Also challenges with sampling.

And if we can go to the next slide please. And we put this slide together, it's essentially our map as we're looking at the

project. It was a three-year project.

Our end goal was coming up with this community action guide that would be useful. That's in plain language. It's intentionally so that anybody who's working on population health improvement can pick it up and use it as a guide.

But there are a couple of key take-aways from this schematic. The first thing we wanted to stress that it was evidence based.

All of the tools and resources and the conceptual framework that are included in the guide were based on an extensive environmental scan of over seven hundred guides -- tools and resources for improving population health.

But it also included multi-stakeholder input, not just from our committee, but also from our field testing group. We selected these ten field testing groups from applicants. About 43 applicants. They came from around the country.

So, we're looking for diversity in terms of geography. But we also wanted groups that were at different stages in their population

health journey. And we also wanted groups that were working on different aspects of population health.

So in the second year, after we had the first iteration of the guide, we asked them to field test it. And we went out to where they are doing their population health work.

We went out to Tulsa. We went out to Michigan. We went out to Trenton, New Jersey to find out how they're working across different sectors to improve the health of those that work in their communities.

And that in the end, in the third year, we had the final version of the community action guide. So next slide.

Okay. So, we learned quite a bit. If you can go to the next slide. You know, it was amazing how open the groups were with us.

Some of them are in very tense political environments. Quite frankly some of the foci or topics that they're dealing with, not necessarily agreed upon by, you know, those in

their State and local government.

But they are carrying on. They were very open with us. We were able to forge like really very strong relationships with them.

Of course this guide wouldn't be where it is without that rich information we got from them. We were also able to understand a little deeper what kinds of data and the data sources they were using for their community health assessments.

We also wanted to understand the drivers that they were used -- or that influenced their ability or inability to align or coordinate their work. And also whether or not they were looking at national measurement programs for alignment or support in moving their population health work. Next slide.

Of course it was beneficial for us to engage with these groups. Because there was a lot of bidirectional learning. We learned so much from them.

In fact there were times we felt

guilty about the information they were able to share with us. But, in some respects they were saying that it was very important for them to engage with NQF, a group at a national level that was setting national standards.

Many of these groups are really challenged by data burden, the collection and reporting for having so many different collection and reporting programs that they're engaged with. But they also received quite a bit of technical assistance from us.

One of the big challenges that we hear about, and we were surprised the extent to which we heard about it on the field, were data source issues. There were a lot of concerns about the consistency and the frequency of data that they're getting, the timeliness of data.

Their inability to get the right data that speaks to the determinant of health that are outside the clinical care delivery system. And the ability to integrate that data.

And for us, one of the things that was

a benefit was the ability to connect that work with work with other projects like this project. Next slide please.

In addition to learning about the difficulties with data generally, we learned what we hear about quite often, is that we just don't have the right measures. We have a lot of measures.

But the measures that really speak to the determinants of health that are outside the clinical care delivery system are scarce. Very scarce for our ten communities that we worked with.

The data issues are -- were -- well, the data issues permeated everything we talked about. The ability to go down to a granular level was a challenge for many.

But some were also concerned about going down too low. Especially if they were in smaller communities. They were scared about the privacy and security issues as well.

They also were concerned about the

timeliness of data, as I mentioned before. And the inability to integrate the data that they were getting from different sources.

They also were concerned because many of them did not have the resources to bring onboard staff that understood how to deal with the data, how to analyze the data. So the next slide.

And we thought it might be interesting to show you some of the data sources that they used. Some of these they were able to use on a frequent basis. Others, not so much because of the timeliness of data that I mentioned before.

And if you can go to the next slide. The great thing about working with this group is that we see many opportunities for future engagement. Whether it is with these ten groups or other communities.

We were able to learn about data most especially. But also how they were making choices in terms of measurement. But there's a lot more to learn there.

It was interesting to see how they were integrating data from different sources. Not just from the clinical care delivery system, but from those unusual sources like police departments and schools.

But they realized too that it was difficult to scale that up. They were able to do it in very limited areas.

And so we see an opportunity there to work with these communities. They also were able to help us to understand how they were prioritizing measures based on local, State and national initiatives.

And you know, we realize that we're not where we need to be with population health measurement or improvement. We need some more robust measures going forward in this field.

And so that is, I think the last slide. And Erin, I'm not sure how you want to do this. Do you want to take questions now? Or --

MS. O'ROURKE: Marshall, Ninez, do you want to take questions? Or have everyone present

and then do global questions?

CO-CHAIR CHIN: Why don't we do -- I mean, how many more presenters do we have?

MS. O'ROURKE: We have, I think, two other -- three others. So, maybe just for the sake of time, --

CO-CHAIR PONCE: Yes.

MS. O'ROURKE: We could go through everything and then --

CO-CHAIR PONCE: Yes. Let's -- yes, let's do --

MS. O'ROURKE: Take them all at the end.

CO-CHAIR PONCE: I'm not sensing an urgency for the questions.

MS. JOHNSON: So good morning. My name is Karen Johnson. I'm one of the Senior Directors here at NQF.

And they asked me to tell you about our rural health project. So I want to say to Bob, who was on my committee for rural health. So let's go to the next slide, please.

And I'm going to talk really fast. I've got five minutes. So let's see if I can do this.

The fancy words at the top was our contractual title for our project. But really we just called it the rural health project.

The context really is the ACA and pay for performance. The idea of it's coming, and we need to be ready. And really, the realization that many rural health providers really aren't ready for that kind of measurement.

As I'm sure all of you know, there are many definitions of rural. And depending on your definition, as many as 28 percent or even as few as 10 percent of Americans can be said to reside in rural areas.

So, we didn't worry too much about definitions in this project. Instead we talked about provider types.

So we were asked specifically to consider critical access hospitals, rural health clinics and community health centers. But to do

the work we also had to think about small rural hospitals and not just CAHs, other small rural clinics and practices, and the clinicians who provided care in any of those settings.

We did for sake of scoping, we pretty much limited our discussion to primary care. And we didn't talk about things other than preferably things like home health or nursing facilities, hospice, that sort of things. But, of course, all of those things did come up in our conversations. Let's go to the next slide.

So really the objective of the project was to identify challenges in healthcare performance with measurement for rural health providers. And then make recommendations for mitigating those challenges, and particularly in the context of CMS, P for P programs.

So, the first piece was to identify key issues for measurement. And I'm not going to go into detail of these. They're kind of self-evident, I believe.

One of course is geographic isolation.

So that brings in questions of access, transportation, capabilities in terms of IT support, capabilities in terms of things like quality improvement. Not, you know, rural providers don't necessarily have a contingent to folks who can help them do QI.

We also have the small practice size. Again, limited resources, limited time to be able to be able to work on QI, much less do things like measurements, et cetera.

That also brought up the geographic isolation, brought up the other kind of subgroup for rural areas, the frontier areas. So not all rural areas are frontier of course. But those are the most sparsely populated areas in our country.

And depending again on definition, could include as many as ten million Americans. And the next slide, please.

Heterogeneity is another big key issue for measurement for rural providers. And really, those four sub-bullets there really get into, I

think, the crux of the problem.

In terms of the social disadvantage, depending on who you look at, and really depending on which area you're talking about, really there's no real rural area. Many are not socially disadvantaged. Many are.

So, you have income disparities, education, unemployment, poverty. You have probably more older people in rural areas then otherwise. Although that's maybe not so much in oldest though.

You have things -- I have culture here. But really that's a loaded word. I don't really know what that means. Because every area is going to have different cultures that you have to think about. And how that might affect a measurement.

It definitely comes into play when you think about health behaviors. And I've heard you guys talk about those things already this morning.

And then of course there's shortage

areas. Things -- fewer health providers in general, IT, transportation, are a few of those.

And all of these things have applicability in terms of measurement and how we measure. Now, I think one of the interesting things about these key issues for measurement that we recognized as part of this work is, these aren't limited to rural areas.

And I didn't mean to forget the low patient volume. That of course can be a problem, but isn't a problem always. Especially when you think about primary care.

So these things aren't limited to rural areas. We can have all of these things going on in urban and suburban areas as well.

And as I was listening to your conversation this morning, I think these key issues for measurement, they may not give you a domain or subdomain for your framework, but I think they are probably things that you will really have to think about in terms of how you might want to measure for disparities.

Because all of these things are going to come into play any time you try to apply any of the measures for the domains that you come up with. And I think the heterogeneity is really key here. Next slide, please.

So we didn't come with a measure framework. Instead we had recommendations.

So the overarching recommendation from the committee was to make participation in CMS programs mandatory for all rural providers. But allow a phased approach and address low volume explicitly.

That could be quite surprising to people. But really the rural providers who participated, who commented on our report, et cetera, really do not want to be left behind.

They realize the advantages of measurement to help improve care. And also, you know, given that there are incentives, sometimes in terms of financial incentives that they're missing out on if they're not included in measures, they really think that they want to be

included in these things.

However, things have to be put in place before that can really happen. So we spent a lot of time talking about development of what we called rural relevant measures.

And some of those I've heard you guys talk about today, access of course being one. Hand offs and transitions being another, drug and alcohol treatment, and the population health. And then finally another one that came up quite a bit was end of life care and advanced directives. That sort of thing.

So, a lot of room for rural relevancy there. And a lot of room for development. The rural relevancy also came up in terms of things need to be broadly applicable.

So if you come up with measures that are really don't apply to certain groups, or you know, don't apply broadly, then a lot of folks can't use them. So, it's something to keep in mind.

Another big issue was risk adjustment.

That came up actually under development of rural relevant measures. Because as I've heard you say already, there are a lot of measures out there already. Are they being adjusted appropriately to take care of the rural groups?

And I think that's still an open question. So, we came up with things like distance and time of travel. And availability of healthcare resources, seasonality, things like that.

Now those may not be the things that you think about in terms of risk adjustment, and maybe there are methodological ways to do it or not do it. You know, we didn't say those had to be.

But I think the question is open. You know, should you be controlling or somehow or another adjusting for healthcare shortages? Maybe you should. I don't know. But it's something we were hoping that you guys could help illuminate for us.

The other three sets of

recommendations, I think I'm not going to concentrate so much on. Because I don't think they had as much applicability to what you guys are talking about today.

The exception is the selection of measures. Our committee actually came up with a set of principles for how you select measures. And I think the thing that really applies for your discussion and consideration today is to be cognizant of unintended consequences for rural residents particularly. And of course for anybody else.

But you know, there's always unintended consequences. So, just try to keep that in mind as you think about your framework. Thank you.

CO-CHAIR PONCE: Thanks Karen. Drew?

DR. ANDERSON: Sure. So I'm going to also move through this pretty quickly. But I think this ties in really well with the conversations you all have been having this morning about connecting to community services

and social services.

So this was a two-year project looking at addressing measure gaps in home and community-based services. It really focused on non-medical services.

But, the committee also looked at services that are connecting health care services with community services. So that care coordination aspect.

So just generally, what are home and community-based services? The services really span the whole gambit of community care or community programs.

It includes transportation, employment, all different -- every -- basically everything that allows people to live independently in their communities. And it's really important for people who are -- who have disabilities and are older.

So the main purpose of the project was to provide multi-stakeholder guidance on the highest priorities for measurements. So this was

also a framework project. So it's a good example to look to of the type of work, or the type of project that's similar to this disparities project.

It really supported the aims of the Affordable Care Act, the National Quality and Strategy and the HHS Community Living Council. And it was very broad and inclusive. And considered like I said, with things within the healthcare system, but mostly outside of the healthcare system or services.

This was the final conceptual framework that the committee put together. And I put this in here because it's an example of where -- it's an example of a framework that came out of a measure gaps project.

But it also includes the domains of measurement that the committee thought were most important. So in the center of the diagram it shows the 11 prioritized domains. Along with these domains there are 40 subdomains that were actually also identified and defined.

For example, one of them was community inclusion. And a subdomain under there was like social connectedness. And I think that's another important subdomain that could carry over into this work.

But I did want to also highlight, one of the domains that the committee did identify was equity. And that there was a real -- they recognized significant disparities in access to home and community-based services.

And so they defined this as the level to which HCBS are equitably available to all individuals who need long term services and supports. And they put in these four subdomains here.

So, equitable access of course, but also transparency and consistency. Which had more to do with equitable administration of laws and regulations that are applicable to these populations.

They also availability, which was the extent to which a service or support is equitably

available. And one that's specifically highlighted reducing gaps in disparities. So closing the gap.

The committee also recognized that some of the recommendations that they have are -- can be doable in the short term. But, and they are more aspirational ones that will take -- it will take a while for the system to get there because the measurement in home and community-based services is sort of still in it's infancy.

So they highlighted a couple here and I'll just kind of go through. One of the short term recommendations was really identifying these equity measures currently use -- in use in programs.

An intermediate one was looking at how can we better use administrative data to construct measures to help assess whether or not disparities still exist? Or whether or not stakeholders are reducing them.

And then a longer term vision of using technological innovations to develop systems to

monitor various indicators of health and services theories. So, I think one of the committee members cited an example of using point of service feedback as Uber or Lyft uses.

So getting more real time feedback from people who are using these services. And that was more of an experience of care measure.

The committee also talked about some sources of measures. So this is also something you can consider.

They discussed measures using data from waiver programs. So the 1915 waivers are an example of some of the measures here.

The percent of consumers with paid employment. The percent of consumers with primary case manager that asked about their preferences.

NQF recently endorsed 19 performance measures related to the new CAHPS Home and Community-Based Services Survey. So that -- those measures specifically focus on -- it's actually broader. So, any type of HCBS that a

consumer is receiving, you could potentially fill out this survey and generate measures from.

So what does this mean for the disparities committee? So, generally a lot of the committee's recommendations, and we can actually send this report around for you all to look through.

But, the committee can really leverage a lot of the recommendations of the HCBS committee to incorporate community-based services in their framework, or in your framework. And really speak more to the importance of linking healthcare services with community services to provide more holistic care.

And then it also is to kind of, which you've already started to talk about, is to expand the scope of traditional measurement outside of healthcare settings into more community settings. And how to connect those two more seamlessly.

Yes. So with that I'll turn it over to Karen.

DR. JAMES: So, I'm going to do this really quickly. If you want to go forward, there are lots of offices in minority health. Okay.

So, we -- and I just put that as point because -- so you know who's doing the work. Which is the CMS Office of Minority Health.

We have our partners across the department that we work with. And we have the VA Office of Heath Equity with Dr. Uchenna who's sitting in the back back there.

This is sort of a framework that guides a little bit of our work of how we think about how we're trying to approach health equity. Where we are increasing understanding and awareness of disparities, developing and disseminating solutions, and implementing sustainable actions.

So, I'm sure as you think about the whole task that we charged you guys with, it fits into several of these buckets of what we're trying to do.

So, if you go to the next slide. One

of the things that we developed over the course of the year is a CMS equity plan for improving quality in Medicare.

And talking to stakeholders across the country. Sort of focusing on, what is that they think we should be doing to address health equity?

So these are the six buckets that we have in our priority areas that we are looking at. As you can see number one is data, data, data, data. And we have a lot of activities that are underway with regards to that.

Second is evaluating disparities impacts and integrating equities solutions into CMS programs. The third is developing and disseminating promising approaches to reduce health disparities.

Fourth is increasing the availability of the healthcare workforce to meet the needs of vulnerable populations. We think about community health workers, integrated care teams, the provision of culture linguistically appropriate

services.

And the fifth one is improving communication and language access needs for individuals not just with limited English proficiency, but also for persons with disabilities. And this also goes back to data as sort of understanding our needs of our beneficiaries and their preferences with regards to communication.

And the sixth one is increasing physical accessibility of healthcare facilities. So, we've launched this in September 2015. So, we're a year and a half in.

And I'm just going to highlight just very quickly a couple of things that we've done under the plan. So, in the next slide you'll see we have a data tool, which is our mapping Medicare disparities tool.

It currently includes fee for service data. It allows you to drill down to the county level. It also has variation in terms of some of those counties that are rural or urban, to

indicate where we're looking at.

It allows you to compare across 18 chronic conditions. As well as looking at costs, morbidity, mortality, and other factors, and comparing to racial and ethnic populations. We've added the territories and are adding other data from the American Community Survey.

On the next slide we have a tool that we've developed with the Massachusetts Disparities Solutions Center, MGH, in reducing readmissions. And are working to update that.

On our next slide we have the accountable health communities model. Where if you go to the next slide, we worked with our colleagues to embed health equity resource statements into the application that was part of the scoring. It was a small part. But it's a start.

In which each of the applicants as you can see, were asked to look at a statement of need, develop an action plan, and follow up on what they plan to do to ensure that as the models

are being implemented, disparities do not worsen. And if they do, how they plan to address that.

We also worked with our colleagues in getting -- achieving health equity as part of the MIPS categorizations for clinical practice improvement activities. And are working on some other things.

And our next slide. One of the things that we recently launched is a health equity TA. To help organizations who are trying to figure out how to address disparities.

And so this is in the Plan-Do-Study-Act model. In which they are trying to address disparities. So we have personalized technical assistance.

