

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, LL.M., 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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1 P-R-O-C-E-E-D-I-N-G-S

2 (9:34 a.m.)

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

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

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

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

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

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

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

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

12 MS. O'ROURKE: Harmony.

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

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

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

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

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

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

18 CO-CHAIR PONCE: No tilde, just Ninez.

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

21 (Laughter.)

22 (Simultaneous speaking.)

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

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

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

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

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

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

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

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

7 (Laughter.)

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

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

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

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

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

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

1 implementing, utilizing, evidence-based measures.

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

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

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

22 And what we have the next day and

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

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

11 Thanks.

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

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

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

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

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

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

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

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

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

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

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

1 regardless.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 very qualified health centers in the Roxbury
2 area.

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

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

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

1 individuals with disabilities, rural populations,
2 and so forth.

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

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

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

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

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

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

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

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

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

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

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

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

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

22 Avalere Health was purchased by

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

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

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

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

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

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

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

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

22 And so through that work we have been

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

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

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

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

22 And then at NQF I also have the

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

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

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

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

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

22 You know, if you look at them compared

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

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

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

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

1 quality improvement programs and also have done
2 some other things.

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

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

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

15 So that will be helpful to this
16 Committee.

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

22 I don't think I have any conflicts to

1 disclose as it relates to the conversation we are
2 having. I will say that we, like so many other
3 organizations, have vigorously embraced not only
4 the notion of but the importance of being mindful
5 of the concept of health equity and the desire to
6 achieve health equity but with that comes a)
7 understanding what that is, and we are involved
8 in that, not only for staff but also for the
9 30,000 or so researchers and others who consider
10 themselves members of the American Heart
11 Association who are conducting research and/or
12 doing clinical work.

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

22 So not only trying to build capacity

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

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

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

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

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

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

4 MEMBER COPELAND: Yes, I am. Good
5 morning.

6 DR. BURSTIN: Good morning.

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

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

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

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

22 The internal conversation we are

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

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

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

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

19 MEMBER NERENZ: Yes, David Nerenz
20 here.

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

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

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

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

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

22 DR. BURSTIN: Great, thanks. Any

1 other Committee members on the phone?

2 (No response.)

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

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

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

22 So we are just delighted to have all

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

3 MS. O'ROURKE: Next slide.

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

6 MS. O'ROURKE: You are.

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

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

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

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

1 the past.

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

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

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

14 DR. BURSTIN: Yes, true.

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

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

1 can't impose our language on you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 Next slide. Am I continuing?

22 CO-CHAIR CHIN: Yes.

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

3 (Laughter.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 it.

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

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

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

14 CO-CHAIR PONCE: Kevin had a question.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 interventions to reduce disparities.

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

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

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

22 After that we will be shifting a

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

4 Yes?

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

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

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

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

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

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

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

21 Yes. Good.

22 MEMBER RAUNER: Are we looking for

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

5 Okay.

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

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

14 DR. BURSTIN: Romana?

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

21 CO-CHAIR CHIN: Yes.

22 MEMBER HASNAIN-WYNIA: But I also

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

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

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

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

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

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

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

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

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

1 distal process and outcome measures.

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

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

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

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

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

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

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

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

22 It gets back to Kevin's point about

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

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

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

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

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

5 DR. BURSTIN: Right.

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

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

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

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

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

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

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

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

22 You know, do we have a portfolio of

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

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

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

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

22 The first step, as Marshall was

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

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

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

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

22 CO-CHAIR CHIN: Yes. Part of the

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

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

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

1 incentivized in payment programs.

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

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

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

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

1 Romana. And Bob concedes to Emilio.

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

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

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

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

1 around providing interpreters for individuals
2 with limited English proficiency.

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

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

12 DR. BURSTIN: Yes.

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

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

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

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

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

1 achieve that. Erin?

2 CO-CHAIR PONCE: Can I --

3 CO-CHAIR CHIN: Yes, go ahead.

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

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

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

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

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

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

14 CO-CHAIR PONCE: Susannah?

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

17 (Simultaneous speaking.)

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

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

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

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

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

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

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

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

1 of the domains.

2 CO-CHAIR PONCE: Noted. And Philip?

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

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

1 equity conversation.

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

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

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

22 MEMBER RAUNER: And -- and maybe this

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

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

14 The problem -- one of the problems is
15 that it -- a common way of verifying it is claims
16 data, and claims data has a couple problems. One
17 is it is often incomplete. It may be off by 15,
18 20 percent. And claims does not have any of the
19 SDS things we are looking at like race,
20 ethnicity, language barrier. So there is a
21 potential great area, which is EHR-based
22 measures, because it is -- well, assuming we can

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

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

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

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

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

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

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

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

8 CO-CHAIR PONCE: Oh, sorry. Yolanda?

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

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

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

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

10 CO-CHAIR PONCE: Thanks, Yolanda.

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

1 connections.

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

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

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

1 and the residential and community context.

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

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

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

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

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

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

22 Just a quick overview of Report 1:

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

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

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

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

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

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

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

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

22 Report 2, the final version of Report

1 2 was submitted last week. Thank you all for
2 your input on this. The purpose of the second
3 report was to look at existing effective
4 interventions to reduce disparities in the five
5 selected condition areas. We focused on existing
6 systematic reviews and other literature reviews
7 already in existence to find those interventions.
8 We identified many cross-cutting interventions
9 that did not stay within one of the condition
10 areas, and we used the selected conditions as
11 illustrative examples, types of common
12 interventions, to paint the picture. We
13 organized these interventions by the level at
14 which we operate and found a good variation
15 there.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 MS. MURPHY: Sure.

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

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

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

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

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

16 CO-CHAIR PONCE: Emilio, then Bob.

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

1 20, 30 percent.

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

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

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

22 I think also when Erin goes over some

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

10 CO-CHAIR PONCE: Bob, then Philip.

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

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

1 (Laughter.)

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

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

6 MS. O'ROURKE: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 MEMBER FERGUSON: So I think what

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

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

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

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

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

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

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

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

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

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

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

1 population spending burden, individual
2 engagement, and community engagement.

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

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

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

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

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

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

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

1 lens of the quality issue.

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

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

9 DR. BURSTIN: Please, yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

22 And in general the chatter that I'm

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

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

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

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

1 a sort of higher level accountability measure.

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

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

13 But completely agree.

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

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

22 Even today as part of the exercise,

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

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

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

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

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

1 There is the third grade reading level for kids.

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

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

12 Romana?

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

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

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

1 we have a lot of measures.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 things.

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

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

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

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

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

4 (Laughter.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 CO-CHAIR PONCE: Bob. You've been

1 waiting patiently.

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

7 And they're being used by HRSA EDS.
8 They're being used by MIPS. They're being used
9 by Medicare Shared Savings with focus on the
10 measures.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 And trying to put together some

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

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

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

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

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

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

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

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

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

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

22 These now become part of MIPS. Or

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

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

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

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

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

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

1 disparities, is going to make sense.

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

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

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

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

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

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

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

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

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

1 at their disposal.

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

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

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

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

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

1 this morning.

2 CO-CHAIR PONCE: Thanks Ron. So I
3 just want to check with Erin. How we're doing on
4 --

5 MS. O'ROURKE: Absolutely.

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

8 MS. O'ROURKE: Yes.

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

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

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

22 To just get back on schedule. And

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

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

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

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

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

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

6 So, that's -- Elisa?

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

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

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

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

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

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

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

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

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

22 It was an evidence-based approach in

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

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

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

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

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

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

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

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

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

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

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

1 project. It was a three-year project.

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

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

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

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

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

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

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

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

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

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

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

1 their State and local government.

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

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

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

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

22 In fact there were times we felt

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

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

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

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

22 And for us, one of the things that was

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

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

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

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

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

22 They also were concerned about the

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

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

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

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

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

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

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

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

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

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

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

1 and then do global questions?

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

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

7 CO-CHAIR PONCE: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 One of course is geographic isolation.

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

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

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

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

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

1 think, the crux of the problem.

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

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

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

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

22 And then of course there's shortage

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

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

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

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

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

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

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

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

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

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

1 included in these things.

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

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

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

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

22 Another big issue was risk adjustment.

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

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

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

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

22 The other three sets of

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

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

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

17 CO-CHAIR PONCE: Thanks Karen. Drew?

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

1 and social services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 So, if you go to the next slide. One

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

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

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

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

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

1 services.

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

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

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

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

1 indicate where we're looking at.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 and Pacific Islanders. Next.

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

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

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

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

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

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

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

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

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

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

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

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

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

22 Finally, after that discussion, a

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

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

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

12 MS. O'ROURKE: Maybe --

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

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

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

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

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

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

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

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

22 MEMBER RAUNER: Yes. The answer --

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

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

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

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

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

1 reasons.

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

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

7 CO-CHAIR PONCE: Oh, okay.

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

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

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

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

1 a local store.

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

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

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

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

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

22 CO-CHAIR PONCE: Does Sarah have a

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

5 DR. ANDERSON: Sure.

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

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

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

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

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

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

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

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

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

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

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

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

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

20 So, there was that tension there as
21 well.

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

1 public comment. Let's open that up.

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

5 And there are no public comments from
6 the phone line.

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

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

16 (Whereupon, the above-entitled matter
17 went off the record at 12:17 p.m. and resumed at
18 12:44 p.m.)

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

22 So I just wanted to briefly go over

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

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

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

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

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

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

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

6 And the system provides support for
7 achieving equity. With some subdomains being
8 financial resources and technical assistance.

9 Next slide.

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

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

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

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

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

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

10 At the microsystem level, some domains
11 --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 So please, don't feel tied to them at

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

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

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

12 DR. BURSTIN: So, Eduardo?

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

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

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

1 very different and really more holistic.

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

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

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

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

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

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

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

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

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

22 I just want us not to forget that when

1 you're in a hospital, and a lot of the original
2 disparities and research was about big things
3 that happened to you in the hospital and how we
4 have disparities in that. You know, not being
5 offered major procedures. Things along that
6 line.

7 And those have probably less to do
8 with the social risk factors and a lot to do with
9 something that's not in here. And someone on the
10 phone had mentioned this which is, like you don't
11 see the word bias in here at all.

12 And we're probably afraid a little bit
13 to use the word racism that goes along with bias.
14 But, something in here that gets to that, it's
15 not all about the social risk factors.

16 And it's not all about the community-
17 based measures. And I'm a big fan of that
18 actually. I think it's super important and a
19 direction we all have to go in.

20 But it just seems completely missing
21 the aspect of in our hospitals, these controlled
22 environments, the research from the '80s, you

1 know, that when people really started looking at
2 all this stuff, really started with like big
3 things. Like why are you not getting transplants
4 done? Why is that discussion not happening?

5 So, that just sort of stuck out to me
6 when you went through that. I don't know if it
7 was intentional or not. But I feel like that has
8 to get kind of woven back into this fabric.

9 Marshall, taking on, see if I'm going
10 to -- I can pause there. But --

11 CO-CHAIR CHIN: Well, go ahead Tom.

12 MEMBER SEQUIST: So, and then I had --
13 well gosh. It just jumped out of my head.

14 Well, those are -- those are probably,
15 since I can't remember the last one, it may not
16 have been as important.

17 CO-CHAIR CHIN: Those are all great
18 comments Tom. So since we have like an
19 organizational level one that would be more like
20 clinic and hospital and what not. And we maybe
21 need to consider maybe they're different measures
22 then for the hospital level, clinic level of

1 those organizations.

2 I think the system was meant to be
3 more then the larger thing that you talked about.
4 Like both a U.S. Healthcare System or a State
5 policy or a Federal policy, something like that.

6 You point about like a bias, I think
7 you're right. That in some ways we have the
8 positive wording on the things. Like the
9 cultural competency things, culturally competent.

10 But you're right, that we need to get
11 through that.

12 MEMBER SEQUIST: Well, but the
13 cultural competence is kind of like a bigger
14 umbrella.

15 CO-CHAIR CHIN: Yes.

16 MEMBER SEQUIST: And so you could say
17 I want my organization to be culturally
18 competent. And that my senior VPs have all been
19 educated on what equity is. Why it's important
20 and we dedicate resources to it.

21 It's very different then an individual
22 physician having a conversation with an

1 individual patient and making a decision about
2 their care that's based on a bias that we all
3 have. I mean, no one -- there's no evil here.
4 Right?

5 It's everyone has, you know, their
6 heuristics and their biases based on their own
7 experience.

8 CO-CHAIR CHIN: Yes. We probably just
9 need to think it through and put it on the table.
10 Like Ron had mentioned it in terms of like to
11 have a structural racism. Which may apply to, it
12 could be like the community level or it could be
13 policy level. Yes, both of those probably.

14 MEMBER SEQUIST: Yes. Sort of all
15 different levels. But I just -- it seemed
16 missing. And I'm sorry, I remember the last
17 thing.

18 Which is, should we be distinguishing,
19 there are social risk factors that it strikes me
20 that are very different depending on the setting
21 that you're in. So, -- and I sort of think a lot
22 about the analogy between how we do high risk

1 care management for ACOs let's say.

2 So you pick out the high risk
3 population, which usually refers to cost. So you
4 have this super-duper high risk patient
5 population.

6 You apply a bunch of tools to them,
7 which maybe different then the needs that the
8 other 95 percent of the chronic disease
9 population needs. There are people in the equity
10 space who are, you know, there are patients who
11 are homeless, have severe mental illness and
12 substance use disorders, that create equity
13 problems.

14 And then there's the majority of the
15 population that also has equity problems that
16 just sort of the American-Indian male with
17 diabetes. And doesn't need the same set of
18 measures or resources.

19 I'm thinking about those enabling
20 resources or resources that that high risk
21 population has. And I feel like we need to kind
22 of think about that distinction between those

1 populations.

2 When I think about, you know, the
3 needs that an American-Indian, you know, the work
4 that we do on the Navajo Reservations that are
5 five hundred miles from nowhere. It's very
6 different then the work we do in inner-city
7 Boston around someone who is inside Mass General
8 Hospital. Right? And is struggling with health
9 equity issues.

10 So, I just feel like that distinction
11 also, it would be great to have that somewhere
12 captured in the model. That there are different
13 levels of social risk that contribute to these
14 sort of issues outside the walls of the hospital
15 or the clinic.

16 CO-CHAIR CHIN: A terrific point.
17 Sort of great like some points that Bob raised
18 this morning. As well as the rural report that
19 we heard for example. Great points.

20 And then Eduardo's point, to
21 potentially the patient one. Where maybe it
22 becomes a patient/family/social network. Yes.

1 MEMBER SANCHEZ: And let me just say,
2 I'm calling out care giver as well. You know, I
3 just think that as -- even as I think about
4 reducing disparities, and I think about patient
5 care, so much of what happens is that the person
6 who -- or persons who maybe most a part of all
7 that happens to get to that better health outcome
8 are not always in the conversation that they need
9 to be a part of.

10 And that might be something we even
11 build into. How could we build that expectation
12 as an intervention that potentially gets us to
13 where we're trying to get.

14 And even as I think about the work
15 that has happened at CMS, some conversation about
16 the role of care giver has been part of how
17 they've begun thinking a little bit differently
18 then maybe they did five or ten years ago.

19 CO-CHAIR CHIN: That's a great point
20 Eduardo. So one more general point before we
21 open it up again.

22 That it reminded me that -- Tom's

1 comments reminded me of what Ninez and Erin kept
2 on coming back to like on our planning call.
3 That like sort of like equity needs to be a lens
4 throughout all of this.

5 And so like when you have these six
6 different levels and these different domains and
7 all. But it's actually, I think, kind of -- it
8 could be easy to actually sort of lose that
9 equity lens.

10 Or as you're saying Tom, to lose the
11 context specific things for different situations.
12 So somehow we need to sort of figure out how do
13 we build that in throughout.

14 CO-CHAIR PONCE: Susannah then Bob.
15 And then Lisa.

16 MEMBER BERNHEIM: So I wanted to raise
17 a consideration of flipping this way of dividing
18 the domains on its side. I feel like it would be
19 more intuitive if we said a domain was addressing
20 the social determinants of health.

21 And here's what could do at a provider
22 level. Here's what you could do at a system

1 level. Here's what you do at a policy level.

2 You know, a domain would be, you know,
3 addressing, you know, providing culturally
4 competent care. Here is the kinds of measures
5 you could use that as policy.

6 It's hard for me to sort of kind of do
7 each of those within -- anyway. So, a thought,
8 not to be too disruptive about sort of trying to
9 actually have the domains be more about the
10 levers and the -- within each domain talking
11 about how you could address those levers with
12 measurement at different levels.

13 MEMBER SCHOLLE: This is Sarah. I
14 have a comment when it's my turn.

15 CO-CHAIR PONCE: Go ahead Sarah.

16 MEMBER SCHOLLE: Thank you. I agree
17 with the previous comments. And I think, so I
18 know we're all on the space of thinking about
19 measures that could apply to the States or
20 communities.

21 But that raises an issue about the
22 accountable entity. And it always makes

1 measurement challenging to think about, you know,
2 how do you specify a measure so that when we get
3 into the nitty-gritty it becomes a little more
4 challenging.

5 And so -- and the other piece, I like
6 the framing -- I like this as a starting point to
7 say, does it make -- this helps me to understand
8 better, well what would an individual -- and I
9 don't know if provider means clinician, or like
10 an individual clinician. And measures that would
11 be used in a program like MIPS or something
12 different.