And that's available now. That we piloted that with some of our healthcare innovation awardees and are working with others.

And next slide. Just in terms of what we're doing. So continuing to implement. We're expanding our horizons and looking at other areas of work.

So, we're working to develop a portfolio within sort of the diabetes to ESRD spectrum and how we can reduce disparities there. Continuing to strengthen our partnerships in implementing this and implementing our evaluation model.

And that is, I think, it. Yes. Four minutes.

CO-CHAIR PONCE: That was nice. Okay. Ignatius.

MR. BAU: Last but not least. So, I'm going to describe two projects that I'm working on. One is funded by the HHS Office of Minority Health.

Many of you are familiar with the CLAS Standards, the culturally and linguistically appropriate standards that OMH promulgated. And then enhanced or updated in 2013.

So this project is being done through PSA, which is a federal contractor. And the National Council for Asian and Pacific Islander Physicians. Although it's not limited to Asians

and Pacific Islanders. Next.

So, our goal is also aligned with the time line for this disparities project. That by the end of September of this year that we're going to try to identify some additional resources to engage physicians particularly on their awareness, and ultimately utilization of the CLAS Standards. Next.

So we have four deliverables. The first is to really understand how the standards have currently been used.

And our theory moving forward is that rather than simply educating physicians and providers about the CLAS Standards, to try to map it onto quality improvement and practice improvement and transformation. And really talk about it with the language of QI in practice improvement.

And so we're going to also develop a frame work or a logic model on how CLAS can really be mapped into quality improvement activities. Next.

And then develop based on that framework or logic model, a set of strategies for how that can continue to be advanced. And then drill down and focus on identifying the resources that would help physicians and other providers increase both their awareness and utilization of the Standards. Next.

So we have a technical advisor group. Next. You will be familiar with many of these names, including Marshall Chin and Helen Burstin, and Sarah Hudson Scholle. Next.

And two resources if you aren't familiar with them, the first one on the left is a compendium of State level activities. And so when there's discussion here about State level measures, it may be a good way, even though they're not measures, it gives you an example of what activities States have done.

And then the second is commissioned by Dr. James' office at CMS OMH. That was completed by NCQA, which was a practical by really pulling together a lot of resources for the CLAS

Standards that we will be building on and using a lot. Next.

And then the second project is from the National Academies of Sciences, Engineering and Medicine. Their roundtable on health literacy. Next.

There was a workshop in October 2015 where they looked at the integration of the concept of health literacy with culture competency and language access services. Next.

And building off of that workshop, that roundtable is now commissioning a paper. Which is also going to be done by NCQA that will identify these measures in these three large domains of measurement.

And think about how there might be an integrated approach to actually measuring all three of these domains or areas. Next. So that paper will be presented in May at a workshop here in Washington, D.C. And then there's going to be some discussion. And then next.

Finally, after that discussion, a

second paper that would be due in October 2017 proposing ways of integrating those three domains into measurements. So again, whatever the fact that Sarah's leading that work for NCQA, will also, I think, help inform the work of this committee.

And again, the time lines are pretty much aligned. Thanks.

CO-CHAIR PONCE: Great. Thank you. So, maybe we could pause. If there's any burning questions?

MS. O'ROURKE: Maybe --

CO-CHAIR PONCE: Or if Sarah -- yes. If Sarah --

MS. MURPHY: Sarah emailed in just a few moments ago and had to step away. But for rural health, she asks, are there any consideration of grouping across a region?

MS. JOHNSON: So short answer was yes. One reason to think about regional grouping is to address the low volume problem.

So, that's obviously, you know, one of

the first things you'd think about. However, when it comes to actually holding providers accountable, the folks on our committee were not enamored of a regional approach actually when you're comparing providers.

Why should, you know, just because I'm small, why should I be compared to, you know, the next small town over, or whatever. So, there was actually some discussion about being able to have voluntary groupings so that you could compare providers.

So, it was kind of an interesting way to think about it. So again, just back to the thing, a regional approach that's kind of assuming, you know, that all rural groups are the same if they're in a particular region.

And we said, that's actually not the case. So, think about it maybe a little differently. And I hope, Bob, I don't know if you have -- you're nodding. So hopefully that rings a bell to you.

MEMBER RAUNER: Yes. The answer --

the short answer is yes. We -- a lot of rural folks are interested. But they need to align it correctly.

So for example, the reason I got distracted is I just got our maps from our State on mammography screening for example. The problem is that they're stratified at the county level doesn't work. Because some of our counties only have like five hundred people in them. So that's not big enough for that.

He's doing it on public health district. But public health districts were designed around political boundaries, not service area boundaries.

So, a lot of rural areas in FQHC or even a small clinic may have satellite clinics. So the three counties for this clinic would be different then the three counties for that health department district.

And so how you slice and dice it is the key. The answer is yes. We should align. But based on the right reasons, not the wrong

reasons.

CO-CHAIR PONCE: Thank you. Any questions from those on the phone? David and Ron?

MS. MURPHY: There's actually one more from Sarah, so.

CO-CHAIR PONCE: Oh, okay.

MS. MURPHY: This one's for population health. Are the communities relying exclusively on data available for existing sources where there's survey claims administrative?

Any progress getting data from education systems for kids? Any focus on sharing for SMI and substance use?

MS. MUNTHALI: Yes. So those are great questions. They are not relying totally on that. But however, the preponderance of data is from claims and the typical data sources.

I can tell you they gave us several examples on how they are trying to integrate data from the unusual sources. There was an example in Trenton, New Jersey where they're working with

a local store.

Trenton is a food desert. And they're working on a local store that started selling fruit cups for -- and they're trying to get youth to start eating healthier foods.

That actually is their most sold item in the store. So they were able to get sales records, link that to some health information that they had.

But those are small examples. They're concerned about scalability, how can you apply it to different areas, not just across the country, but within New Jersey. So, that's been a challenge for them.

Is how to -- how do you integrate this data with those traditional data sources. Because they don't often have number one, the skilled staff to be able to do that.

To be able to collect the data. To be able to analyze the data. But they are trying on a small scale to do that.

CO-CHAIR PONCE: Does Sarah have a

question for Drew? So, Drew you offered to share the report. I'm assuming we can also get the reports for the population health and for the rural health for the committee.

DR. ANDERSON: Sure.

CO-CHAIR PONCE: All right. Any comments? Oh, Lisa? Sorry.

MEMBER IEZZONI: First of all, this was fabulous. I really want to congratulate the people who did this work. It's just so exciting to see.

Across all the reports there was just a theme that I think we are going to have to confront at some point. And that is, not for risk adjustment necessarily, but maybe how we capture the differences in preferences for how they live and for the care that they receive.

And I think this is especially important for long term services and supports. Because there are subgroups of people who just really want to live very differently than other subgroups of people do.

And so I just leave that hanging out there, as how and whether and, you know, to what extent especially as we begin comparing certain population groups outcomes, we do consider the preferences of the people that we're talking about.

CO-CHAIR PONCE: Thank you. Any comments? Emilio?

MEMBER CARRILLO: Yes. I have a question for Elisa. And these data challenges are very notable. Which is a real problem in going forward.

I'm wondering, were some of these groups integrated in sort of a collective impact structure where there would be a backbone organization that has data capability and IT capability. Was that -- did you see that in there?

MS. MUNTHALI: Yes. That came up quite a bit. You know, one of the ten elements we talk about is the ability for collaboratives to work together.

We were thinking it would be more of a linear relationship. And quite frankly, there's some groups that have the infrastructure to do that more than others.

There's some that have the resources in terms of the money or the human resources to be able to do that. They're in a position where folks are looking to them to take the responsibility.

So in areas in which they had those larger groups, the institutions that have been there in a while, they were able to do that sort of thing. And everyone relied on them.

But they also talked about the burden of carrying that weight. I'm talking about partnerships not always being equal. And that people assuming that because you may have the established resources you will be the one to kind of pick up the initiative.

So, there was that tension there as well.

CO-CHAIR PONCE: Okay. Let's go to

public comment. Let's open that up.

OPERATOR: Okay. At this time if you would like to make a comment, please press star then the number one.

And there are no public comments from the phone line.

CO-CHAIR PONCE: Thank you. And I invite everyone for lunch now as we continue the discussion with the prioritized areas of measurement.

MS. O'ROURKE: Yes. So if everyone could just grab lunch and maybe come back to the table in 10, 15 minutes, we'll go through our strawman for the afternoon exercises while you eat.

(Whereupon, the above-entitled matter went off the record at 12:17 p.m. and resumed at 12:44 p.m.)

MS. O'ROURKE: All right. Thanks everyone. And thank you for being willing to have your lunch break shortened a bit.

So I just wanted to briefly go over

the strawman that the staff has put together in consultation with Marshall and Ninez. This is really just intended as a starting point for your conversation this afternoon.

We're not attached to it in any way. Please feel free to change it, throw it out. It's again, just a starting point for conversation.

So, don't be afraid to think completely outside the box here. Next slide.

So as we were talking a bit this morning, we started with the socio-ecological model as our framework to organize how we could think about every level at which we need to start to address disparities. And where interventions could be employed to start to address them and to try to close these gaps and improve outcomes. Next slide.

So at each level we put together some strawman domains for your consideration. Again, feel free to completely disregard these. But, based on what we saw throughout the lit review,

here were some that boiled to the top for us and we wanted to put forward.

So at the policy level we found system accountability. That the system has equity as a meaningful goal.

And the system provides support for achieving equity. With some subdomains being financial resources and technical assistance. Next slide.

So going down to the community level. The domains we found were addressing social determinants of health, implementing population health principals and strategies.

With a subdomain being a risk stratified, tailored care, and healthcare organization collaborates with community partners. Next slide.

Down to the organization level. We found a domain around culturally competent organization.

With some subdomains around collecting the data necessary to stratify and start to find

disparities, measuring and reporting stratified performance measures, culturally tailored quality improvement that addresses specific challenges of at risk populations, and effective language services for limited English proficiency patients.

We found a domain around telehealth. This seemed to be promising idea for increasing access as well as enabling services. Next slide.

At the microsystem level, some domains --

MEMBER SEQUIST: Sorry. What does that mean, enabling services?

MS. O'ROURKE: So, this was just not clear. So basically what you -- an organization could do to make services accessible to all. Kind of a catch all for providing culturally competent language proficient care.

Ignatius, I think you were going to jump in here.

CO-CHAIR PONCE: Yes. Ignatius, go ahead.

MR. BAU: So, in the community health center setting, the Association of Community Health -- Asian and Pacific Community Health Organizations have developed a whole measurement and scale of what enabling services are.

Interpretation, transportation, case management, applications for other services. So there's a whole set that have been defined.

CO-CHAIR PONCE: Yes. In some ways enabling services mediate. Or as Emilio -- Emilio's words, amplify some of the connections with clinical services and getting better health outcomes.

MS. O'ROURKE: So then going down to the microsystem level. There was some promising evidence for team-based care.

With a subdomain of case management, the use of community health workers and patient navigators, and involving patients and their families, social networks in care. Next slide.

Thinking about the provider level. Some best practices that could be potential

domains were a culturally competent workforce, and effective shared decision-making.

And particularly really tailoring the shared decision-making so that health education takes into account a person's literacy and numeracy status. Tailoring to be culturally sensitive and appropriate.

Ensuring that written materials can be accessed by all. Or you also have oral processes in place for when a person might not be able to understand the written materials. Next slide.

So then finally thinking down to the patient level. A domain could potentially be around activating and empowering the patient.

And engaging them in effective shared decision-making. So tying back to the provider level. And next slide.

Oh, sorry. Let's go back. So again, these are really just what we found through our pass at the literature. Just a starting point for a committee conversation.

So please, don't feel tied to them at

all. We're going to use these as the basis for the next three sessions. Which will be putting you into small groups.

For those on the phone, we sent along a dial in. So that you could do a virtual group. Members of the public, we'd ask if you're interested, to please come up and join a group.

So I think we can maybe pause for any questions and conversations on the strawman as a group. And then Mauricio could go through the instructions.

DR. BURSTIN: So, Eduardo?

MEMBER SANCHEZ: Thank you so much. I apologize for those on the phone. More of an observation then a question.

The notion of patient seems so focused on a person. And everything else is really about kind of units.

And I just wonder if we might not intentionally or explicitly talk about patient/care giver/family? Because then the language we use and the way we think about it is

very different and really more holistic.

There is so much stuff that we've done inside of patient care that makes it difficult for care givers to actually be involved and be engaged. And I just wonder if we might not want to include that?

MEMBER SEQUIST: So this is great. I wonder, can you go back to the slide that said policy?

So I had a couple of questions as you sort of went through these. They were kind of circulating through my mind. And it was from the conversation from earlier this morning as well.

I think it would be helpful on this slide if we define what the system is. I'm thinking about to the sort of within and between provider issue.

It's hard to hold a hospital accountable for between hospital causes of disparities. Right? Because what does that -- what can that hospital do about that for a, like a conceptual standpoint?

So if the system is the United States Healthcare System, then I get it. Or if the system is CMS and how they're distributing fundings or how we create safety net health systems, then I get it for between provider -- between hospital disparities.

But if the system is your clinic, there are lots of disparities and measures that are about between clinic differences. It becomes hard when you use that word accountability. Which makes people a little bit, you know, nervous when you start to use that word.

I mean, I think we should. But I just think we have to define the word that came before it with the system a little bit better until we understand it.

A couple of other things that sort of came to my mind in looking at this is -- and I like it, it sort of has a decidedly population health slant to it. And quite ambulatory in nature, a lot of this stuff in here.

I just want us not to forget that when

you're in a hospital, and a lot of the original disparities and research was about big things that happened to you in the hospital and how we have disparities in that. You know, not being offered major procedures. Things along that line.

And those have probably less to do with the social risk factors and a lot to do with something that's not in here. And someone on the phone had mentioned this which is, like you don't see the word bias in here at all.

And we're probably afraid a little bit to use the word racism that goes along with bias. But, something in here that gets to that, it's not all about the social risk factors.

And it's not all about the community-based measures. And I'm a big fan of that actually. I think it's super important and a direction we all have to go in.

But it just seems completely missing the aspect of in our hospitals, these controlled environments, the research from the '80s, you

know, that when people really started looking at all this stuff, really started with like big things. Like why are you not getting transplants done? Why is that discussion not happening?

So, that just sort of stuck out to me when you went through that. I don't know if it was intentional or not. But I feel like that has to get kind of woven back into this fabric.

Marshall, taking on, see if I'm going to -- I can pause there. But --

CO-CHAIR CHIN: Well, go ahead Tom.

MEMBER SEQUIST: So, and then I had -- well gosh. It just jumped out of my head.

Well, those are -- those are probably, since I can't remember the last one, it may not have been as important.

CO-CHAIR CHIN: Those are all great comments Tom. So since we have like an organizational level one that would be more like clinic and hospital and what not. And we maybe need to consider maybe they're different measures then for the hospital level, clinic level of

those organizations.

I think the system was meant to be more then the larger thing that you talked about. Like both a U.S. Healthcare System or a State policy or a Federal policy, something like that.

You point about like a bias, I think you're right. That in some ways we have the positive wording on the things. Like the cultural competency things, culturally competent.

But you're right, that we need to get through that.

MEMBER SEQUIST: Well, but the cultural competence is kind of like a bigger umbrella.

CO-CHAIR CHIN: Yes.

MEMBER SEQUIST: And so you could say I want my organization to be culturally competent. And that my senior VPs have all been educated on what equity is. Why it's important and we dedicate resources to it.

It's very different then an individual physician having a conversation with an

individual patient and making a decision about their care that's based on a bias that we all have. I mean, no one -- there's no evil here. Right?

It's everyone has, you know, their heuristics and their biases based on their own experience.

CO-CHAIR CHIN: Yes. We probably just need to think it through and put it on the table. Like Ron had mentioned it in terms of like to have a structural racism. Which may apply to, it could be like the community level or it could be policy level. Yes, both of those probably.

MEMBER SEQUIST: Yes. Sort of all different levels. But I just -- it seemed missing. And I'm sorry, I remember the last thing.

Which is, should we be distinguishing, there are social risk factors that it strikes me that are very different depending on the setting that you're in. So, -- and I sort of think a lot about the analogy between how we do high risk

care management for ACOs let's say.

So you pick out the high risk population, which usually refers to cost. So you have this super-duper high risk patient population.

You apply a bunch of tools to them, which maybe different then the needs that the other 95 percent of the chronic disease population needs. There are people in the equity space who are, you know, there are patients who are homeless, have severe mental illness and substance use disorders, that create equity problems.

And then there's the majority of the population that also has equity problems that just sort of the American-Indian male with diabetes. And doesn't need the same set of measures or resources.

I'm thinking about those enabling resources or resources that that high risk population has. And I feel like we need to kind of think about that distinction between those

populations.

When I think about, you know, the needs that an American-Indian, you know, the work that we do on the Navajo Reservations that are five hundred miles from nowhere. It's very different then the work we do in inner-city Boston around someone who is inside Mass General Hospital. Right? And is struggling with health equity issues.

So, I just feel like that distinction also, it would be great to have that somewhere captured in the model. That there are different levels of social risk that contribute to these sort of issues outside the walls of the hospital or the clinic.

CO-CHAIR CHIN: A terrific point. Sort of great like some points that Bob raised this morning. As well as the rural report that we heard for example. Great points.

And then Eduardo's point, to potentially the patient one. Where maybe it becomes a patient/family/social network. Yes.

MEMBER SANCHEZ: And let me just say, I'm calling out care giver as well. You know, I just think that as -- even as I think about reducing disparities, and I think about patient care, so much of what happens is that the person who -- or persons who maybe most a part of all that happens to get to that better health outcome are not always in the conversation that they need to be a part of.

And that might be something we even build into. How could we build that expectation as an intervention that potentially gets us to where we're trying to get.

And even as I think about the work that has happened at CMS, some conversation about the role of care giver has been part of how they've begun thinking a little bit differently then maybe they did five or ten years ago.

CO-CHAIR CHIN: That's a great point Eduardo. So one more general point before we open it up again.

That it reminded me that -- Tom's

comments reminded me of what Ninez and Erin kept on coming back to like on our planning call. That like sort of like equity needs to be a lens throughout all of this.

And so like when you have these six different levels and these different domains and all. But it's actually, I think, kind of -- it could be easy to actually sort of lose that equity lens.

Or as you're saying Tom, to lose the context specific things for different situations. So somehow we need to sort of figure out how do we build that in throughout.

CO-CHAIR PONCE: Susannah then Bob. And then Lisa.

MEMBER BERNHEIM: So I wanted to raise a consideration of flipping this way of dividing the domains on its side. I feel like it would be more intuitive if we said a domain was addressing the social determinants of health.

And here's what could do at a provider level. Here's what you could do at a system

level. Here's what you do at a policy level.

You know, a domain would be, you know, addressing, you know, providing culturally competent care. Here is the kinds of measures you could use that as policy.

It's hard for me to sort of kind of do each of those within -- anyway. So, a thought, not to be too disruptive about sort of trying to actually have the domains be more about the levers and the -- within each domain talking about how you could address those levers with measurement at different levels.

MEMBER SCHOLLE: This is Sarah. I have a comment when it's my turn.

CO-CHAIR PONCE: Go ahead Sarah.

MEMBER SCHOLLE: Thank you. I agree with the previous comments. And I think, so I know we're all on the space of thinking about measures that could apply to the States or communities.

But that raises an issue about the accountable entity. And it always makes

measurement challenging to think about, you know, how do you specify a measure so that when we get into the nitty-gritty it becomes a little more challenging.

And so -- and the other piece, I like the framing -- I like this as a starting point to say, does it make -- this helps me to understand better, well what would an individual -- and I don't know if provider means clinician, or like an individual clinician. And measures that would be used in a program like MIPS or something different.

But, I do think trying to think about it the way that -- where we say, here's some topic areas. And this is what different entities could do.

Or these are the kinds of things we'd want to measure at a population level. Which one might be interested in measuring that at a community, regional, state or national level, but that doesn't translate to -- those entities may not be a report -- responsible in a way that it

lends itself to a measure that could be used in a Medicare Advantage, Stars Program or the MIPS Program.

So, I'd like to hear some thinking about that. How to translate this into the accountable entity. Because that's what we'll need to do when we go from the measure concept to the measure certification.

CO-CHAIR PONCE: Thank you Sarah. Bob, Lisa and then Yolanda.

MEMBER RAUNER: I think kind of along the same lines. I think system is part of the problem with this. Because system sometimes implies hospital or health system.

But maybe it should be organizational accountability. It's a little more obvious for an accountable characterization. But, you know, an FQHC should define itself not just the patients it takes care of, but hopefully the neighborhood and the MUA they serve.

But it might even be an ethnic or neighborhood organization like an African-

American or Hispanic organizations are actually taking on the charge of trying to improve cancer screening rates of their constituents even though they're not medical folks.

And so I think maybe not use system. But define how you define your population. Whether it's Hispanic or low income or my neighborhood. Maybe that would be a better way.

CO-CHAIR PONCE: Okay. Thank you. Lisa?

MEMBER IEZZONI: I have a bunch of little tiny responses to everything that's kind of gone before.

But first of all, I just wanted to suggest that maybe at some points we don't use the word patient. That we use the word persons. Because I think that that really is going to be a lot more applicable to what we're talking about.

The other thing is that I would actually be very hesitant to, without a lot more discussion, fold persons, families, care givers all together. Because I think that that's a

very, very complex demographic and interpersonal dynamic that we need to think about.

And especially for some people with disabilities. Their families are not necessarily their supports. They can, especially for a young person with intellectual developmental disability who's trying to transition into adulthood, the family could be the impediment to their kind of growing into an adult role.

So, I think before we would, as a group, agree to do that, I would want to talk at some length about that.

And then the other thing, Tom stepped out of the room, but he was talking about institutional racism. And I agree that that is something that needs to be kind of built into what we're talking about.

But I think the more general concept is stigmatization. And I'm writing an editorial right now for a special issue on sexual and reproductive healthcare for people with disabilities. There's 13 articles.

Twelve of them are all about stigmatization and terrible discrimination against women with disabilities and their sexual and reproductive health. And the 13th suggests that there are increasing numbers of women with disabilities having babies.

Guess what? That number is going to increase going forward. So, I think just the word stigmatization could be a more general word.

And then when I first looked at these domains, they all kind of struck me as structural measures. And I didn't -- they're not measures. Sorry. I didn't mean to use that word.

But I -- do you think that domains as structures or kind of -- because we've been talking about the classic Donabedian triad of structure, process, outcome.

Although remember that Donabedian also looked at interpersonal aspects of care versus technical aspects of care. Which was a second kind of orthogonal set of dimensions that he included.

And so it would just be helpful for me conceptually to understand what -- where the domains kind of fit within that Donabedian framework. If the Donabedian framework is relevant. Which it may not be the way that you think about it.

CO-CHAIR PONCE: Thanks Lisa. Yolanda?

MEMBER OGBOLU: I just wanted to say, when I look at the conceptual frameworks that we used as a background to kind of inform the development of these various levels that you wanted to look at, I think one of the things that's missing from, for example, the social risk factor framework. Which if you look at it, it looks very similar to the WHO Commission on the Social Determinants of Health model.

And what's missing from that model when you compare it to the social factors model is that first block. Which focuses on the structural determinants of health.

Which is hitting some of the issues

that we're talking about in terms of structural racism, bias, looking at the socio-political context of a particular region. That part of the model is missing from that NAM, a social risk factor model.

So then we're looking for a place for where to put things like bias and structural racism. Which normally would have fit in that first category, which would have been called the structural determinants of health.

So I just -- it's more a comment. But I think some of why it's absent is because this is being driven by the eco-sociological model.

And also being driven by that social risk factor model. Which is missing that kind of structural determinant component that looks at those socio-political context. Which a lot of people don't necessarily want to talk about.

And then I was thinking and listening all morning about the different domains that we're talking about for health equity. And cultural competency has come up a lot.

Social determinants of health also. And then community engagement or community inclusion.

And so I guess for me, I starting thinking about how those various buckets so to speak, could be looked at from a measure perspective across policy organizations. And then looking at providers and thinking about payers, hospitals, clinics.

But also thinking about health provides, MD, nurses. But, also the movement with community health workers, where do they fit as providers?

So, that's just what's some of the thoughts that I had based on the feedback of what we're talking about today.

CO-CHAIR PONCE: Thank you, Yolanda. These are all really important thoughts and I was just -- I also was thinking that about the NAM conceptual framework that looks a lot like the WHO social determinants of health framework, but without the structural component.

And I also want to note Lisa's question: are these structural domains? And I think when we think of structural, like structural racism, no, they're not. It seems more -- for me it seems like where's the levers at which -- is it the policy level, the community level, the organizational level?

And I also wanted to acknowledge what you said about the patients, families and caregivers, because I was also thinking when Eduardo was suggesting that, that they may not necessarily be aligned with the whole interest. There might be some -- they may not necessarily be the best agent for the patient, so it's something to -- I mean, we can look at that as a unit and it's -- and get -- not patients -- persons, families -- as you said, persons, families and caregivers to look at that as a unit, but to understand that it's -- they're not necessarily an aligned unit.

I think this is an opportunity for us to -- I think having something to argue about is

important to give us a structure to do the interactions and the group -- like the group -- I was going to say group projects, for later on for our group projects. Are we randomized by the way? Are we assigning, Uchenna?

(Laughter.)

CO-CHAIR PONCE: But I also -- it also feels like what we'll be doing will inform our roadmap and conceptual framework so we can -- given what people have already said now, and I'm sure there will be more insight after we breakout. We'll come back and then have even more insight on how to come up with a better mousetrap, a better roadmap and understanding that. So this isn't all set in stone, right?

MS. O'ROURKE: No, no.

CO-CHAIR PONCE: Okay.

MS. O'ROURKE: So I think to go with what Ninez was saying, I think a lot of the conversation this morning has been really informative to how we can modify the roadmap, think about the use of these measures, some of

the broader big picture things we need to think about.

For this first exercise we're hoping to get the Committee through small group work to think about what should be the proposed domains of measurement that we'd like to see. As Susannah was saying, what are those baskets that you'd like to fill up with measures?

And the straw person is, as Ninez would say, is really just something to start some arguments about you are welcome to flip it on its side. We could discard the socio-ecological model altogether and not think about it that way. You could add to it. It's really just a starting point for you to do with what you will and just get some conversation flowing.

So we've assigned you in two small groups to break out and start to think about -- in groups of three or four, so what you would like to see as the domains.

CO-CHAIR PONCE: Can I just take the Chair's prerogative to call on Romana again to I

think clarify your comment this morning?

MEMBER HASNAIN-WYNIA: So I had --

CO-CHAIR PONCE: Since I'm in violent agreement with you --

MEMBER HASNAIN-WYNIA: Right.

CO-CHAIR CHIN: -- as Helen would say.

MEMBER HASNAIN-WYNIA: So I had the chance to talk to Ninez and Marshall during the lunch break and realized based on what Ninez said to me and then also Ron's comment on the phone that I probably did not clearly articulate what my point was about measuring disparities in terms of closing the gap versus focusing on improvement of a focus on improving outcomes. So I wanted to clarify that.

So the first point of clarification is that I'm not saying that we only focus on improving outcomes and not closing the gap. I absolutely think we have to focus on closing the gap. So what I'm proposing is an either/or -- or both, not either/or.

(Laughter.)

MEMBER HASNAIN-WYNIA: Rather a both. Sorry. I'm having the lunch time brain numbing, I think.

(Laughter.)

MEMBER HASNAIN-WYNIA: So I think we need to do both. And the reason that I had brought up in my earlier comment the importance of context is because I -- I'm sure many of you are familiar with the AHRQ evidence synthesis that was released, I think in 2011 or so, that looked at whether quality improvement reduces disparities.

So I sat on the technical advisory panel for that. And it was a very small advisory panel. There were only five of us. But it was very clear that there was pretty much unanimous -- there was a -- except for mine, a unanimous vote beyond me that one of the inclusion criteria for the evidence that we included, the papers that we included, included studies that actually had two or more groups, because traditional disparities definition requires looking at two or

more groups and showing a closure of the gap. We only ended up after going back maybe 20 years with 17 papers. So the report was pretty inconclusive.

So my point is that in certain circumstances as we think about measure development, there are -- and I get back to the -- if we're looking at within hospital or within systems disparities that improving outcomes may be the important focal point. And if we are focused on looking at evidence, we have to be mindful of the evidence that is out there that may not fit the traditional definition of disparities.

And I can say that from having spent almost five years at PCORI funding projects to address disparities where until I left we had invested over $200 million on projects targeting specific disparities populations with a clear recommendation that we were not interested in studies that were going to recruit from two different groups to show a closing of the gap,

but to focus on targeted populations where we knew there were disparities and focus on showing us which interventions improved outcomes for those groups.

So I would hate to think that if we relied purely on the traditional definition that we would just eliminate that whole evidence base, because we did eliminate an evidence base when we did the AHRQ evidence synthesis.

So that's my point. And so context is important. I do think we need to focus in our recommendations about being explicit about what the definition of disparities is. We have to be explicit about measurement and what we're intending to measure, and we have to be explicit about strategies and what strategies may work within a specific context.

So thank you for the opportunity to clarify. I would not be the person ever, unless something changed drastically to say that we should not be focused on closing the gap, because I very much believe that we need to close the

gap. But I also believe that we have to improve outcomes for target populations. So, thank you.

CO-CHAIR PONCE: Thanks, Romana. I agree with you.

(Laughter.)

MS. O'ROURKE: Mauricio has instructions on how we're going to handle the breakouts.

MR. MENENDEZ: So, right, these will be about 30 to 45-minute breakout sessions. As Erin said, we'll have three different sessions and your task for the first session will be to come up with the different domains and sub-domains.

A few rules for each breakout session: For the first one just designate an assigned note taker and speaker. And Marshall and Ninez will come around to each breakout session, kind of voice their opinion or listen in on what you guys are talking about. And after that we'll come back and debrief and talk about what everybody came up with.

So, yes, I'll pass it back to Erin.

MS. O'ROURKE: So we have assigned groups. If we missed anyone, please feel free to join a group.

Folks on the phone, we assigned a dial-in number. Madison and Ignatius will be facilitating that group. And as Mauricio said, everyone will have a staff person, so we'll just take the flip charts and go around the room.

Members of the public, please feel free to pull up a chair and join the conversation.

Yes, so group one maybe back in that corner, two, three, four. Okay. Let's put three by -- three for Lisa. One, two, three, four. Just to -- so ones over by where Ignatius is standing, twos gather where Eduardo is sitting, threes by Lisa, fours by Yolanda.

(Whereupon, the above-entitled matter went off the record at 1:18 p.m. and resumed at 2:07 p.m.)

CO-CHAIR CHIN: Just to give people a

heads up, so we'll do the four report backs. Our sense is that we're probably going to have to revamp the schedule because it may not make sense to do the next two breakouts as originally planned based upon the revisions that I think we're going to be hearing from the different groups. So we'll need to sort of think on the fly in terms of the best way to spend our afternoon, but there clearly will be things we can do.

But why don't we start? I know Eduardo's been rearing at the bit to report back on his group.

(Laughter.)

MEMBER SANCHEZ: And I might be best because the degree to which there's deviation, ours is probably the least deviant from the strawman domain measurement. We kind of stayed with the socio-ecological model recognizing; and I'll talk a little bit about it, that there are definitely other ways to cut things and look at them.

So if you were to look at the document in front of you -- oh, the document you had that had strawman domains of measurement, I'm just going to talk a little bit about -- kind of go through those and some places where we thought there was some opportunity to maybe refine and/or reconsider some of the sub-domains that are in that taxonomical construct.

So one was -- Lisa, I heard you loud and clear, is that perhaps in -- rather than person-level being lumped with caregiver and family and social support, there at least be a level between the person and the provider that is the family and social network level. And, yes, I do think that there's some evidence around the value of that in a number of different areas.

Go back to the first page. And I'll just say right now that we also in our conversation -- I don't think you can see it over there, but there's a sort of an X and Y axis. We also thought back to -- there are different ways of lumping this. We thought that across every

single one of these domains there's a different way of thinking about the domains.

And you can either do the -- you have domains and domains, and those would include cultural competence up to and including the notion of readiness and preparedness as part of cultural competence would include calling out social determinants of health in each one of those domains in population health issues, the issue of community engagement, which is going to look very different across those domains.

And then the notion of multi-sector collaboration including process measures around intersectionality so that even that socio-ecological domain, while it might suggest that you sort of stay in your lane or stay in your domain, there's actually lots of work that happens across those domains and they're not strict. It's not a strict nested model, nested doll model, right? There's intersectionality.

A couple of things that we called out in the policy level. In addition to the things

that are already there, governance called out might be a sub-domain to look at.

At the community level we talked about addressing the social determinants of health, but also those could be further lumped in terms of some individual social determinants of health that roll up into being aggregate, things like educational attainment level at an individual level, income level, housing.

But then on a population level, while these aren't strictly social determinants of health, they certainly are mitigators or proxies for -- and that's the whole notion of desert communities, whether that's around food access or physical activity availability, health resources including pharmacies; and Bob heard me say this, including loose dogs. And that's sort of my proxy for things that don't fall into some of the things that we usually measure.

On the community level we thought that that second domain that says healthcare organizations collaborating with community

partners probably ought to be shifted; that is, switched because the community partner is the accountable domain in that regard, not the healthcare organization. So it's just putting the responsibility where it belongs.

We talked a -- I -- we didn't talk about this, but one of my thoughts around enabling services I am presuming might include things like payment mechanisms and how payment is decided, because accessibility/affordability are on some level -- can be defined and refined at the organizational level. It seemed to mean, but we didn't talk about this as a group, that organizational level and microsystem level are not necessarily interchangeable, but in some places the practice is the organization. And there's other places where there are many practices that are part of a broader organization and the variability of across the practices is an issue at the organizational level. And so just sort of thinking through those things.