13 But, I do think trying to think about
14 it the way that -- where we say, here's some
15 topic areas. And this is what different entities
16 could do.

17 Or these are the kinds of things we'd
18 want to measure at a population level. Which one
19 might be interested in measuring that at a
20 community, regional, state or national level, but
21 that doesn't translate to -- those entities may
22 not be a report -- responsible in a way that it

1 lends itself to a measure that could be used in a
2 Medicare Advantage, Stars Program or the MIPS
3 Program.

4 So, I'd like to hear some thinking
5 about that. How to translate this into the
6 accountable entity. Because that's what we'll
7 need to do when we go from the measure concept to
8 the measure certification.

9 CO-CHAIR PONCE: Thank you Sarah.
10 Bob, Lisa and then Yolanda.

11 MEMBER RAUNER: I think kind of along
12 the same lines. I think system is part of the
13 problem with this. Because system sometimes
14 implies hospital or health system.

15 But maybe it should be organizational
16 accountability. It's a little more obvious for
17 an accountable characterization. But, you know,
18 an FQHC should define itself not just the
19 patients it takes care of, but hopefully the
20 neighborhood and the MUA they serve.

21 But it might even be an ethnic or
22 neighborhood organization like an African-

1 American or Hispanic organizations are actually
2 taking on the charge of trying to improve cancer
3 screening rates of their constituents even though
4 they're not medical folks.

5 And so I think maybe not use system.
6 But define how you define your population.
7 Whether it's Hispanic or low income or my
8 neighborhood. Maybe that would be a better way.

9 CO-CHAIR PONCE: Okay. Thank you.
10 Lisa?

11 MEMBER IEZZONI: I have a bunch of
12 little tiny responses to everything that's kind
13 of gone before.

14 But first of all, I just wanted to
15 suggest that maybe at some points we don't use
16 the word patient. That we use the word persons.
17 Because I think that that really is going to be a
18 lot more applicable to what we're talking about.

19 The other thing is that I would
20 actually be very hesitant to, without a lot more
21 discussion, fold persons, families, care givers
22 all together. Because I think that that's a

1 very, very complex demographic and interpersonal
2 dynamic that we need to think about.

3 And especially for some people with
4 disabilities. Their families are not necessarily
5 their supports. They can, especially for a young
6 person with intellectual developmental disability
7 who's trying to transition into adulthood, the
8 family could be the impediment to their kind of
9 growing into an adult role.

10 So, I think before we would, as a
11 group, agree to do that, I would want to talk at
12 some length about that.

13 And then the other thing, Tom stepped
14 out of the room, but he was talking about
15 institutional racism. And I agree that that is
16 something that needs to be kind of built into
17 what we're talking about.

18 But I think the more general concept
19 is stigmatization. And I'm writing an editorial
20 right now for a special issue on sexual and
21 reproductive healthcare for people with
22 disabilities. There's 13 articles.

1 Twelve of them are all about
2 stigmatization and terrible discrimination
3 against women with disabilities and their sexual
4 and reproductive health. And the 13th suggests
5 that there are increasing numbers of women with
6 disabilities having babies.

7 Guess what? That number is going to
8 increase going forward. So, I think just the
9 word stigmatization could be a more general word.

10 And then when I first looked at these
11 domains, they all kind of struck me as structural
12 measures. And I didn't -- they're not measures.
13 Sorry. I didn't mean to use that word.

14 But I -- do you think that domains as
15 structures or kind of -- because we've been
16 talking about the classic Donabedian triad of
17 structure, process, outcome.

18 Although remember that Donabedian also
19 looked at interpersonal aspects of care versus
20 technical aspects of care. Which was a second
21 kind of orthogonal set of dimensions that he
22 included.

1 And so it would just be helpful for me
2 conceptually to understand what -- where the
3 domains kind of fit within that Donabedian
4 framework. If the Donabedian framework is
5 relevant. Which it may not be the way that you
6 think about it.

7 CO-CHAIR PONCE: Thanks Lisa.
8 Yolanda?

9 MEMBER OGBOLU: I just wanted to say,
10 when I look at the conceptual frameworks that we
11 used as a background to kind of inform the
12 development of these various levels that you
13 wanted to look at, I think one of the things
14 that's missing from, for example, the social risk
15 factor framework. Which if you look at it, it
16 looks very similar to the WHO Commission on the
17 Social Determinants of Health model.

18 And what's missing from that model
19 when you compare it to the social factors model
20 is that first block. Which focuses on the
21 structural determinants of health.

22 Which is hitting some of the issues

1 that we're talking about in terms of structural
2 racism, bias, looking at the socio-political
3 context of a particular region. That part of the
4 model is missing from that NAM, a social risk
5 factor model.

6 So then we're looking for a place for
7 where to put things like bias and structural
8 racism. Which normally would have fit in that
9 first category, which would have been called the
10 structural determinants of health.

11 So I just -- it's more a comment. But
12 I think some of why it's absent is because this
13 is being driven by the eco-sociological model.

14 And also being driven by that social
15 risk factor model. Which is missing that kind of
16 structural determinant component that looks at
17 those socio-political context. Which a lot of
18 people don't necessarily want to talk about.

19 And then I was thinking and listening
20 all morning about the different domains that
21 we're talking about for health equity. And
22 cultural competency has come up a lot.

1 Social determinants of health also.
2 And then community engagement or community
3 inclusion.

4 And so I guess for me, I starting
5 thinking about how those various buckets so to
6 speak, could be looked at from a measure
7 perspective across policy organizations. And
8 then looking at providers and thinking about
9 payers, hospitals, clinics.

10 But also thinking about health
11 providers, MD, nurses. But, also the movement
12 with community health workers, where do they fit
13 as providers?

14 So, that's just what's some of the
15 thoughts that I had based on the feedback of what
16 we're talking about today.

17 CO-CHAIR PONCE: Thank you, Yolanda.
18 These are all really important thoughts and I was
19 just -- I also was thinking that about the NAM
20 conceptual framework that looks a lot like the
21 WHO social determinants of health framework, but
22 without the structural component.

1 And I also want to note Lisa's
2 question: are these structural domains? And I
3 think when we think of structural, like
4 structural racism, no, they're not. It seems
5 more -- for me it seems like where's the levers
6 at which -- is it the policy level, the community
7 level, the organizational level?

8 And I also wanted to acknowledge what
9 you said about the patients, families and
10 caregivers, because I was also thinking when
11 Eduardo was suggesting that, that they may not
12 necessarily be aligned with the whole interest.
13 There might be some -- they may not necessarily
14 be the best agent for the patient, so it's
15 something to -- I mean, we can look at that as a
16 unit and it's -- and get -- not patients --
17 persons, families -- as you said, persons,
18 families and caregivers to look at that as a
19 unit, but to understand that it's -- they're not
20 necessarily an aligned unit.

21 I think this is an opportunity for us
22 to -- I think having something to argue about is

1 important to give us a structure to do the
2 interactions and the group -- like the group -- I
3 was going to say group projects, for later on for
4 our group projects. Are we randomized by the
5 way? Are we assigning, Uchenna?

6 (Laughter.)

7 CO-CHAIR PONCE: But I also -- it also
8 feels like what we'll be doing will inform our
9 roadmap and conceptual framework so we can --
10 given what people have already said now, and I'm
11 sure there will be more insight after we
12 breakout. We'll come back and then have even
13 more insight on how to come up with a better
14 mousetrap, a better roadmap and understanding
15 that. So this isn't all set in stone, right?

16 MS. O'ROURKE: No, no.

17 CO-CHAIR PONCE: Okay.

18 MS. O'ROURKE: So I think to go with
19 what Ninez was saying, I think a lot of the
20 conversation this morning has been really
21 informative to how we can modify the roadmap,
22 think about the use of these measures, some of

1 the broader big picture things we need to think
2 about.

3 For this first exercise we're hoping
4 to get the Committee through small group work to
5 think about what should be the proposed domains
6 of measurement that we'd like to see. As
7 Susannah was saying, what are those baskets that
8 you'd like to fill up with measures?

9 And the straw person is, as Ninez
10 would say, is really just something to start some
11 arguments about you are welcome to flip it on its
12 side. We could discard the socio-ecological
13 model altogether and not think about it that way.
14 You could add to it. It's really just a starting
15 point for you to do with what you will and just
16 get some conversation flowing.

17 So we've assigned you in two small
18 groups to break out and start to think about --
19 in groups of three or four, so what you would
20 like to see as the domains.

21 CO-CHAIR PONCE: Can I just take the
22 Chair's prerogative to call on Romana again to I

1 think clarify your comment this morning?

2 MEMBER HASNAIN-WYNIA: So I had --

3 CO-CHAIR PONCE: Since I'm in violent
4 agreement with you --

5 MEMBER HASNAIN-WYNIA: Right.

6 CO-CHAIR CHIN: -- as Helen would say.

7 MEMBER HASNAIN-WYNIA: So I had the
8 chance to talk to Ninez and Marshall during the
9 lunch break and realized based on what Ninez said
10 to me and then also Ron's comment on the phone
11 that I probably did not clearly articulate what
12 my point was about measuring disparities in terms
13 of closing the gap versus focusing on improvement
14 of a focus on improving outcomes. So I wanted to
15 clarify that.

16 So the first point of clarification is
17 that I'm not saying that we only focus on
18 improving outcomes and not closing the gap. I
19 absolutely think we have to focus on closing the
20 gap. So what I'm proposing is an either/or -- or
21 both, not either/or.

22 (Laughter.)

1 MEMBER HASNAIN-WYNIA: Rather a both.
2 Sorry. I'm having the lunch time brain numbing,
3 I think.

4 (Laughter.)

5 MEMBER HASNAIN-WYNIA: So I think we
6 need to do both. And the reason that I had
7 brought up in my earlier comment the importance
8 of context is because I -- I'm sure many of you
9 are familiar with the AHRQ evidence synthesis
10 that was released, I think in 2011 or so, that
11 looked at whether quality improvement reduces
12 disparities.

13 So I sat on the technical advisory
14 panel for that. And it was a very small advisory
15 panel. There were only five of us. But it was
16 very clear that there was pretty much unanimous
17 -- there was a -- except for mine, a unanimous
18 vote beyond me that one of the inclusion criteria
19 for the evidence that we included, the papers
20 that we included, included studies that actually
21 had two or more groups, because traditional
22 disparities definition requires looking at two or

1 more groups and showing a closure of the gap. We
2 only ended up after going back maybe 20 years
3 with 17 papers. So the report was pretty
4 inconclusive.

5 So my point is that in certain
6 circumstances as we think about measure
7 development, there are -- and I get back to the
8 -- if we're looking at within hospital or within
9 systems disparities that improving outcomes may
10 be the important focal point. And if we are
11 focused on looking at evidence, we have to be
12 mindful of the evidence that is out there that
13 may not fit the traditional definition of
14 disparities.

15 And I can say that from having spent
16 almost five years at PCORI funding projects to
17 address disparities where until I left we had
18 invested over \$200 million on projects targeting
19 specific disparities populations with a clear
20 recommendation that we were not interested in
21 studies that were going to recruit from two
22 different groups to show a closing of the gap,

1 but to focus on targeted populations where we
2 knew there were disparities and focus on showing
3 us which interventions improved outcomes for
4 those groups.

5 So I would hate to think that if we
6 relied purely on the traditional definition that
7 we would just eliminate that whole evidence base,
8 because we did eliminate an evidence base when we
9 did the AHRQ evidence synthesis.

10 So that's my point. And so context is
11 important. I do think we need to focus in our
12 recommendations about being explicit about what
13 the definition of disparities is. We have to be
14 explicit about measurement and what we're
15 intending to measure, and we have to be explicit
16 about strategies and what strategies may work
17 within a specific context.

18 So thank you for the opportunity to
19 clarify. I would not be the person ever, unless
20 something changed drastically to say that we
21 should not be focused on closing the gap, because
22 I very much believe that we need to close the

1 gap. But I also believe that we have to improve
2 outcomes for target populations. So, thank you.

3 CO-CHAIR PONCE: Thanks, Romana. I
4 agree with you.

5 (Laughter.)

6 MS. O'ROURKE: Mauricio has
7 instructions on how we're going to handle the
8 breakouts.

9 MR. MENENDEZ: So, right, these will
10 be about 30 to 45-minute breakout sessions. As
11 Erin said, we'll have three different sessions
12 and your task for the first session will be to
13 come up with the different domains and sub-
14 domains.

15 A few rules for each breakout session:
16 For the first one just designate an assigned note
17 taker and speaker. And Marshall and Ninez will
18 come around to each breakout session, kind of
19 voice their opinion or listen in on what you guys
20 are talking about. And after that we'll come
21 back and debrief and talk about what everybody
22 came up with.

1 So, yes, I'll pass it back to Erin.

2 MS. O'ROURKE: So we have assigned
3 groups. If we missed anyone, please feel free to
4 join a group.

5 Folks on the phone, we assigned a
6 dial-in number. Madison and Ignatius will be
7 facilitating that group. And as Mauricio said,
8 everyone will have a staff person, so we'll just
9 take the flip charts and go around the room.

10 Members of the public, please feel
11 free to pull up a chair and join the
12 conversation.

13 Yes, so group one maybe back in that
14 corner, two, three, four. Okay. Let's put three
15 by -- three for Lisa. One, two, three, four.
16 Just to -- so ones over by where Ignatius is
17 standing, twos gather where Eduardo is sitting,
18 threes by Lisa, fours by Yolanda.

19 (Whereupon, the above-entitled matter
20 went off the record at 1:18 p.m. and resumed at
21 2:07 p.m.)

22 CO-CHAIR CHIN: Just to give people a

1 heads up, so we'll do the four report backs. Our
2 sense is that we're probably going to have to
3 revamp the schedule because it may not make sense
4 to do the next two breakouts as originally
5 planned based upon the revisions that I think
6 we're going to be hearing from the different
7 groups. So we'll need to sort of think on the
8 fly in terms of the best way to spend our
9 afternoon, but there clearly will be things we
10 can do.

11 But why don't we start? I know
12 Eduardo's been rearing at the bit to report back
13 on his group.

14 (Laughter.)

15 MEMBER SANCHEZ: And I might be best
16 because the degree to which there's deviation,
17 ours is probably the least deviant from the
18 strawman domain measurement. We kind of stayed
19 with the socio-ecological model recognizing; and
20 I'll talk a little bit about it, that there are
21 definitely other ways to cut things and look at
22 them.

1 So if you were to look at the document
2 in front of you -- oh, the document you had that
3 had strawman domains of measurement, I'm just
4 going to talk a little bit about -- kind of go
5 through those and some places where we thought
6 there was some opportunity to maybe refine and/or
7 reconsider some of the sub-domains that are in
8 that taxonomical construct.

9 So one was -- Lisa, I heard you loud
10 and clear, is that perhaps in -- rather than
11 person-level being lumped with caregiver and
12 family and social support, there at least be a
13 level between the person and the provider that is
14 the family and social network level. And, yes, I
15 do think that there's some evidence around the
16 value of that in a number of different areas.

17 Go back to the first page. And I'll
18 just say right now that we also in our
19 conversation -- I don't think you can see it over
20 there, but there's a sort of an X and Y axis. We
21 also thought back to -- there are different ways
22 of lumping this. We thought that across every

1 single one of these domains there's a different
2 way of thinking about the domains.

3 And you can either do the -- you have
4 domains and domains, and those would include
5 cultural competence up to and including the
6 notion of readiness and preparedness as part of
7 cultural competence would include calling out
8 social determinants of health in each one of
9 those domains in population health issues, the
10 issue of community engagement, which is going to
11 look very different across those domains.

12 And then the notion of multi-sector
13 collaboration including process measures around
14 intersectionality so that even that socio-
15 ecological domain, while it might suggest that
16 you sort of stay in your lane or stay in your
17 domain, there's actually lots of work that
18 happens across those domains and they're not
19 strict. It's not a strict nested model, nested
20 doll model, right? There's intersectionality.

21 A couple of things that we called out
22 in the policy level. In addition to the things

1 that are already there, governance called out
2 might be a sub-domain to look at.

3 At the community level we talked about
4 addressing the social determinants of health, but
5 also those could be further lumped in terms of
6 some individual social determinants of health
7 that roll up into being aggregate, things like
8 educational attainment level at an individual
9 level, income level, housing.

10 But then on a population level, while
11 these aren't strictly social determinants of
12 health, they certainly are mitigators or proxies
13 for -- and that's the whole notion of desert
14 communities, whether that's around food access or
15 physical activity availability, health resources
16 including pharmacies; and Bob heard me say this,
17 including loose dogs. And that's sort of my
18 proxy for things that don't fall into some of the
19 things that we usually measure.

20 On the community level we thought that
21 that second domain that says healthcare
22 organizations collaborating with community

1 partners probably ought to be shifted; that is,
2 switched because the community partner is the
3 accountable domain in that regard, not the
4 healthcare organization. So it's just putting
5 the responsibility where it belongs.

6 We talked a -- I -- we didn't talk
7 about this, but one of my thoughts around
8 enabling services I am presuming might include
9 things like payment mechanisms and how payment is
10 decided, because accessibility/affordability are
11 on some level -- can be defined and refined at
12 the organizational level. It seemed to mean, but
13 we didn't talk about this as a group, that
14 organizational level and microsystem level are
15 not necessarily interchangeable, but in some
16 places the practice is the organization. And
17 there's other places where there are many
18 practices that are part of a broader organization
19 and the variability of across the practices is an
20 issue at the organizational level. And so just
21 sort of thinking through those things.

22 On the provider level we talked about

1 rather than culturally competent workforce to
2 actually call it out as culturally competent
3 health team members, because whether you're the
4 doc or the nurse or the MA or the social worker
5 or the person who's scheduling appointments
6 there's a need for cultural competence. And I'm
7 not sure that at that level we think about
8 workforce. We really are thinking about members
9 of the team and how do we dole out responsibility
10 and how do we dole out accountability.

11 I think that captures at least my
12 sense of what we talked about. And again, just
13 to mention, this was acknowledging that there's
14 other ways to slice and dice. Bob talked about
15 doing it by the disease categories that we talked
16 about earlier: cancer, cardiovascular disease,
17 diabetes, infant mortality and mental illness.
18 So I -- it sounds to me as I walked around and
19 tried to cheat and hear what others were saying
20 that there was conversation about different -- a
21 different way of lumping these in a different
22 domain construct than the one that was put there

1 as a strawman.

2 Team, did I get anything close to what
3 we discussed -- articulated in a way that seemed
4 to represent our conversation?

5 Yolanda, do you want to add anything?
6 You had that notion of the other dimensions.

7 MEMBER OGBOLU: Someone had mentioned
8 earlier about the X and Y axis and thinking about
9 various domains going across. And so I think you
10 captured that in talking about cultural
11 competency, community engagement, social
12 determinants of health, multi-sectoral
13 collaboration. We also had health equity
14 preparedness on that row as well. So I think you
15 captured most of what our group discussed.

16 MEMBER SANCHEZ: Bob?

17 MEMBER RAUNER: There's an urban and
18 rural health gap.

19 MEMBER SANCHEZ: Yes, siree, Bob,
20 there is.

21 CO-CHAIR PONCE: Eduardo, can you just
22 talk more again in what you said about community?

1 I didn't quite get that. You said that --

2 (Simultaneous speaking.)

3 MEMBER SANCHEZ: Sure. So at the
4 community level it seems to me that as we think
5 about sub-domains there are -- and it may be that
6 they're all in the same category, but some of
7 these are characteristics -- some of them are
8 characteristics of the people in that community.
9 So those would be things like income levels and
10 educational attainment levels and those sorts of
11 things. And then there's another set of factors
12 that are actually community factors, things like
13 the availability of services and this notion of
14 desert.

15 So as one thinks about a community,
16 there's both things, and how one might go about
17 considering effective interventions, as an
18 example. So one example would be would an
19 effective intervention. I think there's some
20 evidence that increasing the accessibility of
21 physical activity spaces does make a difference.
22 That's very different than a policy around trying

1 to figure out how to increase the graduation rate
2 in a community. I think we would agree both are
3 important.

4 Probably the latter is more important
5 than the former, but the measures or the
6 effective interventions might be different. And
7 you might prioritize the order in which you go
8 about trying to do them or the degree to which
9 you're going to invest your time and energy in
10 doing them slightly differently. And a CMS might
11 actually think about that different array of
12 things.

13 As I think about the community health
14 strategy, it probably lends itself more to
15 investment in park facilities than it would an
16 investment in educational training opportunities.
17 Does that make sense?

18 CO-CHAIR PONCE: Yes, that makes
19 sense. I think there's -- like from a empirical
20 framework there's a compositional and contextual
21 differences in a community effect, and that's
22 hard to sort out. And it kind of gets at also

1 selection to communities that I think Lisa talked
2 about in terms of selection to communities.

3 But also what's modifiable is not --
4 which I -- in talking with Yolanda over there in
5 after-talk after you left that group, and it's
6 not unique to the community level. I think
7 what's modifiable is also across all the
8 different --

9 (Simultaneous speaking.)

10 CO-CHAIR PONCE: Right?

11 MEMBER SANCHEZ: I would completely
12 agree.

13 CO-CHAIR PONCE: Okay.

14 MEMBER SANCHEZ: It -- I was -- I
15 called it out only because I think of kind of the
16 descriptors of -- community is a different way of
17 thinking of your -- the place of intervention.
18 And we can think about that in all the others,
19 but community is almost in my mind a proxy for
20 how in the medical care system one thinks about a
21 patient. The thing you're trying to help improve
22 is the community on some level --

1 CO-CHAIR PONCE: Yes.

2 MEMBER SANCHEZ: -- including the
3 people inside of it. That's why I went down that
4 path.

5 CO-CHAIR PONCE: Yes. Yes, thank you.

6 CO-CHAIR CHIN: Thanks for getting us
7 started, Eduardo. It's hard to always -- hard to
8 be the first person.

9 We're going to hear these four
10 different perspectives, and maybe one thing for
11 all of us to keep in mind that maybe like the
12 goal at the end of this segment, when we'll have
13 the four presentations, but then we'll have some
14 discussion, is for us to have some sense of,
15 well, what is -- what are -- what's the model to
16 be using here in terms of like what are the
17 domains? I'm going to mess myself up here in
18 terms of NQF wording here, but like the domains,
19 which originally were like these -- this level of
20 like the policy down to the individual. How does
21 that link then to the accountable entity that's
22 going to then use it in measurement?

1 So for example, I think, Eduardo, so
2 the four groups, this is going to be the most
3 traditionalist in the sense of like, well,
4 starting with the six different levels of this of
5 this socio-ecological model. What I heard
6 Eduardo do was to add more sub-domains, flesh out
7 the complexity, as well as any very importantly
8 show how it's not as simple as this nested figure
9 where -- it's more fluid. So you mentioned like
10 there are things across different domains. And
11 it's not -- yes, it's not like a simple addition
12 thing here.

13 And to give you an example, you're
14 talking about neighborhoods in place. I have a
15 fellow right now that's writing this nice paper
16 about like -- it's the built environment. So
17 you're talking about the food deserts and like
18 activity in terms of like, well, the physical
19 structures. There's also the social environment.
20 So social cohesion, social capital, group
21 efficacy, that -- etcetera. And then those
22 variables themselves saying -- aren't independent

1 and set, that different contexts -- it's going to
2 vary and all.

3 MEMBER SANCHEZ: Marshall, completely
4 agree. So one example is building a park doesn't
5 necessarily people -- doesn't mean people will
6 come. However, I know we've all heard of
7 examples where there are communities where the
8 park being built completely changed the way
9 people were interacting with one another because
10 now there was a place where that kind of
11 interaction could indeed happen.

12 And so, yes, I agree that it's a bit
13 more complicated than just physical constructs
14 and that then the human element plays a role.
15 But I guess at the end of the day it comes back
16 to things like social connectedness and how are
17 we going to measure those and where are we going
18 to find those measures and is social
19 connectedness -- so do you need the readiness of
20 a community to use the park before you build the
21 park? And that may call into question this
22 notion of community-centeredness as a -- in

1 addition to patient-centeredness.

2 The notion of patient-centeredness is
3 that people ought to be involved in
4 "understanding and making decisions about their
5 health," quote/unquote, but I also think that
6 that same notion applies -- could apply at a
7 community level. And the degree to which things
8 do or don't work, I think we've all discussed
9 today, may be dependent on whether, A, that was
10 even utilized; what does the community want, and
11 B, do we know how to measure those things to
12 understand whether there's a -- kind of a
13 motivational interview and motivational construct
14 to move a community from not being interested to
15 really wanting to make a difference in their
16 community.

17 CO-CHAIR CHIN: So great insights from
18 the group and it's very helpful.

19 So why don't we go to like the other
20 pool where like group 3 -- so Lisa's group
21 basically started by saying we don't like this at
22 all. We're going to blow it up. A very

1 different model. So maybe that would be good to
2 hear now to get that sort of out there, too.

3 Yes.

4 I don't know who in that group is the
5 spokesperson, but it's the one that Tara was the
6 note taker for.

7 MS. MURPHY: So I can just start with
8 what we've written down and then the group
9 members can jump in and add some color
10 commentary.

11 So the group did not like the
12 initially proposed domains and had some
13 discussion around social risk factors and the
14 social determinants of health and decided that
15 the social risk factors could be a domain in and
16 of themselves. Beneath that domain they
17 identified possible sub-domains including
18 segregation based on where you receive care.

19 MEMBER IEZZONI: It's not fair to make
20 you do that. It's really isn't.

21 MS. MURPHY: Okay.

22 (Laughter.)

1 MEMBER IEZZONI: And I was hoping
2 since I took a brief restroom break in the middle
3 that others would come to the floor and help me.
4 But, so the rest of you guys jump in if I kind of
5 am misstating things.

6 First of all, we really did not
7 understand the concept of organizing the tree
8 trunks, which is what we thought we were doing
9 using Helen's kind of tree analogy. We thought
10 that these were setting up with the tree trunks
11 and then the major branches were.

12 We really didn't like organizing that
13 around this notion of levers. Who were the
14 levers or what are the levers? We thought that
15 it was more important, as the second paragraph on
16 the instructions said, to go back to the six
17 levels of whatever it was and the -- Lisa
18 Cooper's model, but we also kind of just took a
19 step back from that. And I'm not sure that we
20 really coalesced around anything more defined
21 than these two broad areas.

22 One of the first things that we did

1 was talk a little bit about our discomfort with
2 the phrase "social determinants of health." And
3 I led into that by saying that last week I gave a
4 talk in Chicago and an anthropologist came up to
5 me afterwards after I'd mentioned social
6 determinants of health as one of the subsections,
7 and she said, you know, determinants is just too
8 deterministic, that it's really more social
9 factors that affect people's health or -- and so
10 we decided, okay, we agree, social determinants
11 is very deterministic. And it is in fact the
12 phrase that everybody uses, but when you really
13 think about it, there are people who do not --
14 because lives are not determined by these things.
15 And so it is better to use the phrase "social
16 factors."

17 And let's see, what did we do? We
18 talked about segregation within communities being
19 a social factor that could affect population
20 health. And we also talked about -- we had a lot
21 of trouble kind of coming up with the right
22 phrase about how literally generations of

1 deprivation in terms of health can affect the
2 health of individuals and populations and came up
3 with the phrase "cumulative structural
4 disadvantage." I think that's right.

5 Do you want to describe what that was?

6 CO-CHAIR PONCE: I just Googled it for
7 you.

8 (Laughter.)

9 MEMBER IEZZONI: I know you did. You
10 searched it. You kind of Googled that for me.

11 CO-CHAIR PONCE: Yes, I did the
12 search. All right. Yes.

13 (Laughter.)

14 MEMBER IEZZONI: Okay. So basically
15 the notion is that we've all heard -- many of us
16 have heard recently that fetal health determines
17 infant health determines child health determines
18 the young adult and then adult health, but it
19 also can go back earlier generations of health,
20 and prior generations can really affect the way
21 that somebody today's health is.

22 And we also talked about the notion of

1 allostatic load. Do people understand that
2 phrase? People have heard of the kind of notion
3 that structural discrimination causes people to
4 experience kind of -- what is it, the adrenal,
5 hypothalamic, pituitary -- which, what -- what is
6 that? All right. You know what I'm talking
7 about, the little pulses of cortisol that just
8 repeatedly kind of cause kind of physiologic
9 damage that affects people's health.

10 And so we really wanted to have a
11 measure of health there. And because what you're
12 going to be measuring is whether that improves,
13 right? And so we wanted to have the measure of
14 health that looks pretty bad because we wanted to
15 know whether it would improve with the
16 implementation of this new measurement scheme
17 that we're going to be positing later in this
18 structure, later in this process.

19 And then for our other trunk; and
20 again, we didn't get that far, we only had
21 basically two trees, but they had a lot of
22 branches and leaves, I invoked the World Health

1 Organization International Classification of
2 Functioning Disability and Health, which was
3 passed uniformly by the nations in the World
4 Health Organization back in 2001. And it says
5 that the environment is very important in terms
6 of facilitating or impeding people's health.

7 And it was a classification scheme
8 around disability, but everybody has levels of
9 functional status regardless of whether they're
10 better than mine or not. And so it's a
11 classification of functioning, and some people's
12 functioning is better than others'. But they
13 talk in terms of facilitators and barriers to
14 that. And one of the branches of the
15 environmental tree is societal attitudes, and
16 that can be structural racism or stigmatization
17 relating to disability or relating to LGBTQ or
18 whatever.

19 Another one is the policy environment.

20 Another branch would be the physical
21 environment of healthcare delivery settings, like
22 whether they have high-low tables or whether they

1 have wheelchair-accessible weight scales.

2 Another branch would be communication,
3 and communication has a lot of leaves on it. It
4 has to do with low-English proficiency and
5 whether there are interpreters, but it also has
6 to do with whether there would be sign language
7 or CART reporters for people who are hard of
8 hearing, or whether there would be braille or
9 large print educational materials, whether the
10 televisions in waiting rooms are closed-
11 captioned, that kind of thing.

12 And the healthcare delivery system is
13 its own entire kind of environment that has a lot
14 of aspects to it, not just the physical
15 environment, but also the nature of the
16 healthcare practitioners who are there and their
17 attitudes and quality of care and their training.
18 And we got stuck on -- as we were finishing got
19 stuck on the phrase "cultural competency," and we
20 all agreed we didn't like that either.

21 So that's kind of where I thought we
22 ended up. Other group 3 members, do you want to

1 admit that you were a member and --

2 CO-CHAIR PONCE: Traci. Traci was a
3 member.

4 MEMBER IEZZONI: -- help me out?

5 (Laughter.)

6 MEMBER IEZZONI: Yes, thank you. I
7 relinquish the podium on this one.

8 CO-CHAIR PONCE: Romana?

9 MEMBER HASNAIN-WYNIA: I'll admit that
10 I was a member of this group.

11 (Laughter.)

12 MEMBER HASNAIN-WYNIA: But I was
13 actually going to speak for Nancy, but Nancy came
14 in, so I don't have to, in terms of the first,
15 because, Lisa, that's when you stepped out in
16 hopes that we'd have it all resolved.

17 So the first one, the segregation
18 based on where people received care. So it was
19 -- and I'll let you kind of pick up since you're
20 the one who raised it, but it was about
21 segregation related to where people get their
22 care and where specific providers are segregated

1 in terms of providing care to populations,
2 targeted disparities populations, so some of the
3 literature that looks at the concentration of
4 primary care docs, that small percentage who take
5 care for a large number of low-income minority
6 patients.

7 Same with hospitals. A thousand or so
8 hospitals out of the 4,600 that -- I think the
9 statistic was at least up until about 2000-and-
10 something where only about a thousand of the
11 hospitals of the 4,600 acute care hospitals in
12 the country saw an African-American patient who
13 presented with AMI. So the importance of that
14 kind of segregation and how that relates to
15 measurement. And it gets back to kind of I think
16 the point I was making about improvement versus
17 closing the gap.

18 Nancy?

19 MEMBER GARRETT: Yes, exactly. And I
20 would just add we were talking about some -- as a
21 measure domain it might be a concept that we want
22 to pay attention to because we know that patients

1 aren't equally distributed across providers and
2 the fact that they're not has a lot of
3 implications in terms of how resources are
4 distributed. Payer mix really varies and that
5 really determines a lot of how -- what the
6 resources are to care for vulnerable populations.
7 And so as a -- there's a residential segregation
8 index that's used in sociology and to understand
9 residential segregation. Maybe there should be
10 an index for healthcare segregation of vulnerable
11 populations as a way to start measuring and
12 therefore understanding how we might need to do
13 measurement and resource allocation differently.

14 MEMBER FERGUSON: And in terms of
15 cultural competency we didn't completely discard
16 it, but did state that it seems to be in terms of
17 documentation. And what is it really in action
18 when you're talking about the second report
19 focused on primary care, which is good, but
20 looking at specialists. When you see a
21 nephrologist, are they having the same type of
22 conversations? Is there a way to document?

1 They see that there's disparities
2 within minority populations about giving --
3 getting or being aware of living kidney -- living
4 donor kidney transplants, of being able to
5 document of all of their populations end-stage
6 renal disease how many have they had
7 conversations with and being able to measure that
8 and document that, and that we needed sort of --
9 in terms of cultural competency needed to be more
10 an action at the provider and at the -- you know,
11 provider level and also at the payer level, too.

12 CO-CHAIR CHIN: So I'm going to pick
13 on Romana here. So when I first joined your
14 group, she immediately said we have no clue what
15 you guys want us to do.

16 (Laughter.)

17 CO-CHAIR CHIN: And so a very
18 different approach than Eduardo's group. I'm
19 trying to get some --

20 MEMBER HASNAIN-WYNIA: Whoa, Marshall,
21 way to make us feel bad.

22 (Laughter.)

1 CO-CHAIR CHIN: I didn't say it was
2 good or bad, just a very different approach. But
3 I was trying to get it nailed down to like where
4 we had to go as a group like and make it concrete
5 regarding domains and then linkage eventually to
6 accountable entities and then use and performance
7 measurement and rewards and incentives, etcetera.