On the provider level we talked about

rather than culturally competent workforce to actually call it out as culturally competent health team members, because whether you're the doc or the nurse or the MA or the social worker or the person who's scheduling appointments there's a need for cultural competence. And I'm not sure that at that level we think about workforce. We really are thinking about members of the team and how do we dole out responsibility and how do we dole out accountability.

I think that captures at least my sense of what we talked about. And again, just to mention, this was acknowledging that there's other ways to slice and dice. Bob talked about doing it by the disease categories that we talked about earlier: cancer, cardiovascular disease, diabetes, infant mortality and mental illness. So I -- it sounds to me as I walked around and tried to cheat and hear what others were saying that there was conversation about different -- a different way of lumping these in a different domain construct than the one that was put there

as a strawman.

Team, did I get anything close to what we discussed -- articulated in a way that seemed to represent our conversation?

Yolanda, do you want to add anything? You had that notion of the other dimensions.

MEMBER OGBOLU: Someone had mentioned earlier about the X and Y axis and thinking about various domains going across. And so I think you captured that in talking about cultural competency, community engagement, social determinants of health, multi-sectoral collaboration. We also had health equity preparedness on that row as well. So I think you captured most of what our group discussed.

MEMBER SANCHEZ: Bob?

MEMBER RAUNER: There's an urban and rural health gap.

MEMBER SANCHEZ: Yes, siree, Bob, there is.

CO-CHAIR PONCE: Eduardo, can you just talk more again in what you said about community?

I didn't quite get that. You said that --

(Simultaneous speaking.)

MEMBER SANCHEZ: Sure. So at the community level it seems to me that as we think about sub-domains there are -- and it may be that they're all in the same category, but some of these are characteristics -- some of them are characteristics of the people in that community. So those would be things like income levels and educational attainment levels and those sorts of things. And then there's another set of factors that are actually community factors, things like the availability of services and this notion of desert.

So as one thinks about a community, there's both things, and how one might go about considering effective interventions, as an example. So one example would be would an effective intervention. I think there's some evidence that increasing the accessibility of physical activity spaces does make a difference. That's very different than a policy around trying

to figure out how to increase the graduation rate in a community. I think we would agree both are important.

Probably the latter is more important than the former, but the measures or the effective interventions might be different. And you might prioritize the order in which you go about trying to do them or the degree to which you're going to invest your time and energy in doing them slightly differently. And a CMS might actually think about that different array of things.

As I think about the community health strategy, it probably lends itself more to investment in park facilities than it would an investment in educational training opportunities. Does that make sense?

CO-CHAIR PONCE: Yes, that makes sense. I think there's -- like from a empirical framework there's a compositional and contextual differences in a community effect, and that's hard to sort out. And it kind of gets at also

selection to communities that I think Lisa talked about in terms of selection to communities.

But also what's modifiable is not -- which I -- in talking with Yolanda over there in after-talk after you left that group, and it's not unique to the community level. I think what's modifiable is also across all the different --

(Simultaneous speaking.)

CO-CHAIR PONCE: Right?

MEMBER SANCHEZ: I would completely agree.

CO-CHAIR PONCE: Okay.

MEMBER SANCHEZ: It -- I was -- I called it out only because I think of kind of the descriptors of -- community is a different way of thinking of your -- the place of intervention. And we can think about that in all the others, but community is almost in my mind a proxy for how in the medical care system one thinks about a patient. The thing you're trying to help improve is the community on some level --

CO-CHAIR PONCE: Yes.

MEMBER SANCHEZ: -- including the people inside of it. That's why I went down that path.

CO-CHAIR PONCE: Yes. Yes, thank you.

CO-CHAIR CHIN: Thanks for getting us started, Eduardo. It's hard to always -- hard to be the first person.

We're going to hear these four different perspectives, and maybe one thing for all of us to keep in mind that maybe like the goal at the end of this segment, when we'll have the four presentations, but then we'll have some discussion, is for us to have some sense of, well, what is -- what are -- what's the model to be using here in terms of like what are the domains? I'm going to mess myself up here in terms of NQF wording here, but like the domains, which originally were like these -- this level of like the policy down to the individual. How does that link then to the accountable entity that's going to then use it in measurement?

So for example, I think, Eduardo, so the four groups, this is going to be the most traditionalist in the sense of like, well, starting with the six different levels of this of this socio-ecological model. What I heard Eduardo do was to add more sub-domains, flesh out the complexity, as well as any very importantly show how it's not as simple as this nested figure where -- it's more fluid. So you mentioned like there are things across different domains. And it's not -- yes, it's not like a simple addition thing here.

And to give you an example, you're talking about neighborhoods in place. I have a fellow right now that's writing this nice paper about like -- it's the built environment. So you're talking about the food deserts and like activity in terms of like, well, the physical structures. There's also the social environment. So social cohesion, social capital, group efficacy, that -- etcetera. And then those variables themselves saying -- aren't independent

and set, that different contexts -- it's going to vary and all.

MEMBER SANCHEZ: Marshall, completely agree. So one example is building a park doesn't necessarily people -- doesn't mean people will come. However, I know we've all heard of examples where there are communities where the park being built completely changed the way people were interacting with one another because now there was a place where that kind of interaction could indeed happen.

And so, yes, I agree that it's a bit more complicated than just physical constructs and that then the human element plays a role. But I guess at the end of the day it comes back to things like social connectedness and how are we going to measure those and where are we going to find those measures and is social connectedness -- so do you need the readiness of a community to use the park before you build the park? And that may call into question this notion of community-centeredness as a -- in

addition to patient-centeredness.

The notion of patient-centeredness is that people ought to be involved in "understanding and making decisions about their health," quote/unquote, but I also think that that same notion applies -- could apply at a community level. And the degree to which things do or don't work, I think we've all discussed today, may be dependent on whether, A, that was even utilized; what does the community want, and B, do we know how to measure those things to understand whether there's a -- kind of a motivational interview and motivational construct to move a community from not being interested to really wanting to make a difference in their community.

CO-CHAIR CHIN: So great insights from the group and it's very helpful.

So why don't we go to like the other pool where like group 3 -- so Lisa's group basically started by saying we don't like this at all. We're going to blow it up. A very

different model. So maybe that would be good to hear now to get that sort of out there, too. Yes.

I don't know who in that group is the spokesperson, but it's the one that Tara was the note taker for.

MS. MURPHY: So I can just start with what we've written down and then the group members can jump in and add some color commentary.

So the group did not like the initially proposed domains and had some discussion around social risk factors and the social determinants of health and decided that the social risk factors could be a domain in and of themselves. Beneath that domain they identified possible sub-domains including segregation based on where you receive care.

MEMBER IEZZONI: It's not fair to make you do that. It's really isn't.

MS. MURPHY: Okay.

(Laughter.)

MEMBER IEZZONI: And I was hoping since I took a brief restroom break in the middle that others would come to the floor and help me. But, so the rest of you guys jump in if I kind of am misstating things.

First of all, we really did not understand the concept of organizing the tree trunks, which is what we thought we were doing using Helen's kind of tree analogy. We thought that these were setting up with the tree trunks and then the major branches were.

We really didn't like organizing that around this notion of levers. Who were the levers or what are the levers? We thought that it was more important, as the second paragraph on the instructions said, to go back to the six levels of whatever it was and the -- Lisa Cooper's model, but we also kind of just took a step back from that. And I'm not sure that we really coalesced around anything more defined than these two broad areas.

One of the first things that we did

was talk a little bit about our discomfort with the phrase "social determinants of health." And I led into that by saying that last week I gave a talk in Chicago and an anthropologist came up to me afterwards after I'd mentioned social determinants of health as one of the subsections, and she said, you know, determinants is just too deterministic, that it's really more social factors that affect people's health or -- and so we decided, okay, we agree, social determinants is very deterministic. And it is in fact the phrase that everybody uses, but when you really think about it, there are people who do not -- because lives are not determined by these things. And so it is better to use the phrase "social factors."

And let's see, what did we do? We talked about segregation within communities being a social factor that could affect population health. And we also talked about -- we had a lot of trouble kind of coming up with the right phrase about how literally generations of

deprivation in terms of health can affect the health of individuals and populations and came up with the phrase "cumulative structural disadvantage." I think that's right.

Do you want to describe what that was?

CO-CHAIR PONCE: I just Googled it for you.

(Laughter.)

MEMBER IEZZONI: I know you did. You searched it. You kind of Googled that for me.

CO-CHAIR PONCE: Yes, I did the search. All right. Yes.

(Laughter.)

MEMBER IEZZONI: Okay. So basically the notion is that we've all heard -- many of us have heard recently that fetal health determines infant health determines child health determines the young adult and then adult health, but it also can go back earlier generations of health, and prior generations can really affect the way that somebody today's health is.

And we also talked about the notion of

allostatic load. Do people understand that phrase? People have heard of the kind of notion that structural discrimination causes people to experience kind of -- what is it, the adrenal, hypothalamic, pituitary -- which, what -- what is that? All right. You know what I'm talking about, the little pulses of cortisol that just repeatedly kind of cause kind of physiologic damage that affects people's health.

And so we really wanted to have a measure of health there. And because what you're going to be measuring is whether that improves, right? And so we wanted to have the measure of health that looks pretty bad because we wanted to know whether it would improve with the implementation of this new measurement scheme that we're going to be positing later in this structure, later in this process.

And then for our other trunk; and again, we didn't get that far, we only had basically two trees, but they had a lot of branches and leaves, I invoked the World Health

Organization International Classification of Functioning Disability and Health, which was passed uniformly by the nations in the World Health Organization back in 2001. And it says that the environment is very important in terms of facilitating or impeding people's health.

And it was a classification scheme around disability, but everybody has levels of functional status regardless of whether they're better than mine or not. And so it's a classification of functioning, and some people's functioning is better than others'. But they talk in terms of facilitators and barriers to that. And one of the branches of the environmental tree is societal attitudes, and that can be structural racism or stigmatization relating to disability or relating to LGBTQ or whatever.

Another one is the policy environment.

Another branch would be the physical environment of healthcare delivery settings, like whether they have high-low tables or whether they

have wheelchair-accessible weight scales.

Another branch would be communication, and communication has a lot of leaves on it. It has to do with low-English proficiency and whether there are interpreters, but it also has to do with whether there would be sign language or CART reporters for people who are hard of hearing, or whether there would be braille or large print educational materials, whether the televisions in waiting rooms are closed-captioned, that kind of thing.

And the healthcare delivery system is its own entire kind of environment that has a lot of aspects to it, not just the physical environment, but also the nature of the healthcare practitioners who are there and their attitudes and quality of care and their training. And we got stuck on -- as we were finishing got stuck on the phrase "cultural competency," and we all agreed we didn't like that either.

So that's kind of where I thought we ended up. Other group 3 members, do you want to

admit that you were a member and --

CO-CHAIR PONCE: Traci. Traci was a member.

MEMBER IEZZONI: -- help me out?

(Laughter.)

MEMBER IEZZONI: Yes, thank you. I relinquish the podium on this one.

CO-CHAIR PONCE: Romana?

MEMBER HASNAIN-WYNIA: I'll admit that I was a member of this group.

(Laughter.)

MEMBER HASNAIN-WYNIA: But I was actually going to speak for Nancy, but Nancy came in, so I don't have to, in terms of the first, because, Lisa, that's when you stepped out in hopes that we'd have it all resolved.

So the first one, the segregation based on where people received care. So it was -- and I'll let you kind of pick up since you're the one who raised it, but it was about segregation related to where people get their care and where specific providers are segregated

in terms of providing care to populations, targeted disparities populations, so some of the literature that looks at the concentration of primary care docs, that small percentage who take care for a large number of low-income minority patients.

Same with hospitals. A thousand or so hospitals out of the 4,600 that -- I think the statistic was at least up until about 2000-and-something where only about a thousand of the hospitals of the 4,600 acute care hospitals in the country saw an African-American patient who presented with AMI. So the importance of that kind of segregation and how that relates to measurement. And it gets back to kind of I think the point I was making about improvement versus closing the gap.

Nancy?

MEMBER GARRETT: Yes, exactly. And I would just add we were talking about some -- as a measure domain it might be a concept that we want to pay attention to because we know that patients

aren't equally distributed across providers and the fact that they're not has a lot of implications in terms of how resources are distributed. Payer mix really varies and that really determines a lot of how -- what the resources are to care for vulnerable populations. And so as a -- there's a residential segregation index that's used in sociology and to understand residential segregation. Maybe there should be an index for healthcare segregation of vulnerable populations as a way to start measuring and therefore understanding how we might need to do measurement and resource allocation differently.

MEMBER FERGUSON: And in terms of cultural competency we didn't completely discard it, but did state that it seems to be in terms of documentation. And what is it really in action when you're talking about the second report focused on primary care, which is good, but looking at specialists. When you see a nephrologist, are they having the same type of conversations? Is there a way to document?

They see that there's disparities within minority populations about giving -- getting or being aware of living kidney -- living donor kidney transplants, of being able to document of all of their populations end-stage renal disease how many have they had conversations with and being able to measure that and document that, and that we needed sort of -- in terms of cultural competency needed to be more an action at the provider and at the -- you know, provider level and also at the payer level, too.

CO-CHAIR CHIN: So I'm going to pick on Romana here. So when I first joined your group, she immediately said we have no clue what you guys want us to do.

(Laughter.)

CO-CHAIR CHIN: And so a very different approach than Eduardo's group. I'm trying to get some --

MEMBER HASNAIN-WYNIA: Whoa, Marshall, way to make us feel bad.

(Laughter.)

CO-CHAIR CHIN: I didn't say it was good or bad, just a very different approach. But I was trying to get it nailed down to like where we had to go as a group like and make it concrete regarding domains and then linkage eventually to accountable entities and then use and performance measurement and rewards and incentives, etcetera.

So can you take us a little bit -- one step closer to like how these good ideas have been sort of -- relate back to our immediate charge like domains and then use and measures and all?

MEMBER HASNAIN-WYNIA: Yes. Well, maybe I'll pick on the cumulative -- what was -- what -- social disadvantage, because I raised that question in the group, too. Structural disadvantage. So the question I raised was is that something that we should be considering within the charge of this larger committee, or does it start to go outside the scope? And I think it was Ninez who said, well, isn't that exactly what we're trying to address?

So within that context I think part of our motivation is to say that we should be thinking about measures as we think about -- again, going back to the beginning of the day where we said we're -- we want to do what we can do now, but we also need to be thinking about what we can push for or do in the future, so looking at specific measures that allow us to track over time whether there are improvements in that structural disadvantaged-type measure.

So I do think that there is a way to tie back our really esteemed group's deliberation about what -- where we wanted to go with this. So some of these I do think are a stretch. Maybe not the healthcare delivery system where we're talking about access, but the structural disadvantage definitely is a stretch. But maybe something that because we're tying this to social risk factors is really important for us to be able to set the groundwork to measure over time. Does that answer your question?

CO-CHAIR CHIN: Yes, that's helpful.

Thanks, Romana.

Tom, do you have a comment?

MEMBER SEQUIST: So, yes, I had a -- just a -- in terms of the -- measuring these sort of between-provider issuers versus the within-provider issues, I just -- I think there -- I just want to make sure that we don't underestimate the importance still of the within-provider issues. So I -- the last analysis I saw of the CMS measures pneumonia, the sort of core CMS measures -- and if you trend them over time from like 2005 to 2010, it's the within-provider disparities that aren't going away. The between-provider disparities have gone down by a lot. So Ultravetti if Brown had looked at this over like a five-year period.

So they're both important, but I just want to make sure that we don't forget about the within-provider ones, because those are the ones that haven't changed that much over time. There has been a pretty dramatic drop in the between-provider disparities.

CO-CHAIR CHIN: Thanks, Tom. That's great to get those first two groups out to sort of set the stakes in the ground in terms of like the two very different sort of perspectives. I think like the other two groups now fall somewhere in between.

So, Mauricio's group?

CO-CHAIR PONCE: That's -- it was -- that was Eduardo's group.

CO-CHAIR CHIN: Oh, okay. Yes.

CO-CHAIR PONCE: Just before we do that, I thought that the last group was a great group. And it was raised -- to Helen, they really liked your -- the tree and the branches and they were getting into the leaves. So they were -- started to talk about measures. But then someone, I think it was Romana -- it was Romana who said what's the root? What are the roots for the tree? So, and in some ways I think the domains you chose were very roots parts. I mean, they're -- really the heavy part is domains. So I think that that's -- so I really liked it. I

just also want to make sure it doesn't get lost in the discussion.

I think Nancy raised the ACE, Adverse Childhood Experience, indicators, so I think that that's -- so they were getting into that -- into ways of measurement.

MEMBER GARRETT: If I could just make one really brief comment. One of the things in the socio-ecological model that we have here with the patients kind of at the beginning here, we're really starting to think increasingly about -- especially when it comes to social risk factors, about the person in the context of the family and the household that they live in and how important that is. And it's hard, because the electronic medical record is really structured on an individual patient basis. And so to start to bring in those family risk factors is actually difficult from an IT perspective.