8 So can you take us a little bit -- one
9 step closer to like how these good ideas have
10 been sort of -- relate back to our immediate
11 charge like domains and then use and measures and
12 all?

13 MEMBER HASNAIN-WYNIA: Yes. Well,
14 maybe I'll pick on the cumulative -- what was --
15 what -- social disadvantage, because I raised
16 that question in the group, too. Structural
17 disadvantage. So the question I raised was is
18 that something that we should be considering
19 within the charge of this larger committee, or
20 does it start to go outside the scope? And I
21 think it was Ninez who said, well, isn't that
22 exactly what we're trying to address?

1 So within that context I think part of
2 our motivation is to say that we should be
3 thinking about measures as we think about --
4 again, going back to the beginning of the day
5 where we said we're -- we want to do what we can
6 do now, but we also need to be thinking about
7 what we can push for or do in the future, so
8 looking at specific measures that allow us to
9 track over time whether there are improvements in
10 that structural disadvantaged-type measure.

11 So I do think that there is a way to
12 tie back our really esteemed group's deliberation
13 about what -- where we wanted to go with this.
14 So some of these I do think are a stretch. Maybe
15 not the healthcare delivery system where we're
16 talking about access, but the structural
17 disadvantage definitely is a stretch. But maybe
18 something that because we're tying this to social
19 risk factors is really important for us to be
20 able to set the groundwork to measure over time.
21 Does that answer your question?

22 CO-CHAIR CHIN: Yes, that's helpful.

1 Thanks, Romana.

2 Tom, do you have a comment?

3 MEMBER SEQUIST: So, yes, I had a --
4 just a -- in terms of the -- measuring these sort
5 of between-provider issuers versus the within-
6 provider issues, I just -- I think there -- I
7 just want to make sure that we don't
8 underestimate the importance still of the within-
9 provider issues. So I -- the last analysis I saw
10 of the CMS measures pneumonia, the sort of core
11 CMS measures -- and if you trend them over time
12 from like 2005 to 2010, it's the within-provider
13 disparities that aren't going away. The between-
14 provider disparities have gone down by a lot. So
15 Ultravetti if Brown had looked at this over like
16 a five-year period.

17 So they're both important, but I just
18 want to make sure that we don't forget about the
19 within-provider ones, because those are the ones
20 that haven't changed that much over time. There
21 has been a pretty dramatic drop in the between-
22 provider disparities.

1 CO-CHAIR CHIN: Thanks, Tom. That's
2 great to get those first two groups out to sort
3 of set the stakes in the ground in terms of like
4 the two very different sort of perspectives. I
5 think like the other two groups now fall
6 somewhere in between.

7 So, Mauricio's group?

8 CO-CHAIR PONCE: That's -- it was --
9 that was Eduardo's group.

10 CO-CHAIR CHIN: Oh, okay. Yes.

11 CO-CHAIR PONCE: Just before we do
12 that, I thought that the last group was a great
13 group. And it was raised -- to Helen, they
14 really liked your -- the tree and the branches
15 and they were getting into the leaves. So they
16 were -- started to talk about measures. But then
17 someone, I think it was Romana -- it was Romana
18 who said what's the root? What are the roots for
19 the tree? So, and in some ways I think the
20 domains you chose were very roots parts. I mean,
21 they're -- really the heavy part is domains. So
22 I think that that's -- so I really liked it. I

1 just also want to make sure it doesn't get lost
2 in the discussion.

3 I think Nancy raised the ACE, Adverse
4 Childhood Experience, indicators, so I think that
5 that's -- so they were getting into that -- into
6 ways of measurement.

7 MEMBER GARRETT: If I could just make
8 one really brief comment. One of the things in
9 the socio-ecological model that we have here with
10 the patients kind of at the beginning here, we're
11 really starting to think increasingly about --
12 especially when it comes to social risk factors,
13 about the person in the context of the family and
14 the household that they live in and how important
15 that is. And it's hard, because the electronic
16 medical record is really structured on an
17 individual patient basis. And so to start to
18 bring in those family risk factors is actually
19 difficult from an IT perspective.

20 So we've actually been working with
21 our vendor to say you've got to change your
22 paradigm here of how this thing even works, and

1 they're actually in discussions with us about it.
2 But I think that's an important aspect that's
3 kind of between the community and the individual.

4 CO-CHAIR CHIN: So you remember going
5 to school and that some of your classmates were
6 like the perfect students that would just do
7 everything just so right? When I looked at this
8 group, it was Erin's group, they already had like
9 about five or six like of these sheets already
10 plastered on the wall in terms of like the ideas.

11 And so you want to talk a little bit
12 about your perfect group?

13 (Laughter.)

14 MS. O'ROURKE: We've actually
15 nominated Philip to be the spokesperson for the
16 group.

17 MEMBER ALBERTI: For the perfect
18 group. That's exciting.

19 Well, like the rabble rousers in group
20 3, we didn't like kind of using the socio-
21 ecologic model levels as the domains, and so we
22 did the Bernheim flip and said we'll look at kind

1 of the actual content areas as domains and think
2 about how to measure across all those different
3 levels. And when Marshall came over, he said
4 maybe we are the most theoretical of the group,
5 which I think he meant that we -- there's no
6 evidence base for anything that that we are
7 proposing. But I like to say that we're
8 aspirational, so we're going to present our
9 aspirational model.

10 So we have six domains. So the first
11 was the institutional culture and structure for
12 equity. And some of the sub-domains included
13 things like workforce diversity, cultural
14 competency, prioritizing equity; maybe that's a
15 leadership kind of domain or sub-domain,
16 addressing bias and stigmatization and structural
17 racism, collecting the data that's required to
18 have this focus, and really incentivizing equity.
19 Specifically we're talking about merit and
20 promotion, kind of policies that would actually
21 allow that culture to develop. So that was one
22 domain.

1 A second domain was the equitable
2 provision of care, so thinking about how to apply
3 an equity lens for all of the equality measures
4 that an institution gathers, thinking about the
5 experience of care and discrimination, again
6 issues of bias. I mean, you could organize these
7 domains and sub-domains in various ways. Full
8 disclosure. Then of course looking at the and
9 assessing the equity of healthcare outcomes and
10 health outcomes based on that equitable provision
11 of care.

12 The third domain we focused on was
13 equitable access to high-quality care, so
14 thinking about the quality of the safety net, and
15 then thinking about the conversation that Romana
16 -- you're coming up a lot, Romana -- led us
17 through earlier thinking about both measuring
18 health outcomes for particular subgroups, but at
19 the same time measuring the gap when and where
20 appropriate, and doing both of those things
21 concomitantly.

22 The fourth domain we're going to newly

1 name it addressing the social correlates of
2 health; because we were told not to say
3 "determinants" we're going to call it the SCOH,
4 and thinking about how -- again across all the
5 levels, whether it's assessing those factors in a
6 patient-by-patient level all the way up through
7 community benefit policies and needs assessments,
8 all the way through thinking about partnerships
9 with other sectors in the community.

10 Which then leads to that fifth domain,
11 which could be a sub-domain, but we wanted to
12 really call it out separately, of collaboration
13 in terms of care coordination at the provider
14 level, inter-professional collaboration cross-
15 sector for the institution level, thinking about
16 engaging with patients and their own care and
17 that kind of patient empowerment and engagement
18 with community as well.

19 And then our final domain; and again
20 we kept it separate because I think there was a
21 sense that we wanted to call it out specifically,
22 was advocacy. And again, thinking about all

1 those different levels, whether it's patient
2 advocacy all the way through kind of state and
3 national advocacy efforts in the equity space, as
4 well as building the capacity of communities to
5 advocate successfully on their own behalf. So
6 again, trying to think about these broad domains,
7 but how you could apply it across all the levels
8 of that. So if I left anything out, other
9 perfect group members, please chime in.

10 (Laughter.)

11 CO-CHAIR CHIN: I think it's actually
12 great that they're so different, the three groups
13 so far, because you sort of see like the
14 strengths and then complementary parts that each
15 is bringing. So for example, Eduardo's group did
16 start with the structure, the six-level
17 structure. And so you have like the potential
18 actors there. But then went way beyond like our
19 initial strawman in terms of the complexity and
20 how it's more fluid and as well as more in depth,
21 the domains and all.

22 The second group talk a lot about, as

1 Ninez said -- and about like in some ways
2 probably the most important drivers ultimately of
3 like these outcomes. You look at like studies
4 about the percentage that different drivers are
5 contributing and like social factors driving the
6 outcomes. And Romana's point about making enough
7 to get there. Some of this may be a little more
8 distal in terms of like the immediate power
9 control of the different entities, but something
10 that needs to be on the score card in terms of
11 like the overall model and aspirational.

12 I feel like I -- Philip -- you
13 actually sort of said it very nicely, Philip, of
14 like -- when I first saw like the list, my
15 initial question was, well, yes, it does -- like
16 when you were talking about the initial strawman,
17 like when the staff came up with the initial
18 strawman, it was based upon the evidence from the
19 lit review. So here's what the evidence shows.
20 So they did a very evidence-based approach.

21 A lot of things you should have up
22 there probably is not like rigorous control

1 studies you can show doing that, but they do
2 reflect probably a lot of what people sort of
3 think in the field and then case studies and all.
4 So there's a role somewhere in this mix. So all
5 very sort of different, but complementary in a
6 good way.

7 Other comments upon Philip's group?

8 CO-CHAIR PONCE: Susannah is --

9 MEMBER BERNHEIM: Just two quick
10 things. Just I was struck by the discussion
11 about within and between, so just putting a
12 highlight on the sort of concept of equitable
13 provision plus equitable access to high-quality,
14 feeling like those kind of conquered the two.
15 One really helps you think about within and the
16 other the between, ensuring that the safety net
17 is strong.

18 And similar to what you said, I mean,
19 I don't know what the right way to do this is,
20 what the X axis and the Y axis should be, but
21 this group really created a -- no, not that group
22 -- whoever your group was, sort of this concept

1 of, oh, an X axis and a Y axis, that sort of
2 there are -- and if you map our five or six
3 domains, at least three or four of them actually
4 overlap pretty heavily. And quite honestly,
5 there's a lot of overlap there, too. So I don't
6 think we're as far from a shared vision. I mean,
7 there's probably not a right way to do this, but
8 as I hear it, there's a lot of resonance in the
9 major domains.

10 CO-CHAIR PONCE: Eduardo?

11 MEMBER SANCHEZ: Yes, I -- you --
12 Susannah, you said basically what I was going to
13 say. If you remember that --

14 No, no, no. So Yolanda's sense of how
15 we might think about this was very, very, very
16 aligned with group 3's presentation. And so it
17 boils back down to if you take that construct --
18 and even some of the sub-domains actually are --
19 will be effectuated in the now seven domains that
20 we had come up with in the socio-ecological
21 model.

22 So again, I think that there's more

1 agreement than not, and it's our -- we're human
2 beings; we're not from another planet, and we can
3 only think in at most two dimensions on a piece
4 of paper. And this really is going to be
5 probably a multidimensional construct that's very
6 hard to capture in words and in paper and in
7 diagrams.

8 But I'm hearing more -- there's more
9 alike thinking that we just don't have a good way
10 of making our brains put our head around, right,
11 because it's -- now we're at three dimensions and
12 I can't wait to hear how we're going to think
13 about -- the fourth dimension is the one I always
14 struggled with throughout my entire early
15 academic career.

16 CO-CHAIR PONCE: Stay tuned.

17 Bob?

18 MEMBER RAUNER: Well, I was also going
19 to talk about the X and the Y and the Z axis for
20 the same reasons.

21 But the other thing I'd like to make
22 as a motion, because I mean, I also equally

1 dislike these social determinants of health and I
2 make a motion that we not use that going forward
3 and that we use something more appropriate like
4 social correlates of health or social influencers
5 of health, because I think that's a much better
6 way to describe it.

7 CO-CHAIR PONCE: What about the social
8 risk factors that group 3 -- it's also the same
9 -- I mean, ASPE used that as well.

10 MEMBER RAUNER: Yes, so whether it be
11 influencers, correlates, but anything but social
12 determinants, because I agree it's too
13 deterministic and wrong.

14 CO-CHAIR PONCE: Anyone second?

15 (Laughter.)

16 That was a motion. No.

17 MEMBER SEQUIST: What's determining?

18 CO-CHAIR PONCE: Social risk factors.

19 MEMBER TEIGLAND: I like it because
20 it's -- it makes it -- it puts it on par with
21 clinical risk factors. They're just as
22 important. So I like to call them risk factors.

1 CO-CHAIR PONCE: I know this isn't for
2 -- any opposition?

3 (No response.)

4 CO-CHAIR PONCE: All right. We'll go
5 with social risk factors. And also acknowledging
6 in terms of themes that are coming up, the
7 segregation based on provision of care and access
8 is also the equitable access and provision.

9 Emilio?

10 MEMBER CARRILLO: Yes, the one minor
11 concern about that is that there are the salutary
12 or beneficial determinants that when we think
13 about social determinants, we think about the
14 adverse negative determinants and we think about
15 positive social determinants like a beautiful
16 neighborhood with very good communication, very
17 good school. So if we frame it in a more
18 negative way, we may lose that important
19 dimension of also looking at the positive
20 determinants.

21 CO-CHAIR PONCE: Eduardo?

22 MEMBER SANCHEZ: The Heart Association

1 actually struggled with this very issue. About a
2 decade ago we moved away from using language in
3 our kind of public statements about
4 cardiovascular disease risk factors and started
5 talking about cardiovascular health factors for
6 that very reason, because your health could be
7 good, your health could be not so good. Disease,
8 generally always bad. Even if it's not so bad,
9 it's still bad compared to health.

10 CO-CHAIR PONCE: I'm going to table
11 then the discussion as we think through this.

12 What about environment, though? From
13 group 3, environment seems like it's both
14 positive and negative.

15 MEMBER IEZZONI: Again, that's the
16 language that's used by the World Health
17 Organization in the classification of functioning
18 disability and health, and it's just simply a
19 word that defines within it a bunch of different
20 kind of constructs.

21 CO-CHAIR PONCE: Okay.

22 MEMBER IEZZONI: Including social,

1 physical, communication, policy. It's just a
2 header.

3 CO-CHAIR PONCE: So we're together
4 through tomorrow, so sleep on it, think about it.
5 I think what's on the table is social risk
6 factors or social correlates. I think that was
7 the other. Social correlates of health, because
8 there's no direction implied in the correlates.
9 Risk factor, the advantage is that it aligns with
10 -- clinical risk factors aligns with other such
11 as -- other reports such as ASPE. And I think
12 National Academy of Medicine also calls it social
13 risk factors in that report that, Lisa, you were
14 part of.

15 Romana?

16 MEMBER HASNAIN-WYNIA: So I just want
17 -- we're -- I understand that we're moving away
18 from social determinants, but we're -- we don't
19 want to use social risk factors?

20 CO-CHAIR PONCE: That's -- yes.

21 MEMBER HASNAIN-WYNIA: So we're
22 thinking about --

1 CO-CHAIR PONCE: No, not that we
2 don't, but we're considering other --

3 MEMBER HASNAIN-WYNIA: Considering --

4 CO-CHAIR PONCE: -- words.

5 MEMBER HASNAIN-WYNIA: So we're
6 thinking social correlates? Is that the -- why
7 don't we just say social factors? I just --

8 CO-CHAIR PONCE: Ah.

9 MEMBER HASNAIN-WYNIA: Why don't we
10 just take away the --

11 CO-CHAIR PONCE: That's great.

12 MEMBER HASNAIN-WYNIA: -- and make it
13 neutral?

14 CO-CHAIR PONCE: Thank you.

15 MEMBER SEQUIST: What are you using
16 this word for? I mean, is this --

17 (Laughter.)

18 MEMBER SEQUIST: Is this a -- is this
19 some formal statement that you're planning to
20 make around the use of the term or --

21 CO-CHAIR PONCE: No, no. No, in fact
22 calling the vote was not really -- we don't

1 really vote on things here. But it's just that
2 there was a -- you know, Bob made the suggestion.
3 And I think just even from the exercise today and
4 the presentations this morning people get caught
5 up in labeling and in words and what it means.
6 And so it's just a way to have a common --
7 sometimes the usage is -- common usage is a way
8 to get at a common understanding so that our
9 discussions then are really fruitful. But I
10 don't think it's really for a policy statement.

11 DR. BURSTIN: Not at all. It may be
12 something you label as a domain or a sub-domain.
13 So I think you're going to come back to this at
14 some level, maybe. Or maybe it's a third
15 dimension or whatever it is. But at some point
16 we're going to want to probably call it something
17 in the sake of this framework, so that's the only
18 reason.

19 MEMBER SEQUIST: I would just say that
20 it's challenging to use a word that's separate
21 from what CMS and IOM and all these other
22 organizations are using like to sort of -- it

1 just will confuse people if we put out a
2 framework that uses a completely different word,
3 or phrase.

4 CO-CHAIR PONCE: On that point, Bob?

5 MEMBER RAUNER: Sorry to make this
6 worse, but sometimes CMS does come along, though,
7 so --

8 (Laughter.)

9 MEMBER RAUNER: And but I think using
10 the term "wrong terminology" frequently leads
11 people to jump to the wrong conclusions, and I
12 think that's the problem with using
13 "determinants." Yes, it's commonly used, but I
14 think it's commonly leading people to jump to the
15 wrong conclusions.

16 MEMBER SEQUIST: Oh, no, they're not
17 using "determinants." They're using "social risk
18 factors."

19 MEMBER RAUNER: Yes. But I also agree
20 with what Eduardo says that it's not -- well, I
21 mean, just like "deviants," you can have both
22 positive and negative deviants. "Risk factor"

1 does mostly imply negative, and so I would maybe
2 choose something a little more neutral, whether
3 it be "correlates" or "influencers," because
4 those are both accurate but do not necessarily
5 imply negative or positive.

6 Because you can have good things about
7 your neighborhood, you can have bad things about
8 your neighborhood. You could have good things
9 about your ethnicity. There can be bad things
10 about your ethnicity that are correlated, for
11 example. I mean, you have the Hispanic paradox
12 where for some reason Hispanics live a lot longer
13 no matter what.

14 So I think using "correlates" or
15 "influencers" would be a better term than
16 "determinant," because I think I literally have
17 that problem in our community right now, because
18 we're doing -- one of our groups is doing this
19 community mapping and they're using that
20 "determinants" all the time and they're acting
21 like if you live downtown, you're going to die
22 when you're 60 and it's -- no, that's not -- and

1 everybody's jumping to the wrong conclusions. So
2 I just really, sorry, I dislike the determinant
3 one because of that.

4 CO-CHAIR PONCE: Okay. Cara, what
5 does CMS think?

6 (Laughter.)

7 (Simultaneous speaking.)

8 DR. JAMES: Right. Right. No, I
9 think -- and I will speak for myself. I want --
10 I applaud the struggle, because I think,
11 personally, I will say risk factors, social risk
12 factors, I don't necessarily like the fact that,
13 being an African-American woman, being African-
14 American is a risk factor. I don't know that I
15 particularly care for that, so I like the more
16 neutral language.

17 I think that the social risk factor
18 language I would say was driven in part by NAM.
19 So those reports that ASPE commissioned to
20 developed sort of where we go is sort of what's
21 driving that. I think we are a little bit at a
22 crossroads as field of trying to figure out what

1 are we talking about? How do we talk about it?
2 How do we communicate it in a way that's not
3 divisive for other individuals, which I think is
4 somewhat why there's a little tension with
5 including structural racism. Like the minute you
6 say the R word, people are leaving the room.

7 So I would like for us to struggle
8 with this. I also would like for us not to get
9 derailed by it at the end of the day, because we
10 can down a rabbit hole and spend days trying to
11 figure out this language, but I do think there is
12 opportunity for some discussion.

13 CO-CHAIR PONCE: Well said. Thank
14 you.

15 Emilio?

16 MEMBER CARRILLO: Yeah, I think that
17 before we toss "social determinant," we should
18 just kind of look at it a little bit deeper.
19 There is a whole literature around -- with the
20 term, not to mention all of the entities that are
21 using it: health organizations, CMS, all the way
22 down the line, AAMC. I mean, social determinant

1 is -- it's a determinant of health. So that has
2 value in that we're looking for what are those
3 social factors that are determinants that impact
4 health?

5 So I think that the term "determinant"
6 does bring us to the attribution discussion. How
7 does this impact health? So I think that the
8 term has value and we should weigh the value with
9 the issues. And there are beneficent
10 determinants of health and there are adverse
11 determinants of health. And so I think that we
12 should maintain that consideration before we toss
13 it away.

14 CO-CHAIR PONCE: Okay. Thank you.

15 CO-CHAIR CHIN: Why don't we move then
16 to the fourth group so that we get the fourth
17 group's ideas out there, which was Emilio's
18 group. So I don't know, I guess, Drew, Emilio,
19 or someone from your group?

20 MEMBER CARRILLO: Well, as Eduardo
21 suggested, we know have a fourth dimension. We
22 take a different cut at this complex question,

1 and actually we're taking a more traditional cut,
2 which is actually along the framework that NQF
3 developed years ago. And basically a lot of the
4 thinking around cultural competency has been
5 based on that framework. So we have a framework.
6 Before we toss it out we should look at it,
7 understand it. Before we improve it, we should
8 also understand it.

9 So we went back and looked at the
10 organizational level as our starting point,
11 although the framework that we came up would
12 apply to the policy level, community level, macro
13 system level, et cetera.

14 So first of all, there's leadership.
15 I mean, leadership is very important. This is
16 something that in terms of driving the
17 organization, in terms of committing to reducing
18 disparities. Leadership is something that is a
19 very important component, particularly if we are
20 into an action-oriented frame of mind. We want
21 to change things. We want to improve things.
22 And leadership is a very important component.

1 Secondly is communication, which is
2 what most people think of first when they think
3 about cultural competency. It's not just
4 communication. It's also understanding. I mean,
5 how well does the person understand the elements
6 of prevention, the elements of where there is
7 access to health, the FQHCs, et cetera? So those
8 are two important things.

9 And, again, we're looking for a
10 framework that is ultimately measurable, things
11 that can be measured. I think that there is
12 measurements of leadership. You can look at what
13 leadership has accomplished, what they have
14 invested, et cetera, et cetera.

15 Thirdly is community engagement that
16 we have talked about in many different settings.
17 And that's a very important component of cultural
18 competency and things like not just being
19 involved in community, but for example, having in
20 your boards, in your driving groups, having
21 actual community involvement, which is something
22 that's very measurable. I mean, to what extent

1 that you're involving the community in your
2 various different planning and implementation
3 efforts.

4 Then the fourth domain in this
5 framework is diversity, and workforce diversity
6 in a stratified form. I mean, not just looking
7 at the fact that a large amount of your -- large
8 volume of your workforce is diverse, but the top
9 leadership is all mono-ethnic. So measurements
10 of workforce diversity are important, and also
11 opportunities for advancement.

12 And then care delivery and supporting
13 mechanisms. What systems are there in place to
14 promote the cultural competency and thereby
15 reducing diversity? What allocation of
16 resources, which is something that is very
17 measurable? How do they fit into this?

18 And then there's policies and the
19 mission and the vision of the organization. What
20 policies are there in place for the entire
21 organization, for the system which -- and do
22 those policies speak to disparities? Do those

1 policies speak to the cultural competency? And
2 that's evidently accessible to study and
3 comparison and looking for elements that should
4 be part of that.

5 And then last but not least is data
6 and stratification, which is a very important
7 aspect of this. So, again, looking for a
8 framework that has been built already that we can
9 look at and change or accept in some ways and
10 which leads to measurement, because we basically
11 -- we're not a theoretical exercise here. We're
12 a exercise in basically creating elements that
13 can be measured so that they can impact policy.

14 Kevin, you want to --

15 MEMBER FISCELLA: Yeah, I was going to
16 say, I think that there's a thread within all of
17 this. A lot of it comes down to empowerment and
18 sharing of resources and transparency and
19 inclusion, that those are -- all factors that
20 shape social disadvantage I think operate at all
21 these levels and I think were all imbedded in
22 Emilio's comments that ultimately if we want to

1 improve equity, it does require addressing those
2 issues. Patients at an individual level need
3 shared power, shared decision-making.

4 Office staff, and Emilio gave an
5 example where he asked his MA about his Latino
6 patients who weren't doing as well as he was
7 expecting. And she explained all of the social
8 issues why they weren't. Now that's a sharing of
9 power between a physician and an MA and creating
10 a psychological safety within that team.

11 And at organizational levels it's
12 empowering groups who feel like they have a
13 genuine opportunity to pursue career pathways so
14 that ultimately the organization will become more
15 diverse. Its programs and transparency and when
16 they make a commitment to equity that they
17 publicly say what it's going to be, what the
18 metrics are, and then present data on how they've
19 been doing and discuss their successes and
20 failures. That's a sharing of power when has
21 that level of transparency.

22 So I really do think that these sort

1 of more fundamental mechanisms underpin many of
2 these factors that are critical to addressing
3 equity. And if we keep our mind on them, I think
4 it's really important that we really not miss the
5 fundamental issues and getting caught up too much
6 in some of the processes, that it really does
7 take sharing of resources, it really does take
8 giving other people a voice at the table when we
9 talk about empowering communities and
10 organizations, working with communities. It's
11 not just engaging the community, but actually
12 sharing resources and sharing decision-making and
13 so on and very much in the way I think PCORI has
14 tried to promulgate.

15 CO-CHAIR CHIN: I think it was Romana,
16 then Eduardo. Okay. I guess Eduardo.

17 MEMBER SANCHEZ: That was very, very
18 compelling, those comments, and it seems to me,
19 Emilio, that a friendly amendment to the list
20 would be decision-making/governance, because I
21 agree that I think the spirit of it is there, but
22 it probably should be called out as a domain.

1 CO-CHAIR CHIN: Just a few
2 observations that -- let's leave the list in
3 here. That seems to be more like organizational-
4 level sort of perspective. Thinking about
5 Emilio's role as a senior management in a major
6 healthcare system, thinking about like -- he
7 works on the disparities solution network, which
8 is a lot of us, in terms of coaching
9 institutions.

10 University of Chicago, we're in like
11 year four of a similar type of a campaign,
12 exactly the same type of domains that really cut
13 across all the things that a major organization
14 needs to work on from the workforce to the
15 culture of the senior management buy-in to the
16 structure of the delivery system, et cetera.

17 I actually see a fair amount of
18 overlap between this one and then the group over
19 here. They use broader terms, but when you get
20 down to like their sub-domains there's a lot of
21 overlap, although I think this group had a
22 broader perspective. So it's organizational, but

1 then it goes beyond in terms of the other
2 different levels there.

3 So I guess back to I think what
4 Eduardo was saying, like there's actually a fair
5 amount of overlap when it comes down to it among
6 these four different entities.

7 Helen?

8 DR. BURSTIN: I completely agree. I
9 could easily see taking these two pieces. I
10 think there's a lot of overlap. I'm also still
11 intrigued by the piece in the back. And I want
12 to remind us, this was all done in the context of
13 race, ethnicity and language only, and so it
14 doesn't really consider -- like, for example,
15 environment has a very particular I think lens as
16 you're looking through disability or geography.
17 That was never part of part of this framing. So
18 some of this as we think about the broader
19 framing you might logically bring in things that
20 would have never been there before. I just want
21 to remind us of that.

22 CO-CHAIR CHIN: Why don't we go to

1 group 5, which is the group on the phone? And so
2 would one of the people on the phone like to be
3 the spokesperson for your group?

4 MEMBER COPELAND: Yeah, Marshall, this
5 is Ron. I was asked to speak for the group, but
6 I think the first thing I'll say is we valued the
7 opportunity to be included in the exercise given
8 that we're not physically in the room, but either
9 the opportunity didn't serve us well or we didn't
10 leverage it effectively. So it was a, I would
11 say, fairly frustrating experience for us to try
12 to scramble virtually to get clarity on the
13 assignment, review the documents, and then engage
14 in conversation.

15 So the only things I will say is that
16 we also experienced some of the dissonance that
17 I've heard described by the first four groups
18 around this version of the domains for a lot of
19 the reasons that have already been described, but
20 we did not get to any detail on providing or
21 proposing an alternative approach to the domains.
22

1 So the limited discussions we actually
2 were able to have were looking at the domains as
3 listed in the sub-domains area underneath and
4 highlighting some additional opportunities that
5 might be considered in whatever further
6 refinement we do. And a lot of that was in the
7 realm of the cultural competency piece, both at
8 the organizational and/or individual provider
9 level. And what we didn't see accounted for was
10 whether the notions of cultural competency at
11 either of those levels is actually measured or
12 not such that you have some way of not assuming
13 it's being done, but actually having some way of
14 putting metrics and/or standards to that.

15 And that led to a further discussion
16 about, given the fragmentation of care delivery
17 models across the landscape, what was the role or
18 value of engaging either licensing or medical
19 education institutions around their role in
20 building up this competency and skill and
21 knowledge development so it doesn't rest solely
22 with the organization where the physician or

1 nurse or care team member happens to sit, that
2 there's a proactive approach to realigning that
3 with the realities of what it takes to drive an
4 equity improvement agenda and where does that fit
5 into this type of construct and the role of
6 standards around the same.

7 So are these things treated as
8 guidelines or are they actually elevated to
9 standards level so that you can have a higher
10 level of consistency, both in education and in
11 practice and measuring results.

12 And then in the social and the
13 community level around the social factors there
14 was comments about assessing the needs -- so, the
15 needs assessment piece we didn't see listed here.
16 There was a presumption that the needs were
17 identified and addressed, but not really called
18 out in a specific way. And maybe that's implied
19 or not, but that came up as part of our
20 discussion.

21 And then the other was the role of
22 community members and persons involved with co-

1 designing solutions and inputs to the process as
2 well.

3 So that's really all we came up with
4 in the limited time we had. So, nothing
5 transformative. And I think what I heard in the
6 first four groups, a lot resonated with some of
7 the discussions we had, but not in terms of
8 specifics for modifying the domains, if you will.

9 And I don't know if Sarah or David are
10 still on the line or not, but if they are, they
11 might have other things to add to that on behalf
12 of the group.

13 MR. BAU: So, this is Ignatius. The
14 other thing that we talked about was actually
15 measuring the diversity of the workforce,
16 including some of the leadership and governance
17 questions. And so, again, ways of reporting that
18 out, of monitoring that. And Dr. Copeland also
19 mentioned specifically within Kaiser they're
20 actually measuring language proficiency of their
21 providers as well. And so that's another area
22 where I think you can actually start applying.

1 We started using "evaluation" rather
2 than "measurement," because, again, it may be a
3 yes or no rather than scales.

4 CO-CHAIR CHIN: So, thank you, Ron.
5 No, it's not an ideal situation, so it's great
6 that you came up with -- those are actually I
7 think important insights that you have that you
8 just mentioned.

9 Anyone else from the call? I guess
10 Ron said David or Sarah. Anyone else, did you
11 want to make any comments now?

12 (No response.)

13 CO-CHAIR CHIN: So I think that's
14 great that this -- I think we would have been
15 delighted at the time we'd done the initial
16 planning for this part of -- we'd be happy we
17 came up with these type of diverse-type of
18 viewpoints.

19 Emilio?

20 MEMBER CARRILLO: Yes, just reflecting
21 on the point that Helen made, we're really
22 talking about social and cultural competence, how

1 socially and culturally competent are our
2 policies? I mean, do they address the social
3 determinants or factors? Do they take into
4 consideration the cultural piece?

5 Community level, social and cultural
6 factors that impact on the community, that impact
7 on the health of the community. Organizational
8 level, macro level, individual level, I think
9 that that might be a better way to couch it
10 rather than as we have traditionally just on the
11 cultural front.

12 CO-CHAIR CHIN: So, in terms of what
13 to do next, first an observation. So I think as
14 many of you know, the staff, NQF staff, we're
15 very lucky to have an amazing staff who do much
16 of the work. And actually one of the stories is
17 when Ninez and I were invited to co-chair this,
18 one of the questions we asked Helen was, who's
19 the team going to be?

20 And so she said, well, we got the
21 dream team of like the people on the committee
22 itself and we got the dream team in terms of the

1 staff. And she mentioned, well, it's going to be
2 Erin and Mauricio and Madison and Drew and Tara.
3 And her point was that she plucked -- she was
4 going to pluck the best people because this is
5 truly a high priority for her.

6 And what happens then is, like when we
7 have these meetings, the staff does an amazing
8 job of like integrating and synthesizing the
9 different ideas and comes up with the drafts that
10 we as a committee will react to. So they do an
11 amazing job.

12 I think, though, that probably we need
13 to get a little bit further though in before we
14 say to them, okay, now you heard these five
15 different presentations and now go for it. And
16 so maybe we can spend a little bit of time as a
17 group -- probably maybe talk about this as a
18 group as opposed to dividing up into four or five
19 groups again. Have a little discussion that gets
20 into the parameters of like, well, eventually to
21 come up with, well, what are these domains and
22 then start mapping them to the measures and all.

1 And we don't have to sort of micro do
2 this, because that will be for the iterations,
3 but to get a little bit further on, now that
4 you've heard these five different groups'
5 perspectives, and there's actually more consensus
6 than not, if we're trying to come up with
7 something that we're all having on the same page
8 as a starting point so that it's far enough along
9 and the staff can then sort of get into the
10 details.

11 Why don't we spend a little bit of
12 time talking about that as a group, then, of
13 like, well, what would be under this revised sort
14 of like model that incorporates the best of
15 things? Like where do you want to start in terms
16 of domains and ways for approaching for this?

17 DR. BURSTIN: Could I suggest that we
18 not forget about the dimensions? I feel like
19 people are actually talking on different planes
20 at times. Maybe if you got that set, I think
21 some of the rest of it would flow better.

22 CO-CHAIR CHIN: Maybe you can explain

1 that again, Helen, just to make sure we're on the
2 same page.

3 DR. BURSTIN: I just heard multiple
4 levels of things like it's the level from
5 community to patient. No, it's the level of --
6 it's some of these key factors. I feel like
7 there's -- it sounds like there's probably a
8 dimension of this that does kind of cross the
9 layers. Then they don't need to be in the
10 domains. They could be separate. And then what
11 would be left in the domains could always then
12 reflect whatever you think that key dimension is.
13 Does that make sense?