So we've actually been working with our vendor to say you've got to change your paradigm here of how this thing even works, and

they're actually in discussions with us about it. But I think that's an important aspect that's kind of between the community and the individual.

CO-CHAIR CHIN: So you remember going to school and that some of your classmates were like the perfect students that would just do everything just so right? When I looked at this group, it was Erin's group, they already had like about five or six like of these sheets already plastered on the wall in terms of like the ideas.

And so you want to talk a little bit about your perfect group?

(Laughter.)

MS. O'ROURKE: We've actually nominated Philip to be the spokesperson for the group.

MEMBER ALBERTI: For the perfect group. That's exciting.

Well, like the rabble rousers in group 3, we didn't like kind of using the socio-ecologic model levels as the domains, and so we did the Bernheim flip and said we'll look at kind

of the actual content areas as domains and think about how to measure across all those different levels. And when Marshall came over, he said maybe we are the most theoretical of the group, which I think he meant that we -- there's no evidence base for anything that that we are proposing. But I like to say that we're aspirational, so we're going to present our aspirational model.

So we have six domains. So the first was the institutional culture and structure for equity. And some of the sub-domains included things like workforce diversity, cultural competency, prioritizing equity; maybe that's a leadership kind of domain or sub-domain, addressing bias and stigmatization and structural racism, collecting the data that's required to have this focus, and really incentivizing equity. Specifically we're talking about merit and promotion, kind of policies that would actually allow that culture to develop. So that was one domain.

A second domain was the equitable provision of care, so thinking about how to apply an equity lens for all of the equality measures that an institution gathers, thinking about the experience of care and discrimination, again issues of bias. I mean, you could organize these domains and sub-domains in various ways. Full disclosure. Then of course looking at the and assessing the equity of healthcare outcomes and health outcomes based on that equitable provision of care.

The third domain we focused on was equitable access to high-quality care, so thinking about the quality of the safety net, and then thinking about the conversation that Romana -- you're coming up a lot, Romana -- led us through earlier thinking about both measuring health outcomes for particular subgroups, but at the same time measuring the gap when and where appropriate, and doing both of those things concomitantly.

The fourth domain we're going to newly

name it addressing the social correlates of health; because we were told not to say "determinants" we're going to call it the SCOH, and thinking about how -- again across all the levels, whether it's assessing those factors in a patient-by-patient level all the way up through community benefit policies and needs assessments, all the way through thinking about partnerships with other sectors in the community.

Which then leads to that fifth domain, which could be a sub-domain, but we wanted to really call it out separately, of collaboration in terms of care coordination at the provider level, inter-professional collaboration cross-sector for the institution level, thinking about engaging with patients and their own care and that kind of patient empowerment and engagement with community as well.

And then our final domain; and again we kept it separate because I think there was a sense that we wanted to call it out specifically, was advocacy. And again, thinking about all

those different levels, whether it's patient advocacy all the way through kind of state and national advocacy efforts in the equity space, as well as building the capacity of communities to advocate successfully on their own behalf. So again, trying to think about these broad domains, but how you could apply it across all the levels of that. So if I left anything out, other perfect group members, please chime in.

(Laughter.)

CO-CHAIR CHIN: I think it's actually great that they're so different, the three groups so far, because you sort of see like the strengths and then complementary parts that each is bringing. So for example, Eduardo's group did start with the structure, the six-level structure. And so you have like the potential actors there. But then went way beyond like our initial strawman in terms of the complexity and how it's more fluid and as well as more in depth, the domains and all.

The second group talk a lot about, as

Ninez said -- and about like in some ways probably the most important drivers ultimately of like these outcomes. You look at like studies about the percentage that different drivers are contributing and like social factors driving the outcomes. And Romana's point about making enough to get there. Some of this may be a little more distal in terms of like the immediate power control of the different entities, but something that needs to be on the score card in terms of like the overall model and aspirational.

I feel like I -- Philip -- you actually sort of said it very nicely, Philip, of like -- when I first saw like the list, my initial question was, well, yes, it does -- like when you were talking about the initial strawman, like when the staff came up with the initial strawman, it was based upon the evidence from the lit review. So here's what the evidence shows. So they did a very evidence-based approach.

A lot of things you should have up there probably is not like rigorous control

studies you can show doing that, but they do reflect probably a lot of what people sort of think in the field and then case studies and all. So there's a role somewhere in this mix. So all very sort of different, but complementary in a good way.

Other comments upon Philip's group?

CO-CHAIR PONCE: Susannah is --

MEMBER BERNHEIM: Just two quick things. Just I was struck by the discussion about within and betweens, so just putting a highlight on the sort of concept of equitable provision plus equitable access to high-quality, feeling like those kind of conquered the two. One really helps you think about within and the other the between, ensuring that the safety net is strong.

And similar to what you said, I mean, I don't know what the right way to do this is, what the X axis and the Y axis should be, but this group really created a -- no, not that group -- whoever your group was, sort of this concept

of, oh, an X axis and a Y axis, that sort of there are -- and if you map our five or six domains, at least three or four of them actually overlap pretty heavily. And quite honestly, there's a lot of overlap there, too. So I don't think we're as far from a shared vision. I mean, there's probably not a right way to do this, but as I hear it, there's a lot of resonance in the major domains.

CO-CHAIR PONCE: Eduardo?

MEMBER SANCHEZ: Yes, I -- you -- Susannah, you said basically what I was going to say. If you remember that --

No, no, no. So Yolanda's sense of how we might think about this was very, very, very aligned with group 3's presentation. And so it boils back down to if you take that construct -- and even some of the sub-domains actually are -- will be effectuated in the now seven domains that we had come up with in the socio-ecological model.

So again, I think that there's more

agreement than not, and it's our -- we're human beings; we're not from another planet, and we can only think in at most two dimensions on a piece of paper. And this really is going to be probably a multidimensional construct that's very hard to capture in words and in paper and in diagrams.

But I'm hearing more -- there's more alike thinking that we just don't have a good way of making our brains put our head around, right, because it's -- now we're at three dimensions and I can't wait to hear how we're going to think about -- the fourth dimension is the one I always struggled with throughout my entire early academic career.

CO-CHAIR PONCE: Stay tuned.

Bob?

MEMBER RAUNER: Well, I was also going to talk about the X and the Y and the Z axis for the same reasons.

But the other thing I'd like to make as a motion, because I mean, I also equally

dislike these social determinants of health and I make a motion that we not use that going forward and that we use something more appropriate like social correlates of health or social influencers of health, because I think that's a much better way to describe it.

CO-CHAIR PONCE: What about the social risk factors that group 3 -- it's also the same -- I mean, ASPE used that as well.

MEMBER RAUNER: Yes, so whether it be influencers, correlates, but anything but social determinants, because I agree it's too deterministic and wrong.

CO-CHAIR PONCE: Anyone second?

(Laughter.)

That was a motion. No.

MEMBER SEQUIST: What's determining?

CO-CHAIR PONCE: Social risk factors.

MEMBER TEIGLAND: I like it because it's -- it makes it -- it puts it on par with clinical risk factors. They're just as important. So I like to call them risk factors.

CO-CHAIR PONCE: I know this isn't for -- any opposition?

(No response.)

CO-CHAIR PONCE: All right. We'll go with social risk factors. And also acknowledging in terms of themes that are coming up, the segregation based on provision of care and access is also the equitable access and provision.

Emilio?

MEMBER CARRILLO: Yes, the one minor concern about that is that there are the salutary or beneficial determinants that when we think about social determinants, we think about the adverse negative determinants and we think about positive social determinants like a beautiful neighborhood with very good communication, very good school. So if we frame it in a more negative way, we may lose that important dimension of also looking at the positive determinants.

CO-CHAIR PONCE: Eduardo?

MEMBER SANCHEZ: The Heart Association

actually struggled with this very issue. About a decade ago we moved away from using language in our kind of public statements about cardiovascular disease risk factors and started talking about cardiovascular health factors for that very reason, because your health could be good, your health could be not so good. Disease, generally always bad. Even if it's not so bad, it's still bad compared to health.

CO-CHAIR PONCE: I'm going to table then the discussion as we think through this.

What about environment, though? From group 3, environment seems like it's both positive and negative.

MEMBER IEZZONI: Again, that's the language that's used by the World Health Organization in the classification of functioning disability and health, and it's just simply a word that defines within it a bunch of different kind of constructs.

CO-CHAIR PONCE: Okay.

MEMBER IEZZONI: Including social,

physical, communication, policy. It's just a header.

CO-CHAIR PONCE: So we're together through tomorrow, so sleep on it, think about it. I think what's on the table is social risk factors or social correlates. I think that was the other. Social correlates of health, because there's no direction implied in the correlates. Risk factor, the advantage is that it aligns with -- clinical risk factors aligns with other such as -- other reports such as ASPE. And I think National Academy of Medicine also calls it social risk factors in that report that, Lisa, you were part of.

Romana?

MEMBER HASNAIN-WYNIA: So I just want -- we're -- I understand that we're moving away from social determinants, but we're -- we don't want to use social risk factors?

CO-CHAIR PONCE: That's -- yes.

MEMBER HASNAIN-WYNIA: So we're thinking about --

CO-CHAIR PONCE: No, not that we don't, but we're considering other --

MEMBER HASNAIN-WYNIA: Considering --

CO-CHAIR PONCE: -- words.

MEMBER HASNAIN-WYNIA: So we're thinking social correlates? Is that the -- why don't we just say social factors? I just --

CO-CHAIR PONCE: Ah.

MEMBER HASNAIN-WYNIA: Why don't we just take away the --

CO-CHAIR PONCE: That's great.

MEMBER HASNAIN-WYNIA: -- and make it neutral?

CO-CHAIR PONCE: Thank you.

MEMBER SEQUIST: What are you using this word for? I mean, is this --

(Laughter.)

MEMBER SEQUIST: Is this a -- is this some formal statement that you're planning to make around the use of the term or --

CO-CHAIR PONCE: No, no. No, in fact calling the vote was not really -- we don't

really vote on things here. But it's just that there was a -- you know, Bob made the suggestion. And I think just even from the exercise today and the presentations this morning people get caught up in labeling and in words and what it means. And so it's just a way to have a common -- sometimes the usage is -- common usage is a way to get at a common understanding so that our discussions then are really fruitful. But I don't think it's really for a policy statement.

DR. BURSTIN: Not at all. It may be something you label as a domain or a sub-domain. So I think you're going to come back to this at some level, maybe. Or maybe it's a third dimension or whatever it is. But at some point we're going to want to probably call it something in the sake of this framework, so that's the only reason.

MEMBER SEQUIST: I would just say that it's challenging to use a word that's separate from what CMS and IOM and all these other organizations are using like to sort of -- it

just will confuse people if we put out a framework that uses a completely different word, or phrase.

CO-CHAIR PONCE: On that point, Bob?

MEMBER RAUNER: Sorry to make this worse, but sometimes CMS does come along, though, so --

(Laughter.)

MEMBER RAUNER: And but I think using the term "wrong terminology" frequently leads people to jump to the wrong conclusions, and I think that's the problem with using "determinants." Yes, it's commonly used, but I think it's commonly leading people to jump to the wrong conclusions.

MEMBER SEQUIST: Oh, no, they're not using "determinants." They're using "social risk factors."

MEMBER RAUNER: Yes. But I also agree with what Eduardo says that it's not -- well, I mean, just like "deviants," you can have both positive and negative deviants. "Risk factor"

does mostly imply negative, and so I would maybe choose something a little more neutral, whether it be "correlates" or "influencers," because those are both accurate but do not necessarily imply negative or positive.

Because you can have good things about your neighborhood, you can have bad things about your neighborhood. You could have good things about your ethnicity. There can be bad things about your ethnicity that are correlated, for example. I mean, you have the Hispanic paradox where for some reason Hispanics live a lot longer no matter what.

So I think using "correlates" or "influencers" would be a better term than "determinant," because I think I literally have that problem in our community right now, because we're doing -- one of our groups is doing this community mapping and they're using that "determinants" all the time and they're acting like if you live downtown, you're going to die when you're 60 and it's -- no, that's not -- and

everybody's jumping to the wrong conclusions. So I just really, sorry, I dislike the determinant one because of that.

CO-CHAIR PONCE: Okay. Cara, what does CMS think?

(Laughter.)

(Simultaneous speaking.)

DR. JAMES: Right. Right. No, I think -- and I will speak for myself. I want -- I applaud the struggle, because I think, personally, I will say risk factors, social risk factors, I don't necessarily like the fact that, being an African-American woman, being African-American is a risk factor. I don't know that I particularly care for that, so I like the more neutral language.

I think that the social risk factor language I would say was driven in part by NAM. So those reports that ASPE commissioned to developed sort of where we go is sort of what's driving that. I think we are a little bit at a crossroads as field of trying to figure out what

are we talking about? How do we talk about it? How do we communicate it in a way that's not divisive for other individuals, which I think is somewhat why there's a little tension with including structural racism. Like the minute you say the R word, people are leaving the room.

So I would like for us to struggle with this. I also would like for us not to get derailed by it at the end of the day, because we can down a rabbit hole and spend days trying to figure out this language, but I do think there is opportunity for some discussion.

CO-CHAIR PONCE: Well said. Thank you.

Emilio?

MEMBER CARRILLO: Yeah, I think that before we toss "social determinant," we should just kind of look at it a little bit deeper. There is a whole literature around -- with the term, not to mention all of the entities that are using it: health organizations, CMS, all the way down the line, AAMC. I mean, social determinant

is -- it's a determinant of health. So that has value in that we're looking for what are those social factors that are determinants that impact health?

So I think that the term "determinant" does bring us to the attribution discussion. How does this impact health? So I think that the term has value and we should weigh the value with the issues. And there are beneficent determinants of health and there are adverse determinants of health. And so I think that we should maintain that consideration before we toss it away.

CO-CHAIR PONCE: Okay. Thank you.

CO-CHAIR CHIN: Why don't we move then to the fourth group so that we get the fourth group's ideas out there, which was Emilio's group. So I don't know, I guess, Drew, Emilio, or someone from your group?

MEMBER CARRILLO: Well, as Eduardo suggested, we know have a fourth dimension. We take a different cut at this complex question,

and actually we're taking a more traditional cut, which is actually along the framework that NQF developed years ago. And basically a lot of the thinking around cultural competency has been based on that framework. So we have a framework. Before we toss it out we should look at it, understand it. Before we improve it, we should also understand it.

So we went back and looked at the organizational level as our starting point, although the framework that we came up would apply to the policy level, community level, macro system level, et cetera.

So first of all, there's leadership. I mean, leadership is very important. This is something that in terms of driving the organization, in terms of committing to reducing disparities. Leadership is something that is a very important component, particularly if we are into an action-oriented frame of mind. We want to change things. We want to improve things. And leadership is a very important component.

Secondly is communication, which is what most people think of first when they think about cultural competency. It's not just communication. It's also understanding. I mean, how well does the person understand the elements of prevention, the elements of where there is access to health, the FQHCs, et cetera? So those are two important things.

And, again, we're looking for a framework that is ultimately measurable, things that can be measured. I think that there is measurements of leadership. You can look at what leadership has accomplished, what they have invested, et cetera, et cetera.

Thirdly is community engagement that we have talked about in many different settings. And that's a very important component of cultural competency and things like not just being involved in community, but for example, having in your boards, in your driving groups, having actual community involvement, which is something that's very measurable. I mean, to what extent

that you're involving the community in your various different planning and implementation efforts.

Then the fourth domain in this framework is diversity, and workforce diversity in a stratified form. I mean, not just looking at the fact that a large amount of your -- large volume of your workforce is diverse, but the top leadership is all mono-ethnic. So measurements of workforce diversity are important, and also opportunities for advancement.

And then care delivery and supporting mechanisms. What systems are there in place to promote the cultural competency and thereby reducing diversity? What allocation of resources, which is something that is very measurable? How do they fit into this?

And then there's policies and the mission and the vision of the organization. What policies are there in place for the entire organization, for the system which -- and do those policies speak to disparities? Do those

policies speak to the cultural competency? And that's evidently accessible to study and comparison and looking for elements that should be part of that.

And then last but not least is data and stratification, which is a very important aspect of this. So, again, looking for a framework that has been built already that we can look at and change or accept in some ways and which leads to measurement, because we basically -- we're not a theoretical exercise here. We're a exercise in basically creating elements that can be measured so that they can impact policy.

Kevin, you want to --

MEMBER FISCELLA: Yeah, I was going to say, I think that there's a thread within all of this. A lot of it comes down to empowerment and sharing of resources and transparency and inclusion, that those are -- all factors that shape social disadvantage I think operate at all these levels and I think were all imbedded in Emilio's comments that ultimately if we want to

improve equity, it does require addressing those issues. Patients at an individual level need shared power, shared decision-making.