14 MEMBER RAUNER: We assumed that was
15 your job to make it all clear for us.

16 (Laughter.)

17 DR. BURSTIN: I can't make into a
18 slide. I can't figure out like the third
19 dimension.

20 CO-CHAIR CHIN: I'm actually going to
21 ask the staff, because they're the ones that are
22 going to take the first crack at it and then

1 coming up with like a more detailed plan.

2 CO-CHAIR PONCE: We did have a break
3 scheduled, so why don't we take a break and --

4 (Laughter.)

5 (Simultaneous speaking.)

6 CO-CHAIR PONCE: Yeah, can we just
7 take the -- we're supposed to give them 15 now
8 anyway, so we could give them 15.

9 CO-CHAIR CHIN: A 15-minute break. So
10 maybe come -- meet again at 3:30?

11 CO-CHAIR PONCE: Sure.

12 CO-CHAIR CHIN: Okay. Great.

13 (Whereupon, the above-entitled matter
14 went off the record at 3:15 p.m. and resumed at
15 3:43 p.m.)

16 CO-CHAIR CHIN: Okay. Thanks,
17 everyone. We had sort of a quick brainstorming
18 session that involved the NQF staff team: Helen,
19 I think Ignatius was there, Ninez and I.

20 And so we're going to show four main
21 slides that are almost like sequential that are
22 our first crack at at least trying to condense

1 some of the ideas people had. And then we need
2 to still sort of work on it as a team here. The
3 four being: measurement domains -- in some ways
4 that was the original thing we had done the
5 breakouts for, to try to come up with measurement
6 domains. And so we tried to put them all down
7 from the five different groups onto one slide and
8 collapse in common categories.

9 A second is the level of focus, which
10 will look more similar to like the original six
11 different levels in our socio-ecological model.

12 Third downstream is going to be
13 accountable entities. Again, downstream NQF has
14 these performance measures and CMS has
15 accountable entities that will then submit their
16 metrics and then be accountable for them.

17 And then the last is again to
18 summarize that the downstream are going to be the
19 policy levers and the recommendations that we'll
20 eventually make as a committee about how this all
21 fits together and how we can use these levers to
22 increase equity.

1 So that's sort of like the four. You
2 almost visualize like these four slides if they
3 were situated left to right, because this is
4 almost sequential in terms of sort of the
5 thinking.

6 So first is the most complicated one.

7 Maybe go to that slide, Madison. So
8 this was the attempt to put down all the major
9 domains from the five different breakouts.

10 MEMBER SCHOLLE: This is Sarah.
11 Sorry, I'm on the phone. Is it being projected
12 on the WebEx?

13 DR. BURSTIN: Is it being projected?
14 Could it be or should we just send it to her?

15 We're taking care of that now, Sarah.
16 It was very quick on the sly --

17 MEMBER SCHOLLE: No, I get it. Thank
18 you, though.

19 CO-CHAIR CHIN: In fact, what we'll
20 do, why don't we like go through the four, five
21 slides quickly and then go back to this one, just
22 so people get a sense of the overall layout.

1 So you see that this one has the
2 individual domains. So this is the closest to
3 like the lists that were on the white sheets that
4 East Group had come out with. And we'll come
5 back to this in more detail in a moment.

6 The next slide is -- so next slide.
7 So these are the amended six levels with the
8 addition of now family social network in between
9 patient and clinician.

10 Next. We kind of wanted -- again, the
11 way to think about this is to like think about
12 the different CMS programs and the different
13 entities that potentially could be a measurement
14 for, so I mentioned clinicians on the bottom,
15 hospitals, health plans, ACOs. You could have
16 these higher aggregates. For example, like
17 regions and states could be accountable. They
18 could be national measures, too. So CMS could be
19 accountable. Accountable entities.

20 MEMBER SANCHEZ: Can you back that up
21 for a second? I'm just -- and so can I talk out-
22 loud? So, regional and state is bigger than a

1 community or city/county level? Are you
2 including that and capturing that or not? I mean
3 --

4 DR. BURSTIN: We were not that
5 precise. We're happy to add that level of
6 precision. We just literally just threw up
7 regional and started throwing stuff around.

8 CO-CHAIR CHIN: This one was 20
9 seconds per slide.

10 MEMBER SANCHEZ: I think back to the
11 point of the -- at city/county level, now you
12 have a local health department that has some
13 responsibility for some of those issues.

14 CO-CHAIR CHIN: That's a great point.

15 DR. BURSTIN: Yes, thank you.

16 CO-CHAIR PONCE: Emilio and Philip?

17 MEMBER CARRILLO: Regulatory entities,
18 such as NCQA for the patient-centered medical
19 home, which is quite important, and The Joint
20 Commission for hospitals.

21 DR. BURSTIN: As accountable entities?
22 So we're thinking about accountable as those who

1 would be measured.

2 MEMBER CARRILLO: Yeah, they're the
3 ones who basically would pass a hospital, give it
4 its certification. The NCQA would give
5 ambulatory sites certification as medical home.
6 So that could be a very important lever driver.
7 And they are accountable entities in the sense
8 that they regulate and provide incentives,
9 positive and negative, for things which could and
10 should include -- and for example, The Joint
11 Commission does look at language services as a
12 very important part of their review.

13 CO-CHAIR CHIN: And maybe like the
14 next one -- actually go to the last slide, that
15 we don't have here right now, but the last slide
16 was going to be policy levers. So that there's
17 all the -- .

18 MEMBER CARRILLO: That's better.

19 CO-CHAIR CHIN: We have like the
20 immediate ones. So like the CMS' value-based
21 person programs, pay-for-performance programs,
22 public reporting.

1 CO-CHAIR PONCE: Sorry, Philip, are
2 you on this point?

3 MEMBER ALBERTI: Just a quick question
4 for clarification. We've discussed a lot today
5 kind of a dual charge to, A, think more broadly,
6 so kind of beyond NQF/CMS work, but also to then
7 focus maybe back in on what we could actually
8 suggest.

9 So some of my comments that I would
10 like to make I'm not making because I'm worried
11 that they're too far afield. So for accountable
12 or entity, community, patients, we're not going
13 to -- you might not measure them, right? They're
14 not accountable to NQF or CMS, but they're
15 certainly accountable in all of this larger
16 conversation. So there are certain policy levers
17 that aren't CMS-able or NQF-able that also are at
18 play here.

19 So are we going for kind of the very
20 targeted, specific recommendations for this piece
21 of the roadmap or really kind of expanding this
22 conversation? Because I thought we taking about

1 a broader, kind of the whole enchilada from which
2 we'll kind of then pare down later.

3 MS. O'ROURKE: Do you want me to try
4 to take that and --

5 CO-CHAIR CHIN: Yeah, go ahead.

6 MS. O'ROURKE: So I think perhaps for
7 now let's put it all out there. I guess I was
8 almost thinking, could we do two types of
9 entities: accountable and supporting, to capture
10 the role of organizations like CMS that might not
11 be directly measured, the patient, to Ron
12 Copeland's point about medical schools, where do
13 they fit in? Emilio, your point about
14 accreditation organizations and what they could
15 do.

16 But we're not, at least in the charge
17 of NQF, measuring those entities as a role there
18 -- because I think we'd like to get it all out
19 there for the roadmap about everything we could
20 do and then focus in on for each of these
21 entities what could you concretely measure
22 through a policy program?

1 MEMBER ALBERTI: Thanks. That's
2 helpful.

3 CO-CHAIR CHIN: Why don't we go back
4 to the mechanism slide? That was the complicated
5 one. I think it's the one that needs the most
6 work where again we basically tried to put down
7 the individual points on the five or six -- five
8 sheets that each group had come up with and tried
9 to do some lumping. So these are the measurement
10 domains. And so I guess either -- I guess a
11 number of different -- well, actually, before we
12 open it up, Helen, you did like some of the
13 lumping. Do you want to talk a little bit about
14 the lumping that isn't color-coded here?

15 DR. BURSTIN: Yeah, and some of it's
16 behind Drew's head over there. We started
17 looking at and it seemed like things like system
18 preparedness could potentially be nicely lumped
19 with -- I'm sorry, Drew, could you move?

20 (Laughter.)

21 DR. BURSTIN: Thank you. Thank you.
22 No, that's fine. I think it's fine there. Yes.

1 So thank you, yes. He'll play Vanna White. So,
2 yes. System preparedness potentially has a lot
3 of the same elements as this institutional
4 culture and structures for equity. There was
5 clearly something about both access to quality
6 care and then provision of care. There was very
7 much something about leadership and leadership
8 accountability. And you could see several of the
9 others listed there.

10 We specifically added environment in
11 here because it was absent from the older
12 cultural competency sort of orientation. And
13 some of the rest of these may wind up being sub-
14 domains. So we just wanted to put them all up
15 there for you so you could see them. Several
16 different groups, the one with stars are the ones
17 that came up multiple times. Something about
18 communication, something about community
19 engagement, something about workforce diversity.

20 So there's a lot of similar themes in
21 there. We think we probably could, with your
22 help, maybe get to five or six of them. They

1 don't look like there's really 15 of them. I
2 think a lot of them would logically collapse. So
3 we thought before you put there back out there to
4 define any of these, it might be useful to have a
5 broader conversation. Is that what the thinking
6 was?

7 CO-CHAIR CHIN: Yes, so maybe if we
8 can blow that back up, just this last slide so
9 maybe we can see it better.

10 So at this point maybe the first sets
11 of feedbacks are things like -- so for instance,
12 are things like missing? Do you see other ways
13 to lump? Again, we don't have to get it all the
14 way down, the staff's going to be able to work on
15 it further, but get them in range.

16 So, yes?

17 MEMBER BERNHEIM: Let me make sure I'm
18 understanding the four-slide concept. So I think
19 originally we were thinking we had to go with one
20 version of domains or another, and what you're
21 saying now, if I'm understanding this right, is
22 there's a whole bunch of things we could measure.

1 There's a bunch of -- what's the next one?
2 There's a bunch of levels, and specifically
3 measured accountable entities. And the levers
4 are sort of ways to measure them, ways to use the
5 measures. And so we're not going back to what we
6 were trying to do before. Now we're just going
7 to sort of stay in those four buckets. Which I'm
8 comfortable with. I just want to make sure I
9 understand.

10 CO-CHAIR CHIN: Yeah, the four buckets
11 in some ways were -- they were try to help the
12 flow of overall work left between now and
13 September for the Committee. Well, ultimately
14 it's going to be like the -- the last one is
15 going to be like the muddy one in terms of like
16 what are the different recommendations this
17 committee for how to use measurement to improve
18 equity? But sort of sequential, where the one
19 we're on now is like what are we going to
20 measure? The ones that are more proximal.
21 There's the one about the accountable entity.
22 So, the most proximate.

1 So to Philip's point about like what's
2 the most relevant for NQF and CMS? Well, CMS'
3 programs and would they require then performance
4 reporting? Well, what are these entities? Like
5 the hospital or like the clinician group? So
6 this is basically sort of the flow. So if we
7 just talk about measurement domains in isolation,
8 then it's hard to sort of say, well, yeah, how
9 does it relate to the ultimate goal and what's
10 the ultimate goal?

11 CO-CHAIR PONCE: Kevin, then Tom.

12 MEMBER FISCELLA: Couple of things
13 that I didn't see under the measurement that I
14 heard come up. Two are implicit -- or explicitly
15 expressed and the other I think probably is
16 implicit.

17 One is the issue of segregation of
18 care that I think I heard some of the work groups
19 mention. And related to that is sort of the
20 concentration of disadvantage, which creates a
21 huge challenge and needs, sort of analogous to
22 city school systems. And perhaps related to that

1 is the issue of how does one then -- and whether
2 this could be a potential measure -- alignment of
3 resources with those needs. So if you have high
4 social needs or high needs to improve the
5 effectiveness of a particular care, do you have
6 the resources, the corresponding resources
7 necessary to do that? So I would add those
8 three.

9 CO-CHAIR CHIN: Yeah, one thing, which
10 I can't remember the exact list right now, but
11 one of the areas that probably needs to be
12 ballooned out was like the social factors one,
13 which I think probably that was sort of imbedded
14 in there, but that needs to be blown out or made
15 more specific. So actually that's something that
16 would be very be greatly useful of what will be
17 some of the key sub-domains within that very
18 broad social factor domain.

19 MEMBER BERNHEIM: I see social risk
20 factors under system preparedness. Adverse
21 social risk factors.

22 DR. BURSTIN: Yeah, those are

1 different yes.

2 MEMBER BERNHEIM: But what's he
3 talking about is different.

4 DR. BURSTIN: Yeah.

5 MEMBER BERNHEIM: He's not talking
6 about the systems preparedness. He's talking
7 about sort of how people are segregated, right?
8 And then the system can only be so prepared to --

9 (Simultaneous speaking.)

10 DR. BURSTIN: I think I tucked that
11 under something, but I can't see what it was. I
12 think it may have been under provision of care,
13 but I think it's an important -- I don't want to
14 lose the concept. It's hard to see the little
15 scribbles. Oh, there it is. I see it. I put it
16 next to the access and provision section. I left
17 segregation. We just forgot to tell Madison on,
18 so she was furiously trying to type up the
19 scribbles.

20 CO-CHAIR PONCE: Tom?

21 MEMBER SEQUIST: So I'm just going to
22 keep harping on this. So you have decision-

1 making, which I assume encompasses bias in
2 decision-making. So I just feel like we should
3 explicitly say that bias is a domain. Like just
4 to destigmatize, I mean, if you were in a patient
5 safety meeting, it would be thrown out
6 immediately. Physicians have bias in their
7 decision-making, right, anchoring, heuristics, or
8 all these other things. I just think it's okay
9 to throw that out there and say physicians have
10 bias in this space as well. If you want to call
11 it a cognitive disposition to respond or
12 whatever.

13 (Laughter.)

14 MEMBER SEQUIST: I'm not making that
15 up. That's right out of the safety literature
16 because people didn't want to use the word
17 "bias."

18 DR. BURSTIN: You can use the word
19 "bias" if you want to use the word "bias."

20 CO-CHAIR PONCE: Romana?

21 MEMBER HASNAIN-WYNIA: I agree with
22 Tom, but I would broaden it to clinician. I

1 mean, we're in the world of team-based care and I
2 would not just say physician.

3 MEMBER BERNHEIM: Just on that, I
4 might think about putting it under the equitable
5 provision of care, not to hide it, but to make it
6 clear that it's one of the drivers of inequitable
7 provision of care. So it may fit there if you're
8 trying to create categories, but I would agree
9 with you, I would name it.

10 MEMBER SEQUIST: There were a couple
11 -- I sort of -- I think the decision-making and
12 the equitable provision of care. I thought you
13 had -- Helen, you'd said probably a bunch of
14 these will get collapsed or --

15 DR. BURSTIN: It's up to you. We
16 would welcome your thoughts. I mean, it seemed
17 like several of them really could be. And maybe
18 one thing we could even do is put these on paper
19 and let you guys have at it, even if you want,
20 later, just to say I think these could be bunched
21 this way.

22 CO-CHAIR CHIN: Yeah, I mean, right

1 now there's not a coherent logic to the list and
2 the order it is right now. It sort of is a
3 hodgepodge. So there's going to be probably a
4 ways to both collapse and order so that it makes
5 conceptually more sense.

6 MR. BAU: So one way that in my head
7 some of this works together, I don't know if this
8 helps or further complicates it, we really are
9 thinking about not the left to right sort of flow
10 of logic, but in some ways a three-dimensional
11 model of saying that these are some topics. And
12 then the question will be, is it appropriate at
13 every of those socio-ecological levels for which
14 there are accountable entities, does it make
15 sense to hold every one of those socio-ecological
16 levels and accountable entities responsible for
17 something like cultural competency? And could we
18 come up with measures at each of those levels and
19 for each of those entities?

20 So it really is toggling sort of this
21 three-dimensional model. And at some point, I've
22 always thought, especially when we get to the

1 community level, the policy level, we're not
2 going to have anything to put into those cells
3 because we just haven't thought of those things.
4 And we're going to be much, much more comfortable
5 populating down at the provider level. We're
6 also, I think, going to have very little at the
7 patient level and the family and social network
8 and caregiver level as well, but that is also, I
9 think, useful for a roadmap to say these are all
10 the areas where we need development.

11 CO-CHAIR CHIN: That's very helpful,
12 Ignatius. And when you look at this particular
13 slide -- like the next slide has some of those
14 dimensions, the different multilevels. When we
15 look at this slide -- yes, this a hard question,
16 but off the top of your head, do you find ways to
17 bring more order to this slide?

18 DR. BURSTIN: And some of that comes
19 back to your comfort level of being a lumper or a
20 splitter. I mean, again, if you're thinking
21 about access, just to throw it out there, as a
22 domain, I think much of what is out there then

1 could become sub-domains. You wouldn't want to
2 look at access without considering the
3 segregation issue as an example of a sort of
4 mental model to do that. And I think you can
5 logically start doing some of those around
6 leadership, potentially, and some of the others,
7 but just a way of thinking about it maybe.

8 MEMBER SCHOLLE: This is Sarah. I'd
9 like to get in the queue when I can.

10 CO-CHAIR CHIN: Sarah, Eduardo, and
11 then Emilio. Go ahead, Sarah.

12 MEMBER SCHOLLE: Okay. So I am
13 definitely a lumper. And just reading this,
14 because I missed some of the last discussion, I
15 do see kind of groupings of things that I might
16 want to propose. Like, for example, cultural
17 competence, to me, as a characteristic is about
18 organizational culture and how you interact with
19 -- but also has a piece of interaction with
20 patients and families. And so, I might think of
21 it as there's leadership and responsibility
22 related to that. You get governance under that.

1 You get policies under that. And then you might
2 have institutional culture and structures for
3 equity. So maybe that becomes one big lump that
4 also includes -- that's more about how the
5 organization is set up.

6 And in the earlier discussions with
7 Ignatius and Ron we talked about social risk
8 factors and how those fit with addressing those
9 factors. There's a piece of collecting the data,
10 being able to provide services, and then
11 connecting to community services around those
12 topics.

13 As I look at this, there's always
14 three or four ways to lump and split categories
15 like this that we've done in other measurement
16 frameworks. And so it might be helpful -- one
17 way that might help to think about how we
18 organize these is to say what's the -- what are
19 we trying to get at through this piece? Like
20 what's the outcome we're trying to get at?

21 And I think different people might
22 want to put these into different groups and I

1 just wonder if it makes sense to -- at the level
2 of these domains it's hard for me to kind of
3 telegraph exactly -- understand exactly what
4 people were thinking about when they put multi-
5 sector collaboration or gave stratification.

6 So I wonder if rather than thinking of
7 them as topics, was there a piece of work that --
8 do we need to go down a little bit to the next
9 level to understand where these are -- how we
10 further define these topics and not allow this to
11 get to groupings, or do we want to group this way
12 and then start to play it out, and then that will
13 tell us what we're missing? You can go either
14 way in a list like this.

15 CO-CHAIR CHIN: Yes, thanks, Sarah.
16 We got like five people in queue, so let's get
17 the ideas out. Then we can circle back on what
18 may be next steps.

19 So I think we had Eduardo, Emilio, Bob
20 and then Philip.

21 CO-CHAIR PONCE: And then Yolanda.

22 CO-CHAIR CHIN: Oh, Yolanda back

1 there.

2 MEMBER SANCHEZ: I'm going to
3 apologize in advance because I'm not sure this is
4 going to make things easier, because I think that
5 the -- when I think about the socio-ecological
6 construct and those domains, not everything --
7 we'd all agree not everything fits into each of
8 those domains. One in particular would be the
9 access and provision of quality care. That's not
10 going to fall at the patient -- at the person
11 level or even at the family level. And I don't
12 know what the equivalent is, but there are some
13 things where the words we're using suggest some
14 kind of equivalency across those. System
15 preparedness for an individual is going to be
16 readiness for change. It could be. I'm just
17 suggesting.

18 Decision-making might be lumped with
19 governance when we're talking at one level of the
20 socio-ecological model. In a different place it
21 is very much about patient care, and actually
22 decision-making would belong at a person level as

1 well when we're thinking about it that way. I
2 would maybe suggest we change "communication and
3 understanding" to "communication and" maybe
4 "comprehension," because the understanding -- I'm
5 almost getting confused with the word "care" as
6 caring about people. And understanding goes both
7 ways, right? It's comprehension and also having
8 a sense of empathy.

9 And then the community engagement,
10 while it might be similar to multi-sector
11 collaboration, the way I think about community
12 engagement is a little bit like thinking about
13 patient-centeredness. It is about thinking of
14 the community as a partner in what you're doing
15 as opposed to just getting them to be part of a
16 multi-sector collaboration, if that's making any
17 sense.

18 So I think this is a great start, but
19 we probably need to do a little bit of thinking
20 about the words, the exact words we're using,
21 what they mean, and try to do a little bit of
22 lumping all simultaneously. Probably a dinner

1 and drink exercise or something.

2 (Laughter.)

3 CO-CHAIR CHIN: Yes, great comments.

4 That -- my guess is like some of these were taken
5 straight from the white sheets so that -- which
6 we're only thinking about one level and --

7 MEMBER SANCHEZ: No, I get that. I
8 mean, I get that we're trying to smash things
9 together that weren't -- that's not the way we
10 constructed them. And we're doing our best.

11 CO-CHAIR CHIN: Okay. So we had
12 Emilio. Then we got -- I think it was Bob,
13 Philip and Yolanda.

14 MEMBER CARRILLO: I would lump them
15 into two categories. One of them would be social
16 and cultural and the other one would be system.
17 And the social and cultural would include
18 environment, equitable access, the seven domains
19 that NQF already has looked at.

20 And in terms of system, I would have
21 system preparedness, multiple sector
22 collaboration, advocacy, equitable provisions.

1 So that gives some rationale lumping the social
2 and cultural and lumping the system. Just a
3 suggestion.

4 CO-CHAIR CHIN: Thanks, Emilio.

5 Bob, Philip, Yolanda.

6 MEMBER RAUNER: Yes, I'm also kind of
7 a lumper, but I'm trying to figure out how to
8 lump these. And the one thing I was talking a
9 little bit earlier with Mauricio about was maybe
10 using the collective impact model framework where
11 you've already established five party areas for
12 us: cardiovascular disease, cancer, diabetes, and
13 that the main domains, maybe those are the shared
14 measures within those.

15 And then a lot of these are factors
16 that are going to affect your ability to impact
17 that measure. Then maybe that might be a
18 hierarchy to put them in because a lot of these
19 are going to help you, for example, improve HPV
20 vaccination or colorectal cancer screening.
21 These are all factors that are resulting in
22 disparities or would help to narrow them. I'm

1 just trying to figure out any way to try to
2 figure out how to lump this and put it in a
3 framework. Maybe collected impact would work,
4 because it has communications as part of it as
5 well and some other things.

6 CO-CHAIR CHIN: Thanks, Bob.

7 Philip and then Yolanda.

8 MEMBER ALBERTI: I'm also going to
9 suggest some radical lumping.

10 So I think it's also important that we
11 focus all of the lumping domains on equity,
12 right? So here's how I would try to do this. I
13 would have a domain that was culture of equity.
14 I think that involves a lot of the things that
15 Emilio was talking about. Then structure for
16 equity. Then access for equity and care for
17 equity.

18 And I think across those four domains part
19 of -- a number of the bullets here were actually
20 some of our sub-domains from getting ahead of
21 ourselves, but I think between the cultural
22 structure, access and care all are oriented

1 toward equity. I think a lot of these plus many
2 of the concepts that aren't on here that we've
3 been flirting with would also potentially fall
4 into one of those four.

5 CO-CHAIR CHIN: Thanks, Philip.

6 Yolanda?

7 MEMBER OGBOLU: So I was going to say
8 definitely there is -- seems to be consensus
9 around having at least one category that focuses
10 at the system level. And I would agree with
11 that.

12 And then as I looked at the
13 measurement domains, it just struck me that
14 health literacy is missing from this list. And
15 then social cohesion or social capital. So I'm
16 not trying to make the list -- add more to the
17 list, but I mean, those ones just seem like they
18 really should be there to me.

19 CO-CHAIR CHIN: Yes, and these --
20 actually some of these -- the labels in some ways
21 need to be broad enough that the sub-domains,
22 like those have a logical home. Yes.

1 MR. BAU: I have a list of eight.

2 (Laughter.)

3 MR. BAU: So mine would be data -- so
4 both at a community level, but also at an
5 individual level, and stratification. So that
6 would be one.

7 Number two is access, which I think is
8 really important as -- all the issues around
9 access including geographic access.

10 Three would be workforce diversity and
11 competence and composition. So all the workforce
12 issues.

13 Four would be the provision of care.
14 That includes bias, but also population health
15 management.

16 Five would be more the interpersonal
17 communication and shared decision-making
18 processes. That would include literacy,
19 language, access, assistive technologies for
20 individuals with disabilities.

21 Six would be community engagement,
22 which would more be the role of patients and

1 consumers in the healthcare system.

2 Seven would be multi-sectoral
3 collaboration and partnerships in the collective
4 impact space of what is the role of health versus
5 other sectors.

6 And then I think the hardest as a
7 policy person is eight, which is the public and
8 private policies.

9 CO-CHAIR CHIN: Yes, these are all
10 helpful. I think we got some good things to work
11 with, and so I think the NQF team will be able to
12 come up with some good options and circle back
13 then to the Committee. This is great.

14 Well, the next slide is -- so I see --
15 and moving on to the next slide.

16 Yes, any comments here? I mean, we
17 see the addition of the family/social network.

18 Next slide. We haven't talked about
19 this much yet as a group. So this is the capital
20 entity issue, the more narrow charge about
21 specifically for CMS and the measures that are
22 being used for current programs or soon-to-be

1 programs.

2 Yes?

3 MEMBER ALBERTI: I do think just for
4 consistency sake, even if there are some blanks
5 in the model, that if we have a model that has
6 all those levels on the proceeding side that
7 there should be accountable entities within all
8 of those levels.

9 CO-CHAIR CHIN: Yes.

10 MEMBER ALBERTI: So if we have a level
11 at the patient level or at the family level,
12 those are still accountable entities even if
13 we're not going to be measuring and publicly
14 holding folks accountable in that space.

15 CO-CHAIR CHIN: Yes, so what else
16 would you add here to this list?

17 MEMBER ALBERTI: I think we should
18 draw all the way down. If the levels go down to
19 patient, family and caregiver, we should go down
20 to patient, family and caregiver.

21 CO-CHAIR CHIN: Tom and Romana? I'm
22 sorry, Tom, Romana and Yolanda, yes.

1 MEMBER SEQUIST: There was a protest
2 to your left, but she didn't have her --

3 (Laughter.)

4 MEMBER SEQUIST: So I wonder on there
5 if we should put in is it accountable entity
6 employers? Big employer groups. So like we
7 think of ourselves as a -- like as a hospital as
8 accountable for our -- the employee -- the health
9 of our employees. And particularly, I mean,
10 there's a lot of diversity in big companies. So
11 it seems like a major pillar of how our health
12 system is sort of set up, because a lot of these
13 people are also paying for all the healthcare,
14 right? All the employers.

15 CO-CHAIR CHIN: Good. Thanks, Tom.

16 So Romana?

17 MEMBER HASNAIN-WYNIA: Can we go back
18 to the previous slide just for a second?

19 So this is level of focus, and I guess
20 when I see the word "community;" I mean, we see
21 it a lot, but I'm not sure what we mean by
22 "community." So when -- sometimes when I think

1 community, I think community as a neighborhood.
2 So neighborhood organizations, community-based
3 organizations.

4 And what is missing here is the focus
5 on the inter-sectoral partnerships. So schools,
6 faith-based. I mean, I'm trying to think of the
7 different -- transportation, housing. And I
8 don't know how to capture that. And I don't know
9 if that's just going to come out in terms of our
10 broader definition or when we start to put a
11 little bit more structure around this that it
12 will come out in that context.

13 But I do think that we need to
14 distinguish what we mean by "community," which
15 seems like a catch-all versus community and these
16 other organizations where there has been some
17 really good work done in terms of that inter-
18 sectoral collaboration.

19 CO-CHAIR CHIN: So, while you have the
20 mic there, Romana, so you mentioned the inter-
21 sectoral part, so that other -- so the non-
22 traditional health sectors. You mentioned

1 neighborhood level. Anything else you would want
2 to have -- put in the mix?

3 MEMBER HASNAIN-WYNIA: Not at this
4 point. I think those are the two that just came
5 to mind.

6 CO-CHAIR CHIN: Okay. Great.

7 CO-CHAIR PONCE: So that was actually
8 -- my point was what -- where would schools fit,
9 for example? And where -- although -- and also
10 what if what we come up with does not really have
11 a policy handle or accountability factor? So are
12 we being aspirational or are we then prescribed
13 to where we know it's within the jurisdiction of
14 a public -- a local public health organization,
15 county health organization? So that was must my
16 thinking.

17 CO-CHAIR CHIN: I like what Philip
18 said, if I get this point, keeping broad. There
19 may be a general model that -- just like the
20 model for everything. And then I think rapidly
21 CMS and staff are going to sort of -- like we
22 have a September deadline and what's the

1 immediate priority for what our charge is? But
2 this will again be a nice foundation for both the
3 September report as well as ongoing work beyond
4 that.

5 CO-CHAIR PONCE: Emilio?

6 MEMBER CARRILLO: I would add to the
7 level of focus population, because population
8 could be taxi drivers in New York, population
9 could be nursing home residents. It could be
10 geographic. And that's the term of art right now
11 in terms of how we look at a lot of health
12 improvement.

13 CO-CHAIR PONCE: I initially agree,
14 but I'm also seeing maybe -- I'm feeling there's
15 discussion on this.

16 Helen?

17 DR. BURSTIN: Just listening to what
18 everybody's been saying, it seems like -- I'm
19 just going to try to be very lumpy, so keep that
20 in mind.

21 (Laughter.)

22 DR. BURSTIN: It seems like there's

1 something around data and identification of
2 social risk or social factors, whatever.
3 Something around the data piece that goes into
4 social risk factors. There's something about
5 environment and access to care. We keep coming
6 back to lots of things could fit under there,
7 playing off of Philip's list. Something around
8 structure, which could include workforce
9 diversity and competence.

10 And then something, which we haven't
11 really -- is just quality, provision of high-
12 quality care. I think some of which is
13 interpersonal communication, health literacy.
14 Some of those issues could get factored under
15 there. I'm still left not sure exactly what to
16 do with this multi-sectoral collaboration because
17 I think it's really unique and important to this
18 space, but at least to me it sounds like much of
19 what we've talked about sort of fit under those
20 four. But we could certainly play with it
21 tonight. We'd love your reactions.

22 Something around data environment --

1 data and identification of social risk. That's
2 sort of one bucket. Environment and access to
3 care is a second. Third, something around
4 structural workforce diversity and competence.
5 And a fourth around provision of high-quality
6 care, keeping in mind many sub-domains could help
7 us really kind of make those sing.

8 CO-CHAIR PONCE: Susannah, Eduardo,
9 then Bob.

10 MEMBER BERNHEIM: On the coordination
11 piece, I don't know what the right category is,
12 but when the -- maybe I'm not remembering, so but
13 I feel like when the IOM wrote what they could
14 about what was known about affected interventions
15 that that was really one of the pieces is this
16 collaboration. So I -- and I agree with you, it
17 doesn't feel like it's falling in. It's this
18 sort of expanding the walls of the institution
19 and make sure that there's coordination between
20 these issues. So I think that can get lost. I'm
21 not sure that that can get subverted into those
22 four.

1 And on the quality I'm fine with that
2 being a big lump, but I just want to -- this
3 issue of sort of patients' experience, not just
4 sort of cultural competence or if the provider
5 checks the box, but the experience the patient
6 has walking into a clinic and whether or not it
7 feels like a place that is welcoming. And we
8 just want to make sure that stays -- if it
9 doesn't have its own bucket, that it stays in the
10 quality bucket, the experience of discrimination
11 or what have you.

12 CO-CHAIR PONCE: Eduardo?

13 MEMBER SANCHEZ: Helen, to the point
14 that you made about multi-sectoral collaboration,
15 I could think of things that would belong there
16 that don't necessarily -- so one might be the
17 transportation system, having a bus route that
18 assures that people can get off at clinics and
19 other social services places. And even the level
20 of accountability is a very different kind of
21 thing than say assuring that the YMCA and the
22 clinic systems have some connectivity around

1 people with diabetes, with pre-diabetes, right?
2 That's an extension of the clinical care system.

3 And the transportation is but one
4 example, but there are probably many. And we
5 would want to figure out how you capture those,
6 because even again the notion of accountability
7 is going to be a very different level of
8 accountability than the YMCA delivering DPP well
9 on behalf of patients.

10 MEMBER RAUNER: I was going to point
11 out some things that are mentioned that I think
12 are often overlooked sources of the health data,
13 one being the schools. So for example, Lincoln,
14 85 percent of their kids are in the school
15 system. The school nurses collect weight
16 screening. They do vaccination reporting. They
17 track that. The PE teachers do FitnessGram,
18 which gives you great aerobic fitness measures.
19 All of it's stratifiable on race, ethnicity,
20 income status with reduced-cost lunch. And so
21 sometimes the schools I think is an overlooked
22 source of health data.

1 The other thing, like Tom mentioned,
2 with employers, if you have a self-insured
3 employer that's doing employee wellness and has
4 an on-site clinic, a lot of what they're doing is
5 very similar to what an ACO is doing. And our
6 community our ACO efforts are starting to run
7 into our self-insured employee efforts in a good
8 way, but it's kind of interesting how these are
9 coming together. And so employer and school data
10 is often another source of health data that's
11 overlooked.

12 CO-CHAIR PONCE: Thank you.

13 Philip?

14 MEMBER ALBERTI: Just to add a bit
15 more detail on the collaboration conversation.
16 We spent a lot of time talking about that in our
17 group, and I think part of the problem we're
18 having is we never -- we didn't use the word
19 "multi-sectoral" in the larger domain. So we
20 thought about again collaboration across all
21 those levels. That could be the shared decision-
22 making between patient and provider all the way

1 up through the kind of multi-sector
2 collaborations that Eduardo was talking about or
3 kind of the learning health system collaborations
4 within the institution. So perhaps if we save
5 the multi-sectoral for that kind of highest level
6 of collaboration. But there's many different
7 other levels kind of below that where entities
8 and individuals can collaborate as a domain.