Office staff, and Emilio gave an example where he asked his MA about his Latino patients who weren't doing as well as he was expecting. And she explained all of the social issues why they weren't. Now that's a sharing of power between a physician and an MA and creating a psychological safety within that team.

And at organizational levels it's empowering groups who feel like they have a genuine opportunity to pursue career pathways so that ultimately the organization will become more diverse. Its programs and transparency and when they make a commitment to equity that they publicly say what it's going to be, what the metrics are, and then present data on how they've been doing and discuss their successes and failures. That's a sharing of power when has that level of transparency.

So I really do think that these sort

of more fundamental mechanisms underpin many of these factors that are critical to addressing equity. And if we keep our mind on them, I think it's really important that we really not miss the fundamental issues and getting caught up too much in some of the processes, that it really does take sharing of resources, it really does take giving other people a voice at the table when we talk about empowering communities and organizations, working with communities. It's not just engaging the community, but actually sharing resources and sharing decision-making and so on and very much in the way I think PCORI has tried to promulgate.

**CO-CHAIR CHIN:** I think it was Romana, then Eduardo. Okay. I guess Eduardo.

**MEMBER SANCHEZ:** That was very, very compelling, those comments, and it seems to me, Emilio, that a friendly amendment to the list would be decision-making/governance, because I agree that I think the spirit of it is there, but it probably should be called out as a domain.

CO-CHAIR CHIN: Just a few observations that -- let's leave the list in here. That seems to be more like organizational-level sort of perspective. Thinking about Emilio's role as a senior management in a major healthcare system, thinking about like -- he works on the disparities solution network, which is a lot of us, in terms of coaching institutions.

University of Chicago, we're in like year four of a similar type of a campaign, exactly the same type of domains that really cut across all the things that a major organization needs to work on from the workforce to the culture of the senior management buy-in to the structure of the delivery system, et cetera.

I actually see a fair amount of overlap between this one and then the group over here. They use broader terms, but when you get down to like their sub-domains there's a lot of overlap, although I think this group had a broader perspective. So it's organizational, but

then it goes beyond in terms of the other different levels there.

So I guess back to I think what Eduardo was saying, like there's actually a fair amount of overlap when it comes down to it among these four different entities.

Helen?

DR. BURSTIN: I completely agree. I could easily see taking these two pieces. I think there's a lot of overlap. I'm also still intrigued by the piece in the back. And I want to remind us, this was all done in the context of race, ethnicity and language only, and so it doesn't really consider -- like, for example, environment has a very particular I think lens as you're looking through disability or geography. That was never part of part of this framing. So some of this as we think about the broader framing you might logically bring in things that would have never been there before. I just want to remind us of that.

CO-CHAIR CHIN: Why don't we go to

group 5, which is the group on the phone? And so would one of the people on the phone like to be the spokesperson for your group?

MEMBER COPELAND: Yeah, Marshall, this is Ron. I was asked to speak for the group, but I think the first thing I'll say is we valued the opportunity to be included in the exercise given that we're not physically in the room, but either the opportunity didn't serve us well or we didn't leverage it effectively. So it was a, I would say, fairly frustrating experience for us to try to scramble virtually to get clarity on the assignment, review the documents, and then engage in conversation.

So the only things I will say is that we also experienced some of the dissonance that I've heard described by the first four groups around this version of the domains for a lot of the reasons that have already been described, but we did not get to any detail on providing or proposing an alternative approach to the domains.

So the limited discussions we actually were able to have were looking at the domains as listed in the sub-domains area underneath and highlighting some additional opportunities that might be considered in whatever further refinement we do. And a lot of that was in the realm of the cultural competency piece, both at the organizational and/or individual provider level. And what we didn't see accounted for was whether the notions of cultural competency at either of those levels is actually measured or not such that you have some way of not assuming it's being done, but actually having some way of putting metrics and/or standards to that.

And that led to a further discussion about, given the fragmentation of care delivery models across the landscape, what was the role or value of engaging either licensing or medical education institutions around their role in building up this competency and skill and knowledge development so it doesn't rest solely with the organization where the physician or

nurse or care team member happens to sit, that there's a proactive approach to realigning that with the realities of what it takes to drive an equity improvement agenda and where does that fit into this type of construct and the role of standards around the same.

So are these things treated as guidelines or are they actually elevated to standards level so that you can have a higher level of consistency, both in education and in practice and measuring results.

And then in the social and the community level around the social factors there was comments about assessing the needs -- so, the needs assessment piece we didn't see listed here. There was a presumption that the needs were identified and addressed, but not really called out in a specific way. And maybe that's implied or not, but that came up as part of our discussion.

And then the other was the role of community members and persons involved with co-

designing solutions and inputs to the process as well.

So that's really all we came up with in the limited time we had. So, nothing transformative. And I think what I heard in the first four groups, a lot resonated with some of the discussions we had, but not in terms of specifics for modifying the domains, if you will.

And I don't know if Sarah or David are still on the line or not, but if they are, they might have other things to add to that on behalf of the group.

MR. BAU: So, this is Ignatius. The other thing that we talked about was actually measuring the diversity of the workforce, including some of the leadership and governance questions. And so, again, ways of reporting that out, of monitoring that. And Dr. Copeland also mentioned specifically within Kaiser they're actually measuring language proficiency of their providers as well. And so that's another area where I think you can actually start applying.

We started using "evaluation" rather than "measurement," because, again, it may be a yes or no rather than scales.

CO-CHAIR CHIN: So, thank you, Ron. No, it's not an ideal situation, so it's great that you came up with -- those are actually I think important insights that you have that you just mentioned.

Anyone else from the call? I guess Ron said David or Sarah. Anyone else, did you want to make any comments now?

(No response.)

CO-CHAIR CHIN: So I think that's great that this -- I think we would have been delighted at the time we'd done the initial planning for this part of -- we'd be happy we came up with these type of diverse-type of viewpoints.

Emilio?

MEMBER CARRILLO: Yes, just reflecting on the point that Helen made, we're really talking about social and cultural competence, how

socially and culturally competent are our policies? I mean, do they address the social determinants or factors? Do they take into consideration the cultural piece?

Community level, social and cultural factors that impact on the community, that impact on the health of the community. Organizational level, macro level, individual level, I think that that might be a better way to couch it rather than as we have traditionally just on the cultural front.

CO-CHAIR CHIN: So, in terms of what to do next, first an observation. So I think as many of you know, the staff, NQF staff, we're very lucky to have an amazing staff who do much of the work. And actually one of the stories is when Ninez and I were invited to co-chair this, one of the questions we asked Helen was, who's the team going to be?

And so she said, well, we got the dream team of like the people on the committee itself and we got the dream team in terms of the

staff. And she mentioned, well, it's going to be Erin and Mauricio and Madison and Drew and Tara. And her point was that she plucked -- she was going to pluck the best people because this is truly a high priority for her.

And what happens then is, like when we have these meetings, the staff does an amazing job of like integrating and synthesizing the different ideas and comes up with the drafts that we as a committee will react to. So they do an amazing job.

I think, though, that probably we need to get a little bit further though in before we say to them, okay, now you heard these five different presentations and now go for it. And so maybe we can spend a little bit of time as a group -- probably maybe talk about this as a group as opposed to dividing up into four or five groups again. Have a little discussion that gets into the parameters of like, well, eventually to come up with, well, what are these domains and then start mapping them to the measures and all.

And we don't have to sort of micro do this, because that will be for the iterations, but to get a little bit further on, now that you've heard these five different groups' perspectives, and there's actually more consensus than not, if we're trying to come up with something that we're all having on the same page as a starting point so that it's far enough along and the staff can then sort of get into the details.

Why don't we spend a little bit of time talking about that as a group, then, of like, well, what would be under this revised sort of like model that incorporates the best of things? Like where do you want to start in terms of domains and ways for approaching for this?

DR. BURSTIN: Could I suggest that we not forget about the dimensions? I feel like people are actually talking on different planes at times. Maybe if you got that set, I think some of the rest of it would flow better.

CO-CHAIR CHIN: Maybe you can explain

that again, Helen, just to make sure we're on the same page.

DR. BURSTIN: I just heard multiple levels of things like it's the level from community to patient. No, it's the level of -- it's some of these key factors. I feel like there's -- it sounds like there's probably a dimension of this that does kind of cross the layers. Then they don't need to be in the domains. They could be separate. And then what would be left in the domains could always then reflect whatever you think that key dimension is. Does that make sense?

MEMBER RAUNER: We assumed that was your job to make it all clear for us.

(Laughter.)

DR. BURSTIN: I can't make into a slide. I can't figure out like the third dimension.

CO-CHAIR CHIN: I'm actually going to ask the staff, because they're the ones that are going to take the first crack at it and then

coming up with like a more detailed plan.

CO-CHAIR PONCE: We did have a break scheduled, so why don't we take a break and --

(Laughter.)

(Simultaneous speaking.)

CO-CHAIR PONCE: Yeah, can we just take the -- we're supposed to give them 15 now anyway, so we could give them 15.

CO-CHAIR CHIN: A 15-minute break. So maybe come -- meet again at 3:30?

CO-CHAIR PONCE: Sure.

CO-CHAIR CHIN: Okay. Great.

(Whereupon, the above-entitled matter went off the record at 3:15 p.m. and resumed at 3:43 p.m.)

CO-CHAIR CHIN: Okay. Thanks, everyone. We had sort of a quick brainstorming session that involved the NQF staff team: Helen, I think Ignatius was there, Ninez and I.

And so we're going to show four main slides that are almost like sequential that are our first crack at at least trying to condense

some of the ideas people had. And then we need to still sort of work on it as a team here. The four being: measurement domains -- in some ways that was the original thing we had done the breakouts for, to try to come up with measurement domains. And so we tried to put them all down from the five different groups onto one slide and collapse in common categories.

A second is the level of focus, which will look more similar to like the original six different levels in our socio-ecological model.

Third downstream is going to be accountable entities. Again, downstream NQF has these performance measures and CMS has accountable entities that will then submit their metrics and then be accountable for them.

And then the last is again to summarize that the downstream are going to be the policy levers and the recommendations that we'll eventually make as a committee about how this all fits together and how we can use these levers to increase equity.

So that's sort of like the four. You almost visualize like these four slides if they were situated left to right, because this is almost sequential in terms of sort of the thinking.

So first is the most complicated one.

Maybe go to that slide, Madison. So this was the attempt to put down all the major domains from the five different breakouts.

MEMBER SCHOLLE: This is Sarah. Sorry, I'm on the phone. Is it being projected on the WebEx?

DR. BURSTIN: Is it being projected? Could it be or should we just send it to her?

We're taking care of that now, Sarah. It was very quick on the sly --

MEMBER SCHOLLE: No, I get it. Thank you, though.

CO-CHAIR CHIN: In fact, what we'll do, why don't we like go through the four, five slides quickly and then go back to this one, just so people get a sense of the overall layout.

So you see that this one has the individual domains. So this is the closest to like the lists that were on the white sheets that East Group had come out with. And we'll come back to this in more detail in a moment.

The next slide is -- so next slide. So these are the amended six levels with the addition of now family social network in between patient and clinician.

Next. We kind of wanted -- again, the way to think about this is to like think about the different CMS programs and the different entities that potentially could be a measurement for, so I mentioned clinicians on the bottom, hospitals, health plans, ACOs. You could have these higher aggregates. For example, like regions and states could be accountable. They could be national measures, too. So CMS could be accountable. Accountable entities.

MEMBER SANCHEZ: Can you back that up for a second? I'm just -- and so can I talk out-loud? So, regional and state is bigger than a

community or city/county level? Are you including that and capturing that or not? I mean --

DR. BURSTIN: We were not that precise. We're happy to add that level of precision. We just literally just threw up regional and started throwing stuff around.

CO-CHAIR CHIN: This one was 20 seconds per slide.

MEMBER SANCHEZ: I think back to the point of the -- at city/county level, now you have a local health department that has some responsibility for some of those issues.

CO-CHAIR CHIN: That's a great point.

DR. BURSTIN: Yes, thank you.

CO-CHAIR PONCE: Emilio and Philip?

MEMBER CARRILLO: Regulatory entities, such as NCQA for the patient-centered medical home, which is quite important, and The Joint Commission for hospitals.

DR. BURSTIN: As accountable entities? So we're thinking about accountable as those who

would be measured.

MEMBER CARRILLO: Yeah, they're the ones who basically would pass a hospital, give it its certification. The NCQA would give ambulatory sites certification as medical home. So that could be a very important lever driver. And they are accountable entities in the sense that they regulate and provide incentives, positive and negative, for things which could and should include -- and for example, The Joint Commission does look at language services as a very important part of their review.

CO-CHAIR CHIN: And maybe like the next one -- actually go to the last slide, that we don't have here right now, but the last slide was going to be policy levers. So that there's all the -- .

MEMBER CARRILLO: That's better.

CO-CHAIR CHIN: We have like the immediate ones. So like the CMS' value-based person programs, pay-for-performance programs, public reporting.

CO-CHAIR PONCE: Sorry, Philip, are you on this point?

MEMBER ALBERTI: Just a quick question for clarification. We've discussed a lot today kind of a dual charge to, A, think more broadly, so kind of beyond NQF/CMS work, but also to then focus maybe back in on what we could actually suggest.

So some of my comments that I would like to make I'm not making because I'm worried that they're too far afield. So for accountable or entity, community, patients, we're not going to -- you might not measure them, right? They're not accountable to NQF or CMS, but they're certainly accountable in all of this larger conversation. So there are certain policy levers that aren't CMS-able or NQF-able that also are at play here.

So are we going for kind of the very targeted, specific recommendations for this piece of the roadmap or really kind of expanding this conversation? Because I thought we taking about

a broader, kind of the whole enchilada from which we'll kind of then pare down later.

MS. O'ROURKE: Do you want me to try to take that and --

CO-CHAIR CHIN: Yeah, go ahead.

MS. O'ROURKE: So I think perhaps for now let's put it all out there. I guess I was almost thinking, could we do two types of entities: accountable and supporting, to capture the role of organizations like CMS that might not be directly measured, the patient, to Ron Copeland's point about medical schools, where do they fit in? Emilio, your point about accreditation organizations and what they could do.

But we're not, at least in the charge of NQF, measuring those entities as a role there -- because I think we'd like to get it all out there for the roadmap about everything we could do and then focus in on for each of these entities what could you concretely measure through a policy program?

MEMBER ALBERTI: Thanks. That's helpful.

CO-CHAIR CHIN: Why don't we go back to the mechanism slide? That was the complicated one. I think it's the one that needs the most work where again we basically tried to put down the individual points on the five or six -- five sheets that each group had come up with and tried to do some lumping. So these are the measurement domains. And so I guess either -- I guess a number of different -- well, actually, before we open it up, Helen, you did like some of the lumping. Do you want to talk a little bit about the lumping that isn't color-coded here?

DR. BURSTIN: Yeah, and some of it's behind Drew's head over there. We started looking at and it seemed like things like system preparedness could potentially be nicely lumped with -- I'm sorry, Drew, could you move?

(Laughter.)

DR. BURSTIN: Thank you. Thank you. No, that's fine. I think it's fine there. Yes.

So thank you, yes. He'll play Vanna White. So, yes. System preparedness potentially has a lot of the same elements as this institutional culture and structures for equity. There was clearly something about both access to quality care and then provision of care. There was very much something about leadership and leadership accountability. And you could see several of the others listed there.

We specifically added environment in here because it was absent from the older cultural competency sort of orientation. And some of the rest of these may wind up being sub-domains. So we just wanted to put them all up there for you so you could see them. Several different groups, the one with stars are the ones that came up multiple times. Something about communication, something about community engagement, something about workforce diversity.

So there's a lot of similar themes in there. We think we probably could, with your help, maybe get to five or six of them. They

don't look like there's really 15 of them. I think a lot of them would logically collapse. So we thought before you put there back out there to define any of these, it might be useful to have a broader conversation. Is that what the thinking was?

CO-CHAIR CHIN: Yes, so maybe if we can blow that back up, just this last slide so maybe we can see it better.

So at this point maybe the first sets of feedbacks are things like -- so for instance, are things like missing? Do you see other ways to lump? Again, we don't have to get it all the way down, the staff's going to be able to work on it further, but get them in range.

So, yes?

MEMBER BERNHEIM: Let me make sure I'm understanding the four-slide concept. So I think originally we were thinking we had to go with one version of domains or another, and what you're saying now, if I'm understanding this right, is there's a whole bunch of things we could measure.

There's a bunch of -- what's the next one? There's a bunch of levels, and specifically measured accountable entities. And the levers are sort of ways to measure them, ways to use the measures. And so we're not going back to what we were trying to do before. Now we're just going to sort of stay in those four buckets. Which I'm comfortable with. I just want to make sure I understand.

CO-CHAIR CHIN: Yeah, the four buckets in some ways were -- they were try to help the flow of overall work left between now and September for the Committee. Well, ultimately it's going to be like the -- the last one is going to be like the muddy one in terms of like what are the different recommendations this committee for how to use measurement to improve equity? But sort of sequential, where the one we're on now is like what are we going to measure? The ones that are more proximal. There's the one about the accountable entity. So, the most proximate.

So to Philip's point about like what's the most relevant for NQF and CMS? Well, CMS' programs and would they require then performance reporting? Well, what are these entities? Like the hospital or like the clinician group? So this is basically sort of the flow. So if we just talk about measurement domains in isolation, then it's hard to sort of say, well, yeah, how does it relate to the ultimate goal and what's the ultimate goal?

CO-CHAIR PONCE: Kevin, then Tom.

MEMBER FISCELLA: Couple of things that I didn't see under the measurement that I heard come up. Two are implicit -- or explicitly expressed and the other I think probably is implicit.

One is the issue of segregation of care that I think I heard some of the work groups mention. And related to that is sort of the concentration of disadvantage, which creates a huge challenge and needs, sort of analogous to city school systems. And perhaps related to that

is the issue of how does one then -- and whether this could be a potential measure -- alignment of resources with those needs. So if you have high social needs or high needs to improve the effectiveness of a particular care, do you have the resources, the corresponding resources necessary to do that? So I would add those three.

CO-CHAIR CHIN: Yeah, one thing, which I can't remember the exact list right now, but one of the areas that probably needs to be ballooned out was like the social factors one, which I think probably that was sort of imbedded in there, but that needs to be blown out or made more specific. So actually that's something that would be very be greatly useful of what will be some of the key sub-domains within that very broad social factor domain.

MEMBER BERNHEIM: I see social risk factors under system preparedness. Adverse social risk factors.

DR. BURSTIN: Yeah, those are

different yes.

MEMBER BERNHEIM: But what's he talking about is different.

DR. BURSTIN: Yeah.

MEMBER BERNHEIM: He's not talking about the systems preparedness. He's talking about sort of how people are segregated, right? And then the system can only be so prepared to --

(Simultaneous speaking.)

DR. BURSTIN: I think I tucked that under something, but I can't see what it was. I think it may have been under provision of care, but I think it's an important -- I don't want to lose the concept. It's hard to see the little scribbles. Oh, there it is. I see it. I put it next to the access and provision section. I left segregation. We just forgot to tell Madison on, so she was furiously trying to type up the scribbles.

CO-CHAIR PONCE: Tom?

MEMBER SEQUIST: So I'm just going to keep harping on this. So you have decision-

making, which I assume encompasses bias in decision-making. So I just feel like we should explicitly say that bias is a domain. Like just to destigmatize, I mean, if you were in a patient safety meeting, it would be thrown out immediately. Physicians have bias in their decision-making, right, anchoring, heuristics, or all these other things. I just think it's okay to throw that out there and say physicians have bias in this space as well. If you want to call it a cognitive disposition to respond or whatever.

(Laughter.)

MEMBER SEQUIST: I'm not making that up. That's right out of the safety literature because people didn't want to use the word "bias."

DR. BURSTIN: You can use the word "bias" if you want to use the word "bias."

CO-CHAIR PONCE: Romana?

MEMBER HASNAIN-WYNIA: I agree with Tom, but I would broaden it to clinician. I

mean, we're in the world of team-based care and I would not just say physician.

MEMBER BERNHEIM: Just on that, I might think about putting it under the equitable provision of care, not to hide it, but to make it clear that it's one of the drivers of inequitable provision of care. So it may fit there if you're trying to create categories, but I would agree with you, I would name it.

MEMBER SEQUIST: There were a couple -- I sort of -- I think the decision-making and the equitable provision of care. I thought you had -- Helen, you'd said probably a bunch of these will get collapsed or --

DR. BURSTIN: It's up to you. We would welcome your thoughts. I mean, it seemed like several of them really could be. And maybe one thing we could even do is put these on paper and let you guys have at it, even if you want, later, just to say I think these could be bunched this way.

CO-CHAIR CHIN: Yeah, I mean, right

now there's not a coherent logic to the list and the order it is right now. It sort of is a hodgepodge. So there's going to be probably a ways to both collapse and order so that it makes conceptually more sense.

MR. BAU: So one way that in my head some of this works together, I don't know if this helps or further complicates it, we really are thinking about not the left to right sort of flow of logic, but in some ways a three-dimensional model of saying that these are some topics. And then the question will be, is it appropriate at every of those socio-ecological levels for which there are accountable entities, does it make sense to hold every one of those socio-ecological levels and accountable entities responsible for something like cultural competency? And could we come up with measures at each of those levels and for each of those entities?

So it really is toggling sort of this three-dimensional model. And at some point, I've always thought, especially when we get to the

community level, the policy level, we're not going to have anything to put into those cells because we just haven't thought of those things. And we're going to be much, much more comfortable populating down at the provider level. We're also, I think, going to have very little at the patient level and the family and social network and caregiver level as well, but that is also, I think, useful for a roadmap to say these are all the areas where we need development.

CO-CHAIR CHIN: That's very helpful, Ignatius. And when you look at this particular slide -- like the next slide has some of those dimensions, the different multilevels. When we look at this slide -- yes, this a hard question, but off the top of your head, do you find ways to bring more order to this slide?

DR. BURSTIN: And some of that comes back to your comfort level of being a lumper or a splitter. I mean, again, if you're thinking about access, just to throw it out there, as a domain, I think much of what is out there then

could become sub-domains. You wouldn't want to look at access without considering the segregation issue as an example of a sort of mental model to do that. And I think you can logically start doing some of those around leadership, potentially, and some of the others, but just a way of thinking about it maybe.

MEMBER SCHOLLE: This is Sarah. I'd like to get in the queue when I can.

CO-CHAIR CHIN: Sarah, Eduardo, and then Emilio. Go ahead, Sarah.

MEMBER SCHOLLE: Okay. So I am definitely a lumper. And just reading this, because I missed some of the last discussion, I do see kind of groupings of things that I might want to propose. Like, for example, cultural competence, to me, as a characteristic is about organizational culture and how you interact with -- but also has a piece of interaction with patients and families. And so, I might think of it as there's leadership and responsibility related to that. You get governance under that.

You get policies under that. And then you might have institutional culture and structures for equity. So maybe that becomes one big lump that also includes -- that's more about how the organization is set up.

And in the earlier discussions with Ignatius and Ron we talked about social risk factors and how those fit with addressing those factors. There's a piece of collecting the data, being able to provide services, and then connecting to community services around those topics.

As I look at this, there's always three or four ways to lump and split categories like this that we've done in other measurement frameworks. And so it might be helpful -- one way that might help to think about how we organize these is to say what's the -- what are we trying to get at through this piece? Like what's the outcome we're trying to get at?

And I think different people might want to put these into different groups and I

just wonder if it makes sense to -- at the level of these domains it's hard for me to kind of telegraph exactly -- understand exactly what people were thinking about when they put multi-sector collaboration or gave stratification.

So I wonder if rather than thinking of them as topics, was there a piece of work that -- do we need to go down a little bit to the next level to understand where these are -- how we further define these topics and not allow this to get to groupings, or do we want to group this way and then start to play it out, and then that will tell us what we're missing? You can go either way in a list like this.

CO-CHAIR CHIN: Yes, thanks, Sarah. We got like five people in queue, so let's get the ideas out. Then we can circle back on what may be next steps.

So I think we had Eduardo, Emilio, Bob and then Philip.

CO-CHAIR PONCE: And then Yolanda.

CO-CHAIR CHIN: Oh, Yolanda back

there.

MEMBER SANCHEZ: I'm going to apologize in advance because I'm not sure this is going to make things easier, because I think that the -- when I think about the socio-ecological construct and those domains, not everything -- we'd all agree not everything fits into each of those domains. One in particular would be the access and provision of quality care. That's not going to fall at the patient -- at the person level or even at the family level. And I don't know what the equivalent is, but there are some things where the words we're using suggest some kind of equivalency across those. System preparedness for an individual is going to be readiness for change. It could be. I'm just suggesting.

Decision-making might be lumped with governance when we're talking at one level of the socio-ecological model. In a different place it is very much about patient care, and actually decision-making would belong at a person level as

well when we're thinking about it that way. I would maybe suggest we change "communication and understanding" to "communication and" maybe "comprehension," because the understanding -- I'm almost getting confused with the word "care" as caring about people. And understanding goes both ways, right? It's comprehension and also having a sense of empathy.

And then the community engagement, while it might be similar to multi-sector collaboration, the way I think about community engagement is a little bit like thinking about patient-centeredness. It is about thinking of the community as a partner in what you're doing as opposed to just getting them to be part of a multi-sector collaboration, if that's making any sense.

So I think this is a great start, but we probably need to do a little bit of thinking about the words, the exact words we're using, what they mean, and try to do a little bit of lumping all simultaneously. Probably a dinner

and drink exercise or something.

(Laughter.)

CO-CHAIR CHIN: Yes, great comments. That -- my guess is like some of these were taken straight from the white sheets so that -- which we're only thinking about one level and --

MEMBER SANCHEZ: No, I get that. I mean, I get that we're trying to smash things together that weren't -- that's not the way we constructed them. And we're doing our best.

CO-CHAIR CHIN: Okay. So we had Emilio. Then we got -- I think it was Bob, Philip and Yolanda.

MEMBER CARRILLO: I would lump them into two categories. One of them would be social and cultural and the other one would be system. And the social and cultural would include environment, equitable access, the seven domains that NQF already has looked at.

And in terms of system, I would have system preparedness, multiple sector collaboration, advocacy, equitable provisions.

So that gives some rationale lumping the social and cultural and lumping the system. Just a suggestion.

CO-CHAIR CHIN: Thanks, Emilio.

Bob, Philip, Yolanda.

MEMBER RAUNER: Yes, I'm also kind of a lumper, but I'm trying to figure out how to lump these. And the one thing I was talking a little bit earlier with Mauricio about was maybe using the collective impact model framework where you've already established five party areas for us: cardiovascular disease, cancer, diabetes, and that the main domains, maybe those are the shared measures within those.

And then a lot of these are factors that are going to affect your ability to impact that measure. Then maybe that might be a hierarchy to put them in because a lot of these are going to help you, for example, improve HPV vaccination or colorectal cancer screening. These are all factors that are resulting in disparities or would help to narrow them. I'm

just trying to figure out any way to try to figure out how to lump this and put it in a framework. Maybe collected impact would work, because it has communications as part of it as well and some other things.

CO-CHAIR CHIN: Thanks, Bob.

Philip and then Yolanda.

MEMBER ALBERTI: I'm also going to suggest some radical lumping.

So I think it's also important that we focus all of the lumping domains on equity, right? So here's how I would try to do this. I would have a domain that was culture of equity. I think that involves a lot of the things that Emilio was talking about. Then structure for equity. Then access for equity and care for equity.

And I think across those four domains part of -- a number of the bullets here were actually some of our sub-domains from getting ahead of ourselves, but I think between the cultural structure, access and care all are oriented

toward equity. I think a lot of these plus many of the concepts that aren't on here that we've been flirting with would also potentially fall into one of those four.

CO-CHAIR CHIN: Thanks, Philip.

Yolanda?

MEMBER OGBOLU: So I was going to say definitely there is -- seems to be consensus around having at least one category that focuses at the system level. And I would agree with that.

And then as I looked at the measurement domains, it just struck me that health literacy is missing from this list. And then social cohesion or social capital. So I'm not trying to make the list -- add more to the list, but I mean, those ones just seem like they really should be there to me.

CO-CHAIR CHIN: Yes, and these -- actually some of these -- the labels in some ways need to be broad enough that the sub-domains, like those have a logical home. Yes.

MR. BAU: I have a list of eight.

(Laughter.)

MR. BAU: So mine would be data -- so both at a community level, but also at an individual level, and stratification. So that would be one.

Number two is access, which I think is really important as -- all the issues around access including geographic access.

Three would be workforce diversity and competence and composition. So all the workforce issues.

Four would be the provision of care. That includes bias, but also population health management.

Five would be more the interpersonal communication and shared decision-making processes. That would include literacy, language, access, assistive technologies for individuals with disabilities.

Six would be community engagement, which would more be the role of patients and

consumers in the healthcare system.

Seven would be multi-sectoral collaboration and partnerships in the collective impact space of what is the role of health versus other sectors.

And then I think the hardest as a policy person is eight, which is the public and private policies.

CO-CHAIR CHIN: Yes, these are all helpful. I think we got some good things to work with, and so I think the NQF team will be able to come up with some good options and circle back then to the Committee. This is great.

Well, the next slide is -- so I see -- and moving on to the next slide.

Yes, any comments here? I mean, we see the addition of the family/social network.

Next slide. We haven't talked about this much yet as a group. So this is the capital entity issue, the more narrow charge about specifically for CMS and the measures that are being used for current programs or soon-to-be

programs.

Yes?

MEMBER ALBERTI: I do think just for consistency sake, even if there are some blanks in the model, that if we have a model that has all those levels on the proceeding side that there should be accountable entities within all of those levels.

CO-CHAIR CHIN: Yes.

MEMBER ALBERTI: So if we have a level at the patient level or at the family level, those are still accountable entities even if we're not going to be measuring and publicly holding folks accountable in that space.

CO-CHAIR CHIN: Yes, so what else would you add here to this list?

MEMBER ALBERTI: I think we should draw all the way down. If the levels go down to patient, family and caregiver, we should go down to patient, family and caregiver.

CO-CHAIR CHIN: Tom and Romana? I'm sorry, Tom, Romana and Yolanda, yes.

MEMBER SEQUIST: There was a protest to your left, but she didn't have her --

(Laughter.)

MEMBER SEQUIST: So I wonder on there if we should put in is it accountable entity employers? Big employer groups. So like we think of ourselves as a -- like as a hospital as accountable for our -- the employee -- the health of our employees. And particularly, I mean, there's a lot of diversity in big companies. So it seems like a major pillar of how our health system is sort of set up, because a lot of these people are also paying for all the healthcare, right? All the employers.

CO-CHAIR CHIN: Good. Thanks, Tom.

So Romana?

MEMBER HASNAIN-WYNIA: Can we go back to the previous slide just for a second?

So this is level of focus, and I guess when I see the word "community;" I mean, we see it a lot, but I'm not sure what we mean by "community." So when -- sometimes when I think

community, I think community as a neighborhood. So neighborhood organizations, community-based organizations.

And what is missing here is the focus on the inter-sectoral partnerships. So schools, faith-based. I mean, I'm trying to think of the different -- transportation, housing. And I don't know how to capture that. And I don't know if that's just going to come out in terms of our broader definition or when we start to put a little bit more structure around this that it will come out in that context.

But I do think that we need to distinguish what we mean by "community," which seems like a catch-all versus community and these other organizations where there has been some really good work done in terms of that inter-sectoral collaboration.

CO-CHAIR CHIN: So, while you have the mic there, Romana, so you mentioned the inter-sectoral part, so that other -- so the non-traditional health sectors. You mentioned

neighborhood level. Anything else you would want to have -- put in the mix?

MEMBER HASNAIN-WYNIA: Not at this point. I think those are the two that just came to mind.

CO-CHAIR CHIN: Okay. Great.

CO-CHAIR PONCE: So that was actually -- my point was what -- where would schools fit, for example? And where -- although -- and also what if what we come up with does not really have a policy handle or accountability factor? So are we being aspirational or are we then prescribed to where we know it's within the jurisdiction of a public -- a local public health organization, county health organization? So that was must my thinking.

CO-CHAIR CHIN: I like what Philip said, if I get this point, keeping broad. There may be a general model that -- just like the model for everything. And then I think rapidly CMS and staff are going to sort of -- like we have a September deadline and what's the

immediate priority for what our charge is? But this will again be a nice foundation for both the September report as well as ongoing work beyond that.

CO-CHAIR PONCE: Emilio?

MEMBER CARRILLO: I would add to the level of focus population, because population could be taxi drivers in New York, population could be nursing home residents. It could be geographic. And that's the term of art right now in terms of how we look at a lot of health improvement.

CO-CHAIR PONCE: I initially agree, but I'm also seeing maybe -- I'm feeling there's discussion on this.

Helen?

DR. BURSTIN: Just listening to what everybody's been saying, it seems like -- I'm just going to try to be very lumpy, so keep that in mind.

(Laughter.)

DR. BURSTIN: It seems like there's

something around data and identification of social risk or social factors, whatever. Something around the data piece that goes into social risk factors. There's something about environment and access to care. We keep coming back to lots of things could fit under there, playing off of Philip's list. Something around structure, which could include workforce diversity and competence.

And then something, which we haven't really -- is just quality, provision of high-quality care. I think some of which is interpersonal communication, health literacy. Some of those issues could get factored under there. I'm still left not sure exactly what to do with this multi-sectoral collaboration because I think it's really unique and important to this space, but at least to me it sounds like much of what we've talked about sort of fit under those four. But we could certainly play with it tonight. We'd love your reactions.

Something around data environment --

data and identification of social risk. That's sort of one bucket. Environment and access to care is a second. Third, something around structural workforce diversity and competence. And a fourth around provision of high-quality care, keeping in mind many sub-domains could help us really kind of make those sing.

CO-CHAIR PONCE: Susannah, Eduardo, then Bob.