9 DR. BURSTIN: And maybe just
10 collaboration as a domain --

11 MEMBER ALBERTI: Yes. Yes.

12 DR. BURSTIN: -- that much of this
13 stuff could fit under.

14 CO-CHAIR CHIN: So a request from Erin
15 that we go back to that first slide that had the
16 domains. I'd ask Erin what does she and her team
17 need to -- most need? They're going to try to
18 actually come up with a strawman set of collapsed
19 domain categories tonight to show to us tomorrow.

20 When we look at this raw one here with
21 all the different ones, are there any key things
22 that are already missing beyond what people have

1 already said. I remember that Yolanda mentioned
2 a couple things. I'll just mention a couple
3 things. Anything else missing that people want
4 to put on the table now?

5 CO-CHAIR PONCE: Kevin?

6 MEMBER FISCELLA: Yes, Philip
7 mentioned the idea of a learning health system,
8 and I think that that whole principle of learning
9 and the cycle of having a goal, planning, action
10 steps, reflection, sharing, learning from others
11 and then regrouping and again adapting to hit
12 that target -- I think that that encapsulated --
13 and call it improvement in a PDA cycle really
14 applies across all levels, whether it's the -- a
15 patient doing their own self-management planning
16 and figuring out what works or not, it's all the
17 way up to high levels of government where one is
18 learning from what one's done based on the data.

19 And I think that the robustness of
20 that sort of complex adaptive system of learning
21 is almost fundamental to change and being able to
22 enact stated priorities, in this case health and

1 healthcare equity.

2 And so I mean, I could see where maybe
3 you could group it under maybe system
4 preparedness, but I think it's really perhaps
5 more fundamental because it's one of the things
6 that we would want to incentivize. I think
7 ultimately it's not going to be finding some off-
8 the-table intervention and applying it there.
9 It's -- we know that context is everything. And
10 it's really going to be how robust is that system
11 for learning from others and adapting and
12 engaging a continuous learning cycle.

13 CO-CHAIR CHIN: Yes, of course this
14 would be like in the original strawman it was a
15 culturally tailored QI component with the idea
16 that it's going to be a continuous process, it's
17 going to be tailored for equity, this learning
18 healthcare system.

19 MEMBER FISCELLA: And across all
20 levels.

21 CO-CHAIR CHIN: Yes. Yes.

22 MEMBER FISCELLA: Yes.

1 CO-CHAIR PONCE: Christie?

2 MEMBER TEIGLAND: I just want to throw
3 out again the concept of value here because we
4 all know logically that improved outcomes should
5 lead to value, but it doesn't always. And the
6 example I gave in our group discussion was we're
7 working on this study of air transport, and
8 particularly from a rural area we can't show
9 value, but we know there's great value to those
10 patients who receive it, but it's never going to
11 pay for itself, even though the outcome could be
12 that person won't die versus they do, right? But
13 it's that you can show value if it's a -- within
14 a city or something like that.

15 And when we're talking about issues
16 like transportation and we're making these
17 collective decisions, it's always going to come
18 down to who's paying for that. Who's responsible
19 for making sure the bus -- who's paying for that,
20 right? So how do we incorporate the value
21 structures into this to make sure in practice and
22 in the world we live in it can happen, right?

1 And I'm not sure what the answer is.

2 CO-CHAIR CHIN: Can you define
3 "value?" Like what you're getting at. This is
4 the age-old question, but just to make sure we
5 all understand what you mean by "value" here.

6 MEMBER TEIGLAND: Yes, I really mean
7 showing cost-benefit value that are the questions
8 that payers always get asked that lots of
9 programs are structured around now from the
10 Pioneer shared savings programs. They're all
11 value-based care. All of those demonstration
12 projects that are going on. It comes down to,
13 yes, what does it cost and can you show us that
14 it's worth it, the money we're spending.

15 CO-CHAIR PONCE: Isn't ASPE doing some
16 simulations that address some of the value of
17 addressing social risk factors? I thought that
18 was the next phase.

19 CO-CHAIR CHIN: I think they were --
20 they're doing simulations. It was in something
21 like -- when Karen gave her presentation, they
22 were doing simulations showing things like, well,

1 who benefitted, who it harmed and what the cost
2 was to like safety net hospitals, that type of
3 thing. So a little bit different than --

4 CO-CHAIR PONCE: Different -- I guess
5 I'm saying I think we need to be mindful of that,
6 but that's also -- I'm not sure we can
7 incorporate it. I mean, or -- that's either
8 implicit here or they'll be I think more
9 difficult to incorporate now explicitly.

10 Kevin?

11 MEMBER FISCELLA: One other thing I
12 want to come back to; I was reminded when I saw
13 the telehealth measures early on, which is the
14 issue of economic burden. I really do think we
15 need to call that out as a special measurement
16 domain. I mean, it's only going to get bigger
17 regardless of what happens with healthcare
18 reform. I think it was the census data that said
19 -- that reported that only about half of
20 Americans have a little more than \$400 in the
21 case of an emergency. And with out-of-pocket
22 payments and premiums and so on like to continue

1 to go up, I think we need a measure of economic
2 burden and perhaps even some sort of ratio of
3 economic burden relative to income or something
4 like that. But I think we really do need to
5 track that over time.

6 CO-CHAIR PONCE: Okay. Noted.

7 I want to go back to the value
8 proposition, Christie, just because I think your
9 example then that worries me that we're not going
10 to have value for smaller rarer populations or
11 populations where it's really expensive, but
12 those may have to be the populations we care
13 about or we don't address their needs. So if you
14 start out with that economic value as a domain,
15 then it might have a -- it might be counter to
16 what we're trying to do in terms of equity
17 preparedness.

18 MEMBER TEIGLAND: No, I agree, but
19 it's bound to run into each other eventually, I
20 think.

21 CO-CHAIR PONCE: Yes.

22 MEMBER TEIGLAND: It's -- I mean, the

1 same thing is happening with the Affordable Care
2 Act and the expansion of Medicaid. Who's being
3 affected most? Those most vulnerable
4 populations, those most disadvantaged populations
5 who don't have -- whose economic benefit ratio is
6 so --

7 CO-CHAIR PONCE: Is the highest, yes.

8 MEMBER TEIGLAND: Right? But then
9 it's happening.

10 CO-CHAIR PONCE: Nancy?

11 MEMBER GARRETT: So two points: One
12 is the concept of concentration of social risk
13 factors. I don't think that's -- that's
14 indicated there by segregation under equitable
15 provision of care, but I'm not thinking of that
16 as a subset of equitable provision of care. And
17 that's certainly one example, but I think that's
18 a bigger category. I think there's more in
19 there. It has to do with how resources are
20 distributed across providers. It has to do --
21 there's good things about concentration of social
22 factors.

1 For example, if you have a lot of
2 speakers of a particular language at one
3 provider, then you can better provide care to
4 them. So it's not a value judgment of good or
5 bad. It's more of a thing that I think we need
6 to measure in order to understand disparity. So
7 I guess I would just argue that that's a separate
8 category.

9 And then another thing that I wonder
10 if we're missing is about cost. And the way that
11 we have measured cost so far is really around
12 cost to a payer, but what does it really cost to
13 reduce disparities from the perspective of things
14 that are not reimbursed that might be happening
15 at a provider as well as the whole social
16 services sector, and what does it take to really
17 address disparities from that bigger picture of
18 medical care and social needs? And in order to
19 truly address disparities, it seems like we have
20 to know what it costs so that we can make the
21 investments.

22 MEMBER TEIGLAND: Exactly my point.

1 CO-CHAIR PONCE: So that would be --
2 so, okay. So that would be societal cost?

3 Traci?

4 MEMBER FERGUSON: And I think to add
5 to that is when you're talking about those
6 patients who it will save that one individual in
7 terms of their life, whether we get to a point
8 where we know that there's going to be a very
9 huge financial impact that -- going up to the
10 policy level of just deciding these are a class
11 of individuals that become a protected class so
12 that we have -- in terms of like end-stage renal
13 disease and how they are -- you have end-stage
14 renal disease, that will qualify you for
15 Medicare. So we define certain groups or certain
16 entities that because of the cost to implement
17 these strategies would be so onerous that it may
18 require or we can highly recommend there is a
19 policy to add them as a protected class.

20 CO-CHAIR PONCE: Noted. Thank you.

21 Any more splitters here in the group?

22 (Laughter.)

1 CO-CHAIR PONCE: So I see health
2 literacy is there. I think social cohesion was
3 noted also by Yolanda. Social cohesion, social
4 capital. Economic burden was noted by Kevin.
5 And then I'm going to call it value in societal
6 cost. Is that fair?

7 Susannah?

8 MEMBER BERNHEIM: I'm a lump, so I'm
9 going to try and --

10 CO-CHAIR PONCE: Okay.

11 MEMBER BERNHEIM: -- not lump those
12 things.

13 CO-CHAIR PONCE: You just sit. Okay.
14 So a lot of what -- there was a category -- when
15 Helen was creating sort of mite-categories, there
16 was one about collection of information. So I
17 think to the extent that the issues around
18 segregation, both of institutions and of groups
19 -- concentrations of populations -- that can be
20 an important sub-domain of collection, right? So
21 if we're trying to understand data, we're not
22 just trying to understand a patient's background,

1 but we're trying to understand the way patients
2 are aggregated and the way institutions are
3 aggregated. So I'm just trying to help you. I'm
4 just suggesting that those don't need to be their
5 own domains if you use Helen's initial system.

6 DR. BURSTIN: I just called it data
7 and social risk, just sort of a broader category.

8 MEMBER BERNHEIM: Right, so that we're
9 trying to -- if we're trying to -- if one of our
10 categories is sort of are we collecting
11 information about social risk, I think collecting
12 information about communities and how they're
13 organized could fit into that, and that way we're
14 representing that concept without creating
15 another domain.

16 And similarly, I think the financial
17 burden ones, you really can imagine them at all
18 levels, right? So the concept of financial
19 burden for an individual who may or may not be
20 able to stand it, is parallel to financial burden
21 for a institution that may have to invest more in
22 certain activities. So I feel like you could

1 also lump -- I think you were getting at that
2 with value, but I think you could put those into
3 a single domain with this idea that you're going
4 to measure this at different levels. So just one
5 thing.

6 CO-CHAIR PONCE: You talk about
7 learning from different communities. So did I
8 miss -- was it Kevin's point or Phil's point on
9 learning -- I think Kevin's point on learning
10 from each other on interventions or -- could you
11 restate it again?

12 MEMBER FISCELLA: Yes, it's a
13 combination of culture and processes and
14 infrastructure that allows one to learn and move
15 ahead from a -- structured experiences and
16 processes that I think occurs at all levels and
17 the robustness stuff that often will affect
18 whether an entity is able to actually do what
19 they say they're going to do, even sometimes when
20 they want to do it but doesn't have the
21 resources.

22 MEMBER BERNHEIM: I think I may have

1 confused you because I may have credited to Kevin
2 that maybe was mis-credited. So I was -- that
3 concept of sort of --

4 CO-CHAIR PONCE: Was different, yes.

5 MEMBER BERNHEIM: -- yes, of quality
6 improvement and learning from different
7 institutions about addressing these issues, I was
8 not trying to lump --

9 (Simultaneous speaking.)

10 CO-CHAIR PONCE: So that's a separate
11 QI, yes.

12 MEMBER BERNHEIM: Right, it was --
13 people brought up these issues of how -- the
14 composition of communities, the segregation of
15 communities, both of the individuals within the
16 community -- Nancy, was that you? I'm sorry.
17 Now, I don't remember who said it. But I was
18 just saying that to me is as important,
19 understanding how patients and persons and
20 families are grouped and not just the
21 individuals, that that's part of data collection.
22 And similarly how populations feed into

1 hospitals. So understanding the composition of
2 populations as part of the data piece.

3 (Simultaneous speaking.)

4 CO-CHAIR PONCE: And the social
5 capital of patients, too.

6 MEMBER BERNHEIM: Yes, exactly.

7 CO-CHAIR PONCE: Emilio?

8 MEMBER CARRILLO: It's been mentioned,
9 but I don't see it in -- sort of in this
10 splitting process, patient experience, which is
11 an important measure established and something
12 that we should look at.

13 CO-CHAIR PONCE: Right, I think
14 Susannah said that earlier, too.

15 MEMBER CARRILLO: Yes.

16 CO-CHAIR PONCE: So we should make
17 sure we have patient experience.

18 I think the longer we go, we're going
19 to become more splitters.

20 (Laughter.)

21 CO-CHAIR CHIN: So what we're thinking
22 in terms of -- okay, remind you of -- yes?

1 MEMBER HASNAIN-WYNIA: So I'm just
2 curious. So I'm looking at the third bullet, the
3 social risk factors, and wondering -- maybe I
4 missed the conversation on this, but what
5 happened to the cumulative structural
6 disadvantage, because those have very different
7 measurement, right? So I don't know why it's not
8 here.

9 DR. BURSTIN: Just those wound up
10 being sort of under the top level things on that
11 sheet. We didn't lose them. We just kind of --

12 MEMBER HASNAIN-WYNIA: Okay. All
13 right.

14 DR. BURSTIN: -- scribbled them on the
15 side.

16 MEMBER HASNAIN-WYNIA: Okay.

17 DR. BURSTIN: But again, I guess the
18 question back for you is if you focused on social
19 risk and data, would that be a potential sub-
20 domain that you would want to make sure you
21 capture?

22 MEMBER HASNAIN-WYNIA: I think so. I

1 mean, this was a recommendation in our group by
2 Lisa, and I think it really is a very important
3 measurement. Maybe it's the -- it's where we
4 want to make sure we're going in the future, so I
5 think it's important to include it as a sub-
6 domain.

7 CO-CHAIR PONCE: Definitely.

8 CO-CHAIR CHIN: Thanks, Romana.

9 So where we're at now is that we have
10 -- we'd ask for public comments again so that --
11 give people the opportunity. What we're thinking
12 then is that it's been a long day. You guys have
13 been amazing. It's been a great discussion
14 today. Really far-ranging and I think really,
15 really fruitful.

16 We're going to -- I think the staff is
17 immediately after going to take a crack at trying
18 to collapse down to an abbreviated set of domain
19 categories. If anyone wants to join us, they're
20 welcome.

21 Then tomorrow, like on the agenda --
22 so we have it what, starting at 9:00, I believe.

1 Breakfast at 9:00. You'll see that at 9:45 the
2 original item was to update the conceptual model
3 framework. This is the one that -- this is the
4 slide that has like the measurement cycle circle
5 at the top and then you have like -- then like
6 policy actions you can take and then outcomes at
7 the bottom.

8 We're thinking as opposed to doing
9 that, which some people seemed to think was in
10 pretty good shape as it, replacing that then
11 spending an hour then going over the strawman
12 that staff comes up with tonight so that we get
13 another crack at it here in the in-person
14 meeting. I think we have more opportunities on
15 the phone and by email, but that will give us
16 another hour in person to really get pretty far
17 along with it, probably, so that by the end of
18 that hour then we're probably going to be in
19 pretty good shape then for staff to develop
20 further.

21 Anything else, Erin? Okay. Go ahead,
22 Erin.

1 MS. O'ROURKE: So just to get back a
2 little time, if people would be amenable to --
3 we'll start breakfast at 8:30 and we'll actually
4 start the meeting at 9:00 to get a little more
5 time so that we can cover some of the work we
6 wanted to do around defining the domains
7 precisely and then starting to think of measure
8 concepts. I don't know that we need to go all
9 the way into prioritization, but to at least
10 spend some time with the Committee getting
11 concepts on the table.

12 So if we could, I think we'll take
13 public comments and adjourn for now. There will
14 be details on the dinner before we do that. And
15 then please come back at 8:30 for breakfast and
16 we'll start promptly at 9:00.

17 CO-CHAIR PONCE: We're open for public
18 comments on the phone.

19 OPERATOR: If you would like to make
20 a public comment, please press star, one.

21 (Pause.)

22 OPERATOR: And there are no public

1 comments at this time.

2 CO-CHAIR CHIN: Thank you. And we're
3 open for public comments for those who have
4 joined us in the room.

5 DR. UCHENDU: Uchenna Uchendu,
6 Department of Veterans Affairs, Office of Health
7 Equity. Just want to say this is great work, but
8 just the discourse today has been very
9 heartwarming, and I appreciate the opportunity
10 also to join one of the brainstorming groups and
11 the discussion. I'm looking forward to the
12 product of this work. The definitions definitely
13 will be very important, that we are talking about
14 the same thing, because there's a lot of activity
15 in the health equity space and population health.
16 And a few of the words get thrown together and
17 sometimes we lose sight.

18 And then the other piece would be
19 taking into account the political climate and all
20 the discourse that's going around in the country.
21 How do you delicately enough make this continue
22 to be relevant, but also model the inclusion that

1 we are working toward in health equity.

2 CO-CHAIR PONCE: Thank you. Thank
3 you, Uche.

4 I believe we can adjourn at this
5 point. Thank you for all your hard work.

6 (Whereupon, the above-entitled matter
7 went off the record at 4:45 p.m.)
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Before: NQF

Date: 03-27-17

Place: Washington, DC

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