MEMBER BERNHEIM: On the coordination piece, I don't know what the right category is, but when the -- maybe I'm not remembering, so but I feel like when the IOM wrote what they could about what was known about affected interventions that that was really one of the pieces is this collaboration. So I -- and I agree with you, it doesn't feel like it's falling in. It's this sort of expanding the walls of the institution and make sure that there's coordination between these issues. So I think that can get lost. I'm not sure that that can get subverted into those four.

And on the quality I'm fine with that being a big lump, but I just want to -- this issue of sort of patients' experience, not just sort of cultural competence or if the provider checks the box, but the experience the patient has walking into a clinic and whether or not it feels like a place that is welcoming. And we just want to make sure that stays -- if it doesn't have its own bucket, that it stays in the quality bucket, the experience of discrimination or what have you.

CO-CHAIR PONCE: Eduardo?

MEMBER SANCHEZ: Helen, to the point that you made about multi-sectoral collaboration, I could think of things that would belong there that don't necessarily -- so one might be the transportation system, having a bus route that assures that people can get off at clinics and other social services places. And even the level of accountability is a very different kind of thing than say assuring that the YMCA and the clinic systems have some connectivity around

people with diabetes, with pre-diabetes, right? That's an extension of the clinical care system.

And the transportation is but one example, but there are probably many. And we would want to figure out how you capture those, because even again the notion of accountability is going to be a very different level of accountability than the YMCA delivering DPP well on behalf of patients.

MEMBER RAUNER: I was going to point out some things that are mentioned that I think are often overlooked sources of the health data, one being the schools. So for example, Lincoln, 85 percent of their kids are in the school system. The school nurses collect weight screening. They do vaccination reporting. They track that. The PE teachers do FitnessGram, which gives you great aerobic fitness measures. All of it's stratifiable on race, ethnicity, income status with reduced-cost lunch. And so sometimes the schools I think is an overlooked source of health data.

The other thing, like Tom mentioned, with employers, if you have a self-insured employer that's doing employee wellness and has an on-site clinic, a lot of what they're doing is very similar to what an ACO is doing. And our community our ACO efforts are starting to run into our self-insured employee efforts in a good way, but it's kind of interesting how these are coming together. And so employer and school data is often another source of health data that's overlooked.

CO-CHAIR PONCE: Thank you.

Philip?

MEMBER ALBERTI: Just to add a bit more detail on the collaboration conversation. We spent a lot of time talking about that in our group, and I think part of the problem we're having is we never -- we didn't use the word "multi-sectoral" in the larger domain. So we thought about again collaboration across all those levels. That could be the shared decision-making between patient and provider all the way

up through the kind of multi-sector collaborations that Eduardo was talking about or kind of the learning health system collaborations within the institution. So perhaps if we save the multi-sectoral for that kind of highest level of collaboration. But there's many different other levels kind of below that where entities and individuals can collaborate as a domain.

DR. BURSTIN: And maybe just collaboration as a domain --

MEMBER ALBERTI: Yes. Yes.

DR. BURSTIN: -- that much of this stuff could fit under.

CO-CHAIR CHIN: So a request from Erin that we go back to that first slide that had the domains. I'd ask Erin what does she and her team need to -- most need? They're going to try to actually come up with a strawman set of collapsed domain categories tonight to show to us tomorrow.

When we look at this raw one here with all the different ones, are there any key things that are already missing beyond what people have

already said. I remember that Yolanda mentioned a couple things. I'll just mention a couple things. Anything else missing that people want to put on the table now?

CO-CHAIR PONCE: Kevin?

MEMBER FISCELLA: Yes, Philip mentioned the idea of a learning health system, and I think that that whole principle of learning and the cycle of having a goal, planning, action steps, reflection, sharing, learning from others and then regrouping and again adapting to hit that target -- I think that that encapsulated -- and call it improvement in a PDA cycle really applies across all levels, whether it's the -- a patient doing their own self-management planning and figuring out what works or not, it's all the way up to high levels of government where one is learning from what one's done based on the data.

And I think that the robustness of that sort of complex adaptive system of learning is almost fundamental to change and being able to enact stated priorities, in this case health and

healthcare equity.

And so I mean, I could see where maybe you could group it under maybe system preparedness, but I think it's really perhaps more fundamental because it's one of the things that we would want to incentivize. I think ultimately it's not going to be finding some off-the-table intervention and applying it there. It's -- we know that context is everything. And it's really going to be how robust is that system for learning from others and adapting and engaging a continuous learning cycle.

CO-CHAIR CHIN: Yes, of course this would be like in the original strawman it was a culturally tailored QI component with the idea that it's going to be a continuous process, it's going to be tailored for equity, this learning healthcare system.

MEMBER FISCELLA: And across all levels.

CO-CHAIR CHIN: Yes. Yes.

MEMBER FISCELLA: Yes.

CO-CHAIR PONCE: Christie?

MEMBER TEIGLAND: I just want to throw out again the concept of value here because we all know logically that improved outcomes should lead to value, but it doesn't always. And the example I gave in our group discussion was we're working on this study of air transport, and particularly from a rural area we can't show value, but we know there's great value to those patients who receive it, but it's never going to pay for itself, even though the outcome could be that person won't die versus they do, right? But it's that you can show value if it's a -- within a city or something like that.

And when we're talking about issues like transportation and we're making these collective decisions, it's always going to come down to who's paying for that. Who's responsible for making sure the bus -- who's paying for that, right? So how do we incorporate the value structures into this to make sure in practice and in the world we live in it can happen, right?

And I'm not sure what the answer is.

CO-CHAIR CHIN: Can you define "value?" Like what you're getting at. This is the age-old question, but just to make sure we all understand what you mean by "value" here.

MEMBER TEIGLAND: Yes, I really mean showing cost-benefit value that are the questions that payers always get asked that lots of programs are structured around now from the Pioneer shared savings programs. They're all value-based care. All of those demonstration projects that are going on. It comes down to, yes, what does it cost and can you show us that it's worth it, the money we're spending.

CO-CHAIR PONCE: Isn't ASPE doing some simulations that address some of the value of addressing social risk factors? I thought that was the next phase.

CO-CHAIR CHIN: I think they were -- they're doing simulations. It was in something like -- when Karen gave her presentation, they were doing simulations showing things like, well,

who benefitted, who it harmed and what the cost was to like safety net hospitals, that type of thing. So a little bit different than --

CO-CHAIR PONCE: Different -- I guess I'm saying I think we need to be mindful of that, but that's also -- I'm not sure we can incorporate it. I mean, or -- that's either implicit here or they'll be I think more difficult to incorporate now explicitly.

Kevin?

MEMBER FISCELLA: One other thing I want to come back to; I was reminded when I saw the telehealth measures early on, which is the issue of economic burden. I really do think we need to call that out as a special measurement domain. I mean, it's only going to get bigger regardless of what happens with healthcare reform. I think it was the census data that said -- that reported that only about half of Americans have a little more than $400 in the case of an emergency. And with out-of-pocket payments and premiums and so on like to continue

to go up, I think we need a measure of economic burden and perhaps even some sort of ratio of economic burden relative to income or something like that. But I think we really do need to track that over time.

CO-CHAIR PONCE: Okay. Noted.

I want to go back to the value proposition, Christie, just because I think your example then that worries me that we're not going to have value for smaller rarer populations or populations where it's really expensive, but those may have to be the populations we care about or we don't address their needs. So if you start out with that economic value as a domain, then it might have a -- it might be counter to what we're trying to do in terms of equity preparedness.

MEMBER TEIGLAND: No, I agree, but it's bound to run into each other eventually, I think.

CO-CHAIR PONCE: Yes.

MEMBER TEIGLAND: It's -- I mean, the

same thing is happening with the Affordable Care Act and the expansion of Medicaid. Who's being affected most? Those most vulnerable populations, those most disadvantaged populations who don't have -- whose economic benefit ratio is so --

CO-CHAIR PONCE: Is the highest, yes.

MEMBER TEIGLAND: Right? But then it's happening.

CO-CHAIR PONCE: Nancy?

MEMBER GARRETT: So two points: One is the concept of concentration of social risk factors. I don't think that's -- that's indicated there by segregation under equitable provision of care, but I'm not thinking of that as a subset of equitable provision of care. And that's certainly one example, but I think that's a bigger category. I think there's more in there. It has to do with how resources are distributed across providers. It has to do -- there's good things about concentration of social factors.

For example, if you have a lot of speakers of a particular language at one provider, then you can better provide care to them. So it's not a value judgment of good or bad. It's more of a thing that I think we need to measure in order to understand disparity. So I guess I would just argue that that's a separate category.

And then another thing that I wonder if we're missing is about cost. And the way that we have measured cost so far is really around cost to a payer, but what does it really cost to reduce disparities from the perspective of things that are not reimbursed that might be happening at a provider as well as the whole social services sector, and what does it take to really address disparities from that bigger picture of medical care and social needs? And in order to truly address disparities, it seems like we have to know what it costs so that we can make the investments.

MEMBER TEIGLAND: Exactly my point.

CO-CHAIR PONCE: So that would be -- so, okay. So that would be societal cost?

Traci?

MEMBER FERGUSON: And I think to add to that is when you're talking about those patients who it will save that one individual in terms of their life, whether we get to a point where we know that there's going to be a very huge financial impact that -- going up to the policy level of just deciding these are a class of individuals that become a protected class so that we have -- in terms of like end-stage renal disease and how they are -- you have end-stage renal disease, that will qualify you for Medicare. So we define certain groups or certain entities that because of the cost to implement these strategies would be so onerous that it may require or we can highly recommend there is a policy to add them as a protected class.

CO-CHAIR PONCE: Noted. Thank you.

Any more splitters here in the group?

(Laughter.)

CO-CHAIR PONCE: So I see health literacy is there. I think social cohesion was noted also by Yolanda. Social cohesion, social capital. Economic burden was noted by Kevin. And then I'm going to call it value in societal cost. Is that fair?

Susannah?

MEMBER BERNHEIM: I'm a lumper, so I'm going to try and --

CO-CHAIR PONCE: Okay.

MEMBER BERNHEIM: -- not lump those things.

CO-CHAIR PONCE: You just sit. Okay. So a lot of what -- there was a category -- when Helen was creating sort of mite-categories, there was one about collection of information. So I think to the extent that the issues around segregation, both of institutions and of groups -- concentrations of populations -- that can be an important sub-domain of collection, right? So if we're trying to understand data, we're not just trying to understand a patient's background,

but we're trying to understand the way patients are aggregated and the way institutions are aggregated. So I'm just trying to help you. I'm just suggesting that those don't need to be their own domains if you use Helen's initial system.

DR. BURSTIN: I just called it data and social risk, just sort of a broader category.

MEMBER BERNHEIM: Right, so that we're trying to -- if we're trying to -- if one of our categories is sort of are we collecting information about social risk, I think collecting information about communities and how they're organized could fit into that, and that way we're representing that concept without creating another domain.

And similarly, I think the financial burden ones, you really can imagine them at all levels, right? So the concept of financial burden for an individual who may or may not be able to stand it, is parallel to financial burden for a institution that may have to invest more in certain activities. So I feel like you could

also lump -- I think you were getting at that with value, but I think you could put those into a single domain with this idea that you're going to measure this at different levels. So just one thing.

CO-CHAIR PONCE: You talk about learning from different communities. So did I miss -- was it Kevin's point or Phil's point on learning -- I think Kevin's point on learning from each other on interventions or -- could you restate it again?

MEMBER FISCELLA: Yes, it's a combination of culture and processes and infrastructure that allows one to learn and move ahead from a -- structured experiences and processes that I think occurs at all levels and the robustness stuff that often will affect whether an entity is able to actually do what they say they're going to do, even sometimes when they want to do it but doesn't have the resources.

MEMBER BERNHEIM: I think I may have

confused you because I may have credited to Kevin that maybe was mis-credited. So I was -- that concept of sort of --

CO-CHAIR PONCE: Was different, yes.

MEMBER BERNHEIM: -- yes, of quality improvement and learning from different institutions about addressing these issues, I was not trying to lump --

(Simultaneous speaking.)

CO-CHAIR PONCE: So that's a separate QI, yes.

MEMBER BERNHEIM: Right, it was -- people brought up these issues of how -- the composition of communities, the segregation of communities, both of the individuals within the community -- Nancy, was that you? I'm sorry. Now, I don't remember who said it. But I was just saying that to me is as important, understanding how patients and persons and families are grouped and not just the individuals, that that's part of data collection. And similarly how populations feed into

hospitals. So understanding the composition of populations as part of the data piece.

(Simultaneous speaking.)

CO-CHAIR PONCE: And the social capital of patients, too.

MEMBER BERNHEIM: Yes, exactly.

CO-CHAIR PONCE: Emilio?

MEMBER CARRILLO: It's been mentioned, but I don't see it in -- sort of in this splitting process, patient experience, which is an important measure established and something that we should look at.

CO-CHAIR PONCE: Right, I think Susannah said that earlier, too.

MEMBER CARRILLO: Yes.

CO-CHAIR PONCE: So we should make sure we have patient experience.

I think the longer we go, we're going to become more splitters.

(Laughter.)

CO-CHAIR CHIN: So what we're thinking in terms of -- okay, remind you of -- yes?

MEMBER HASNAIN-WYNIA: So I'm just curious. So I'm looking at the third bullet, the social risk factors, and wondering -- maybe I missed the conversation on this, but what happened to the cumulative structural disadvantage, because those have very different measurement, right? So I don't know why it's not here.

DR. BURSTIN: Just those wound up being sort of under the top level things on that sheet. We didn't lose them. We just kind of --

MEMBER HASNAIN-WYNIA: Okay. All right.

DR. BURSTIN: -- scribbled them on the side.

MEMBER HASNAIN-WYNIA: Okay.

DR. BURSTIN: But again, I guess the question back for you is if you focused on social risk and data, would that be a potential sub-domain that you would want to make sure you capture?

MEMBER HASNAIN-WYNIA: I think so. I

mean, this was a recommendation in our group by Lisa, and I think it really is a very important measurement. Maybe it's the -- it's where we want to make sure we're going in the future, so I think it's important to include it as a sub-domain.

CO-CHAIR PONCE: Definitely.

CO-CHAIR CHIN: Thanks, Romana.

So where we're at now is that we have -- we'd ask for public comments again so that -- give people the opportunity. What we're thinking then is that it's been a long day. You guys have been amazing. It's been a great discussion today. Really far-ranging and I think really, really fruitful.

We're going to -- I think the staff is immediately after going to take a crack at trying to collapse down to an abbreviated set of domain categories. If anyone wants to join us, they're welcome.

Then tomorrow, like on the agenda -- so we have it what, starting at 9:00, I believe.

Breakfast at 9:00. You'll see that at 9:45 the original item was to update the conceptual model framework. This is the one that -- this is the slide that has like the measurement cycle circle at the top and then you have like -- then like policy actions you can take and then outcomes at the bottom.

We're thinking as opposed to doing that, which some people seemed to think was in pretty good shape as it, replacing that then spending an hour then going over the strawman that staff comes up with tonight so that we get another crack at it here in the in-person meeting. I think we have more opportunities on the phone and by email, but that will give us another hour in person to really get pretty far along with it, probably, so that by the end of that hour then we're probably going to be in pretty good shape then for staff to develop further.

Anything else, Erin? Okay. Go ahead, Erin.

MS. O'ROURKE: So just to get back a little time, if people would be amenable to -- we'll start breakfast at 8:30 and we'll actually start the meeting at 9:00 to get a little more time so that we can cover some of the work we wanted to do around defining the domains precisely and then starting to think of measure concepts. I don't know that we need to go all the way into prioritization, but to at least spend some time with the Committee getting concepts on the table.

So if we could, I think we'll take public comments and adjourn for now. There will be details on the dinner before we do that. And then please come back at 8:30 for breakfast and we'll start promptly at 9:00.

CO-CHAIR PONCE: We're open for public comments on the phone.

OPERATOR: If you would like to make a public comment, please press star, one.

(Pause.)

OPERATOR: And there are no public

comments at this time.

CO-CHAIR CHIN: Thank you. And we're open for public comments for those who have joined us in the room.

DR. UCHENDU: Uchenna Uchendu, Department of Veterans Affairs, Office of Health Equity. Just want to say this is great work, but just the discourse today has been very heartwarming, and I appreciate the opportunity also to join one of the brainstorming groups and the discussion. I'm looking forward to the product of this work. The definitions definitely will be very important, that we are talking about the same thing, because there's a lot of activity in the health equity space and population health. And a few of the words get thrown together and sometimes we lose sight.

And then the other piece would be taking into account the political climate and all the discourse that's going around in the country. How do you delicately enough make this continue to be relevant, but also model the inclusion that

we are working toward in health equity.

CO-CHAIR PONCE: Thank you. Thank you, Uche.

I believe we can adjourn at this point. Thank you for all your hard work.

(Whereupon, the above-entitled matter went off the record at 4:45 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Disparities Standing Committee

Before: NQF

Date: 03-27-17

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

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Court Reporter